

Enclosure 3

**PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE
PLAN FACE SHEET**

Form No. 1

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

County Name: Fresno County	Date: 07/07/2009
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COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):

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AUTHORIZING SIGNATURE

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

Signature 
County Mental Health Director

07/07/2009
Date

Executed at Fresno, California

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Abbreviation	Definition
ADAB	Alcohol and Drug Advisory Board
ADHD	Attention Deficit Hyper Disorder
AHTA	American Horticultural Therapy Association
API	Asian- Pacific Islander
ASQ/SE	Ages and Stages Questionnaire/Social Emotional
BEP	Behavior Education Program
BOQ	Benchmark of Quality
C/Y	Children and Youth
CBO	Community Based Organization
CCA	Central California Alliance
CDC	Center for Disease Control
CHW	Community Health Worker
CIS	Crisis Intervention Services
CIT	Crisis Intervention Team
CPS	Child Protective Services
CSS	Community Supports and Services
CSU	California State University
CYS	Comprehensive Youth Services
DBH	Department of Behavioral Health
DCFS	Department of Children and Family Services
DMH	Department of Mental Health
DPH	Department of Public Health
DSH	Deliberate self-harm
EI	Early Intervention
EMT	Emergency Medical Technician
EPSDT	Early Periodic Screening, Diagnosis and Screening
EPU	Exceptional Parents Unlimited
FBO	Faith Based Organization
FCOE	Fresno County Office of Education
FIRM	Fresno Interdenominational Refugee Ministries
FIT	Families in Transition
FQHC	Federally Funded Health Centers

FTE	Full Time Employee
FUSD	Fresno Unified School District
GSA	Gay-Straight Alliance
GSD	General System Development
HIV	Human Immuno-Deficiency
IEP	Individualized Education Plan
IT	Information Technology
LCSW	Licensed Community Social Worker
LGBTQ	Lesbian, Gay, Bi-sexual, transgender and questioning
LVN	Licensed Vocational Nurse
MH	Mental Health
MHA	Mental Health America
MHB	Mental Health Board
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission
MOU	Memorandum of Understanding
NAMI	National Alliance on Mental Illness
NFP	Nurse Family Partnership
NRC	Neighborhood Resource Center
OAC	Oversight and Accountability Commission
OCD	Obsessive Compulsive Disorder
ODR	Office Discipline Referrals
PBIS	Positive Behavior Intervention and Supports
PCIT	Parent-Child Interaction Therapy
PEI	Prevention and Early Intervention
PFLAG	Parents, Family and Friends of Lesbians and Gays
PHQ-9	Patient Health Questionnaire (no.9)
PTA	Parent Teacher Association
PTSD	Post-Traumatic Stress Disorder
RFP	Request for Proposal
RJ	Restorative Justice
RN	Registered Nurse
RtI ²	Response to Instruction and Intervention
S.A.R.T	Screening, Assessment, Referral and Treatment

SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SAS	Substance Abuse Services
SED	Serious Emotional Disturbance
SELPA	Special Education Local Plan Area
SET	School-wide Evaluation Tool
SMART	Screening, Making a Decision, Assessment, Referral, and Treatment
SMI	Serious Mental Illness
SOS	Survivors of Suicide
SPAN	Sierra Peoples Action Network
SWIS	School-wide Information System
SWPBS	School-wide Positive Behavior Supports
TAY	Transition Aged Youth
TBD	To Be Determined
UCSF	University of California San Francisco
WET	Workforce Education & Training

I. BACKGROUND

The intent of the PEI strategies is to engage persons prior to the development of serious mental illness or serious emotional disturbances, or, in the case of early intervention, to alleviate the need for additional mental health treatment and/or to transition to extended mental health treatment.

PEI funding is to be used to achieve specific PEI outcomes for individuals, programs/systems and communities. PEI funding may support relatively short duration and low intensity approaches to achieve intended outcomes, *not* for filling gaps in treatment and recovery services for individuals who have been diagnosed with a serious mental illness or serious emotional disturbance and their families.

Exception for Early Onset of a Serious Psychiatric Illness with Psychotic Features: The standards of low intensity and short duration do not apply to services for individuals experiencing early onset of a serious psychiatric illness with psychotic features that receive this type of transformational intervention.

Fresno County will be allocated approx. \$6.5 million per year, plus unspent PEI Project funds,. MHSAs administration will allocate approximately \$3.6 million for the prudent reserve, per DMH Information Notice 09-16. Approximately 13% of the budget will be used for administrative costs. Additionally, PEI related activities will be funded through DMH Information Notice 08-37 and will be included in a separate request. The following funding parameters were established in accordance with State DMH guidelines and local directives:

- All ages must be served
- At least 51% of the overall PEI budget must be targeted to individuals age 0-25
- Disparities in access to services for underserved ethnic communities that were not well funded through CSS due to their lower utilization of mental health services must be addressed
- All regions of the County must have access to services, with special focus on un-served and underserved areas of Fresno County

II. COMMUNITY PLANNING PROCESS

Our local planning process was designed to elicit input from numerous and diverse stakeholders especially consumers, family members and members of underserved ethnic and language groups:

- Over 1600 community members participated in 7 large community input meetings, 26 focus group meetings in every region of the County, 6 community educational meetings, and 2 Surveys (Survey A, 96 respondents, Survey B, 954 respondents) over the course of 12 months (January, 2008 through beginning of December, 2008).
- The Planning Panel, comprised of 6 sub-committees, called *Working Groups*, coded and analyzed community input data from surveys and focus groups, and developed 12 priority strategies, over the course of two months of weekly meetings.
- The entire Planning Panel met 5 times throughout the Working Group Process, once at the beginning, twice throughout, and once to prioritize the strategy recommendations. A final meeting will be scheduled to review the entire plan during the 30-day public review process.
- The community stakeholders, with strong representation from consumers/families, and diverse un-served and underserved community representatives, drafted and reviewed the 12 strategies and directed MHSA staff to design programs with full budget information for 12 strategies.
- Consumers and their families were vital in the Community Input Phase and represent approximately 30% of the Planning Panel and working group participants. Three focus groups were specifically made up of consumers. Approximately 37% of survey responses were from consumers, while another 9.6% were family members, and 6.3% declined to self identify. Consumers and family members actively participated in drafting all strategy recommendations.

III. PROGRAMS

*PEI Programs are required to address one or more of the following Community Mental Health Needs:

1. **Disparities in Access to Mental Health Services:** reduce disparities in access to early mental health interventions due to stigma, lack of knowledge about mental health services or lack of suitability (i.e., cultural competency) of traditional mainstream services
2. **Psycho-Social Impact of Trauma:** reduce the negative psycho-social impact of trauma on all ages
3. **At-Risk Children, Youth and Young Adult Populations:** increase prevention efforts and response to early signs of emotional and behavioral health problems among specific at-risk populations
4. **Stigma and Discrimination:** reduce stigma and discrimination affecting individuals with mental illness and mental health problems
5. **Suicide Risk:** increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide

As shown in Table 1.1, many of the PEI Projects were developed to address the specific cultural needs of underserved age and ethnic groups. It is the intent of the staff at Fresno County MHSA that the PEI Projects will also support additional high need groups who may be inappropriately served by the mental health system, including the physically disabled and lesbian, gay bisexual, transgender, and questioning (LGBTQ) communities.

Table 1.1 Proposed Prevention and Early Intervention Programs

Program	Program Description	Mental Health Needs	Approx. annual unduplicated clients served	Annual PEI Budget
Integration of Primary Care and Mental Health Services at Federally funded Rural, Native American or Community Clinics for Indigent Care	This project will colocate mental health prevention and early intervention screening, short term services for individuals presenting in the early manifestation of mental illness, and provide referrals to appropriate services, as needed	Disparities	2,000 individuals	\$579,612
Cultural-based Access-Navigation Specialists (CHW) and Peer Support	This project develops community healthcare outreach workers (CHW) employed by community organizations and features a culture-specific peer support	Disparities	2,000 individuals 1,600 families	\$338,728
		Trauma		
Peri-Natal Prevention and Early Intervention Program for Pregnant/Parenting Women and their Infants	This project includes outreach, early identification through screening, assessment, and referral to mental health services for pregnant and parenting women and their infants.	Trauma	360 individuals/families	\$626,948
		At-Risk C/Y		
Schools-based Prevention and Intervention Program for Kindergarten through Eighth Grade	This project will incorporate a three-tiered integrated approach emphasizing Primary Prevention, Secondary Prevention, and linking to Tertiary interventions (specialized, individualized systems for students with high-risk behavior).	Disparities	3,750	\$338,728
		At-Risk C/Y		
Horticultural Therapeutic Community Center as Neighborhood Resource Center and Community Site for Peer Support	This project provides culturally appropriate community centers that serve as NRCs for peer support; for CHW outreach and engagement with trusted individuals from community.	Disparities	1,500 individuals and families	\$135,490
		Trauma		
		Stigma		
		Suicide		
First-Onset Consumer and Family Support 6a	This project will help individuals experiencing first onset of SMI through wrap-around services from the crisis through recovery process (up to 180 days) to reduce incidence of decompensation.	Disparities	110 Individual/Families	\$968,119
		Stigma		
		Suicide		

Program	Program Description	Mental Health Needs	Approx. annual unduplicated clients served	Annual PEI Budget
First-Onset Consumer and Family Support 6b	This project will host a UCSF educational seminar on scientific advances in the understanding of psychosis and early onset signs in the prodromal phase. A one-time cost of approximately \$7,800.00.	Disparities Stigma Suicide	400 individuals and families	see above
Crisis Intervention	This project provides crisis intervention training for first responders at mental health crisis access points to ensure the best way to transfer an individual from site of crisis to appropriate mental health triage.	Stigma Suicide	500	\$220,969
The Center	This part of the PEI process would move CSS funded programs or components of programs that are prevention and early intervention by definition and pay for them through MHSAs Prevention and Early Intervention funds	Disparities At-Risk C/Y Stigma	1,200 individuals	\$1,005,436
Team Decision Making	This part of the PEI process would move CSS funded programs or components of programs that are prevention and early intervention by definition and pay for them through MHSAs Prevention and Early Intervention funds	Disparities At-Risk C/Y Stigma	315 individuals	\$471,297
Outreach and Engagement	This part of the PEI process would move CSS funded programs or components of programs that are prevention and early intervention by definition and pay for them through MHSAs Prevention and Early Intervention funds	Disparities At-Risk C/Y Stigma	2,400 individuals	\$566,906
Functional Family Therapy	This part of the PEI process would move CSS funded programs or components of programs that are prevention and early intervention by definition and pay for them through MHSAs Prevention and Early Intervention funds	Disparities At-Risk C/Y Stigma	210 individuals and families	\$544,581

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

County: FRESNO

Date: June 11, 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

- Giang Nguyen, Department of Behavioral Health, Director
- Catherine Huerta, Department of Children and Family Services, Director
- Donna Taylor, Department of Children and Family Services, Assistant Director

Supported by the **MHSA Planning Team:**

- James A. Ritchie, Ph.D., MHSA PEI Community Facilitator
- Karen Markland, MHSA, Division Manager
- David Tijerina, MHSA, Program Technician
- Cathy Charves, MHSA, Program Technician
- Rachel Ebrahimzadeh, MHSA, Office Assistant
- Patricia Riederer, MHSA, Office Assistant
- Preet Sanghera, MHSA, Senior Staff Analyst
- Francisco Escobedo, MHSA, Staff Analyst

b. Coordination and management of the Community Program Planning Process

The **MHSA Project Management Team (PMT):**

- Giang Nguyen, Department of Behavioral Health, Director
- Catherine Huerta, Department of Children and Family Services, Director
- Donna Taylor, Department of Children and Family Services, Assistant Director

- Karen Markland, MHSA, Division Manager
- James Ritchie, Ph.D., MHSA, PEI Community Facilitator
- Supported by the **MHSA Planning Team** (as listed above)

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

The **MHSA Project Management Team** and **MHSA Planning Team** strictly adhered to the MHSOAC guidelines and provided significant outreach, incentives, translation, transportation, Fresno County MHSA website on PEI for updates, data, and guidelines to authentically ensure opportunities for participation by representatives and/or all stakeholders, and populations of Fresno County. Additionally, MHSA staff conducted this process in the open and with maximum transparency.

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

a. Included representatives of un-served and/or underserved populations and family members of un-served/underserved populations

The MHSA Planning Team worked with other Fresno County DBH and DCFS staff, Fresno County Mental Health Board Members and the Fresno County Board of Supervisors to implement an expansive outreach effort to educate members of the community and include them at each stage of the planning process. Efforts were made to provide targeted outreach to groups traditionally underserved by the mental health system and provide opportunities for their meaningful participation throughout the planning process. The process included the engagement of diverse local stakeholders, including those from required strategic sectors, systems and organizations.

Members of the community were encouraged to become involved in the PEI Planning Process in a variety of ways. They were invited to participate in Public Stakeholder Meetings, complete the Community Survey, develop and participate in focus groups, sit on the PEI Planning Panel, draft PEI strategies through the Planning Panel working groups, and vote on the priority ranking of the PEI draft strategies. These opportunities for participation were planned and advertised in the following ways:

- Invitations were sent to individuals, organizations, including schools, faith-based organizations, community-based organizations, mental health providers, primary care clinics and providers, consumer advocacy groups, and ethnic

advocacy organizations throughout the county in multiple languages, including Spanish, Hmong, and Lao using mailing lists and email list-servs.

- Kings View Corporation, a contracted MHPA agency for Fresno County Outreach and Engagement efforts worked with consumers/family members on community needs survey's, provided transportation for consumers/family members to PEI events/meetings, provided culturally diverse Parent Partner staff to assist with translations and dialogue with diverse communities, and provided food/refreshments and stipends to attend PEI events.
- Public Stakeholder Meetings were planned throughout geographically disperse areas of Fresno County to reach:
 - Migrant Workers, Undocumented, Latino, Punjabi, and Sikh populations on the western side of Fresno County
 - Rural and Native American populations in the foothills of the Sierra Nevadas on the eastern side of Fresno County
 - Urban and ethnic populations in Fresno metropolitan area, including Hmong, Native American, Latino, African American, Lao, and Khmer populations
- The Stakeholder Meetings were advertised using a variety of media:
 - Hmong radio stations *KQEQ* and *KBIF*
 - Latino media, including *Radio Bilingue* and *Univision*
 - Public radio, including *Fresno State KFSR*, *KFCF*
 - Commercial radio, including *Clear Channel Communications*, and *KJWL*
 - Advertisements in local newspapers throughout the county
 - Strategically distributed flyers announcing local Stakeholder Meetings
 - Made significant efforts to include individuals from the LGBTQ community. Staff attended the LGBTQ Social Work event, requested survey responses, key informant interviews, and made multiple phone calls to/spoke with individuals from PFLAG, CCA, Breaking the Silence, Youth Alliance, Wesley United Methodist Church, GSA Network, NCLP, and CYC
- PEI focus groups targeting un-served and underserved populations were planned and conducted with the help of several calls for focus groups which were posted and sent to various organizations and providers who specifically work with these populations
- Additionally, information was obtained from underserved communities through the completion of two PEI Community Surveys. There were 1050 individuals who responded to these surveys

Planning Phase I: Community Input Phase

This initial outreach and education phase began in January, 2008 with six (6) initial MHSA PEI educational meetings, which engaged approximately 60 individual stakeholders plus additional MHSA, DBH, and DCFS staff members, and at which we presented PEI goals and funding guidelines to diverse stakeholders. In addition to the educational meetings, the Community Input Phase of PEI planning involving stakeholders, consumers, advocates, and individuals from various un-served and underserved communities was begun on August 21, 2008 and continued through early December, 2008. Six Stakeholder meetings, engaging approximately 150 individuals also took place. These meetings also provided an opportunity for individuals to provide input on the mental health needs of their community, potential sites at which prevention and early intervention projects would be beneficial, the types of prevention and early intervention programs that they wanted, and identifying the prevention and early intervention activities in their community that could possibly be expanded or leveraged. Surveys in English, Spanish, and Hmong were distributed and collected at each of the Stakeholder Meetings. Real-time translation for Hmong and Spanish speakers was offered at each of these meetings. Information was also obtained from un-served and underserved communities through the distribution and collection of two PEI Community Surveys. There were 1050 who responded to these surveys from a diverse population (see Table 1.2). As a result of some of the difficulties in collecting surveys from various ethnic and linguistically diverse communities due to a number of reasons which include illiteracy, distrust, and disinterest, 26 focus groups were developed through a formal call for focus groups through various organizations and community partners (see Table 1.3 for specific focus groups). Seven (7) Community Meetings were also attended as opportunities to present MHSA PEI information and collect community input.

Figure 1.1 Illustration of PEI Planning Process

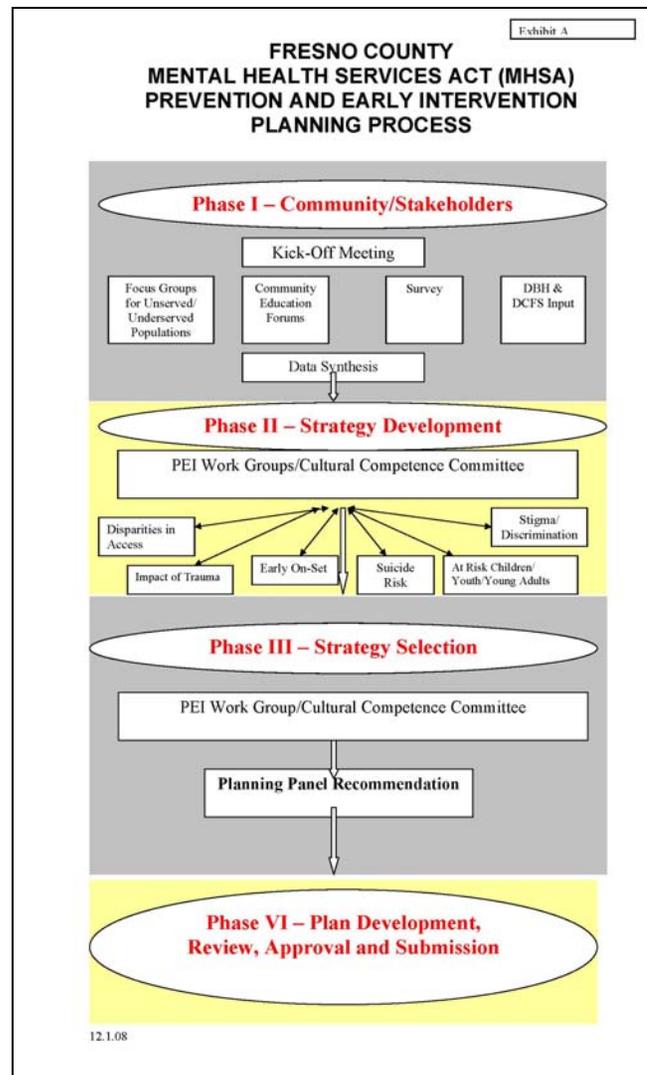


Table 1.2 Ethnic breakdowns of survey respondents

	Survey A	Survey B
Latino	36.4%	33.5%
Asian/Pacific Islander	0.7%	4.7%
African American	13.3%	8.5%
Native American	3.7%	4.2%
White, non-Hispanic	45.7%	41.5%
Consumers/Family	-	46.5%
Declined to respond	16.3%	7.3%
Total Number of Individuals	419	954
No. of individuals who did not answer the demographics question	14	94

In order to elicit information from individuals within specific underserved groups who felt more comfortable in a smaller setting, 26 focus group discussions of twenty or fewer people were held throughout the County among a variety of populations (shown in Tables 1.4). Specific information about the types and dates of meetings is also shown in Table 1.3.

Figure 1.2 MHSA PEI Stakeholder Brochure

Priority Populations
www.co.fresno.ca.us/mhsa

Priority Populations

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

PEI OBJECTIVES

- To increase capacity for mental health prevention and early intervention programs
- At sites where people currently go for purposes other than mental health treatment services.
- Potential program participants and their families involved in planning, implementing and evaluating PEI programs.
- Designed and implemented in collaboration with other systems and/or organizations.
- Programs will be delivered in a natural community setting
- Awareness that poverty and other environmental and social factors impact wellness

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Next Steps

- Focus Groups, and Face-to-Face Interviews to be completed by 11/15/08
- To schedule a focus group, call 559.452.3472
- Distribute surveys and post results to MHSA website by 11/15/08
- Gather focus group chairpersons and establish a writing group, which will:
 - Review community input and
 - Draft strategy recommendations
 - Complete recommendations by 12/20/08
- Announce applications for Planning Panel by 11/26/08

PEI FUNDING

- To achieve specific PEI outcomes for individuals, programs/systems and communities
- To reduce risk factors or stressors, build protective factors and skills
- Low intensity intervention appropriate to measurably improve mental health problems or concerns
- *Not* for filling gaps in treatment and recovery services for individuals who have been diagnosed with a serious mental illness
- Exception for Individuals Experiencing At Risk Mental State (ARMS) or First Onset of a Serious Psychiatric Illness with Psychotic Features



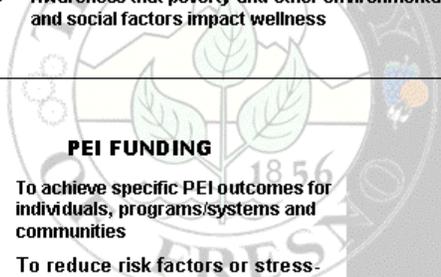
Mental Health Services Act



Prevention & Early Intervention Community Planning



Mental Health Services Act
5108 E. Clinton Way, Ste. 108, Fresno, CA 93727



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PEI Planning 2008

www.co.fresno.ca.us/mhsa

www.co.fresno.ca.us/mhsa

PEI Planning Process

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

Early Intervention is directed toward individuals and families for whom a short duration (usually less than 1 year), relatively low intensity intervention is appropriate to measurably improve mental health problems or concerns. Early Intervention efforts can result in a reduced need for more extensive mental health treatment or services or prevent a problem from getting worse.

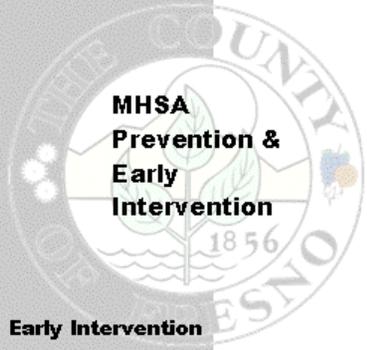
You are invited to share your ideas at our upcoming PEI Community Stakeholder Meetings. Your input will help design new, innovative programs that will address key community mental health needs:

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

Come to Stakeholder Meetings to learn about state PEI guidelines and provide input on what our local priorities should be. The meetings are:

- ❖ OPEN TO THE PUBLIC!
- ❖ FREE!
- ❖ AT A LOCATION NEAR YOU!

Smaller Focus Groups are also being planned. Contact us at 559.452-3460 if you or your organization would like to attend or host a Focus Group of 20 people or less.



Community Stakeholder Meetings

- KERMAN COMMUNITY CENTER**
15101 W. Kearny, Kerman, CA 93630
Tuesday, October 21, 2008
6:30-8:30 pm
- REEDLEY COLLEGE**, Reedley, Ca 93654
Social Sciences Bldg. Rm 32
Wednesday, October 22, 2008
2:00-4:00 pm
- COALINGA COUNCIL CHAMBERS**
155 W. Durian, Coalinga, Ca 93210
Thursday, October 23, 2008
1:00-3:00 pm
- SIERRA OAKS SENIOR CENTER**
33276 Lodge Road, Tollhouse, Ca 93667
Tuesday, Oct. 28, 2008
6:00-8:00 pm
- SELMA REGIONAL CENTER**
3880 N. McCall, Selma, Ca 93662
Thursday, October 30, 2008
10:00 am - 12:00 pm

PEI Planning 2008



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www.co.fresno.ca.us/mhsa

Table 1.3 Phase I: Community Input Meetings

Date	Type of Meeting	Location
8/21/2008	MHSA PEI Kick Off Roundtable	Fresno
9/8/2008	Community Stakeholder Meeting	Fresno
9/18/2008	Metro Ministries Health Care Roundtable	Trinity Lutheran Church
9/23/2008	Mendota City Council Meeting	Mendota
9/26/2008	Native American Day at Fresno City College	Fresno City College
10/2/2008	LGBTQ Fair for Social Workers	Fresno
10/7/2008	DCFS Clinical Supervisor's Meeting	Heritage Centre, Fresno
10/12/2008	Sanger Community Health Fair	Centro La Familia/Sanger
10/21/2008	Community Stakeholder Meeting	Kerman
10/22/2008	Community Stakeholder Meeting	Reedley
10/23/2008	Community Stakeholder Meeting	Coalinga
10/28/2008	Community Stakeholder Meeting	Tollhouse
10/29/2008	Change Agent Meeting	Westcare
10/30/2008	Community Stakeholder Meeting	Selma
11/6/2008	Planning Panel (Kick Off)	UC Center
11/14/2008	Interagency Collaborative Meeting	FCOE
11/20/2008	Planning Panel	UC Center
12/18/2008	Planning Panel	Alliant
1/23/2009	Planning Panel Workshop	Manchester
2/6/2009	Planning Panel (Strategy Prioritization)	Elections Office
TBD	Planning Panel (3-Year PEI Plan Review)	TBD

Table 1.4 Phase I: Focus Groups

DATE	TYPE	NAME
10/14/2008	Focus Group	Trauma Exposed (Blue Sky)
10/15/2008	Focus Group	Native American Gathering up at Haslett
10/21/2008	Focus Group	Cultural Issues and Consumers (Blue Sky)
10/28/2008	Focus Group	Hmong At-risk Children and Youth (Lao Family Center)
10/28/2008	Focus Group	Seniors Issues (Blue Sky)
11/5/2008	Focus Group	Co-Occurring
11/6/2008	Focus Group	Babies First
11/7/2008	Focus Group	S.A.R.T
11/8/2008	Focus Group	Substance Abuse (UC Center)
11/10/2008	Focus Group	Youth in Juvenile Justice (Girls) (Juvenile Justice Center)
11/11/2008	Focus Group	Teen Success (Planned Parenthood-Marmonte)
11/12/2008	Focus Group	Spanish-speaking Parents (Mendota)
11/13/2008	Focus Group	West Fresno Health Care (Fresno)
11/17/2008	Focus Group	Fresno County Office of Education
11/18/2008	Focus Group	Sierra Peoples Action Network (SPAN) (Tollhouse)
11/18/2008	Focus Group	Youth in Juvenile Justice (Boys) (Juvenile Justice Center)
11/19/2008	Focus Group	First 5, DCFS (DCFS)
11/20/2008	Focus Group	Faith-based (United Christian Church)
11/25/2008	Focus Group	Boys/Girls Club (Pinedale)
12/3/2008	Focus Group	EPU-Consumers
12/5/2008	Focus Group	FIRM Hmong Families (in Hmong)
12/5/2008	Focus Group	Spirit of Women
12/9/2008	Focus Group	Survivors of Suicide
12/10/2008	Focus Group	EPU-Staff
12/11/2008	Focus Group	Early Head Start
12/16/2008	Focus Group	Sikh/Punjabi-Kerman

Individuals from un-served and underserved communities within Fresno County were educated about MHSA Prevention and Early Intervention and given opportunities to provide input through various community meetings, focus groups, and stakeholder meetings. Surveys were also distributed and collected at each of these meetings and distributed and collected through community partners and contracted vendors. Data from the meetings and surveys was collected, organized, compiled and coded to facilitate the strategy development phase of the Planning Process.

Planning Phase II: Strategy Development

The MHSA Planning Team identified a large number of individuals representing various interests, organizations, and diversity to be invited to join the MHSA PEI Planning Panel. In all, 219 individuals were invited on the PEI Planning Panel. Those included individuals who (1) appropriately represented the DMH Required and Recommended Sectors, including consumers and their families for participation, (2) represented a broad range of ethnic diversity, and (3) represented the distinct geographic regions of the County. In all, 148 actually participated to varying degrees.

At its first meeting the Planning Panel decided to split into six subcommittees, called *Working Groups*. Each Working Group represented the *five key mental health needs* plus a sixth Working Group to address the *first onset of serious mental illness*. Each Planning Panel Working Group was charged with drafting PEI strategy recommendations based on the community input from Phase 1 of the PEI Planning Process. Each Working Group met weekly for two and a half months. The first several meetings were devoted to coding the focus group responses for three parameters: *priority populations, key mental health needs, and age groups*. Each Planning Panel Working Group developed its own structure for decision making and identifying priority strategies within the allocated timeframe.

Fresno County's unique cultural, ethnic, racial, and linguistic make-up requires different strategies to deal with that diversity. For example, Fresno County has one of the largest Hmong populations in North America. Linguistic and cultural barriers to mental health services are unique in that many adults and certainly older adults in the Hmong communities are illiterate. Moreover, linguistic barriers within the dialects of Hmong (Green Hmong and White Hmong) prevent simple translation of existing mental health jargon and definitions. Additionally, transportation and cross-cultural trust issues present additional barriers to access. As a result, other means of communication, including radio spots, reading of surveys and collection of survey responses for illiterate individuals, and travel to where the un-served and underserved individuals naturally go were among the strategies included in the process.

The Latino population in Fresno County also presents some unique challenges that require specific strategies. For example, a strategy that appropriately addresses the documented Latinos will not work for undocumented Latino migrant workers in the western parts of the County. There are also migrant groups from Mexico that are not Latino, but First Americans, such as the Mixteco and Zapoteco. These communities do not speak Spanish, are undocumented, and have

additional challenges that other undocumented individuals from Mexico or Latin America do not have. They have many of the same types of linguistic challenges that are seen in the Hmong communities.

Table 1.5 Phase II: Working Group Meetings

DATE	TYPE	PLACE
11/14/2008	At Risk Children, Youth and Young Adult	MHSA
12/5/2008	At Risk Children, Youth and Young Adult	DCFS
12/12/2008	At Risk Children, Youth and Young Adult	DCFS
12/19/2008	At Risk Children, Youth and Young Adult	DCFS
1/2/2009	At Risk Children, Youth and Young Adult	DCFS
1/9/2009	At Risk Children, Youth and Young Adult	DCFS
1/16/2009	At Risk Children, Youth and Young Adult	DCFS
1/23/2009	At Risk Children, Youth and Young Adult	DCFS
1/29/2009	At Risk Children, Youth and Young Adult	DCFS
11/17/2008	Psycho Social Impact of Trauma	Genesis
11/18/2008	Psycho Social Impact of Trauma	MHSA
12/1/2008	Psycho Social Impact of Trauma	DCFS
12/15/2008	Psycho Social Impact of Trauma	DCFS
12/22/2008	Psycho Social Impact of Trauma	DCFS
12/29/2008	Psycho Social Impact of Trauma	DCFS
1/26/2009	Psycho Social Impact of Trauma	DCFS
2/2/2009	Psycho Social Impact of Trauma	DCFS
12/5/2009	Psycho Social Impact of Trauma	DCFS
12/12/2009	Psycho Social Impact of Trauma	DCFS
11/18/2008	Suicide Risk	MHSA
12/2/2008	Suicide Risk	DCFS
12/16/2008	Suicide Risk	DCFS
12/30/2008	Suicide Risk	DCFS
1/6/2009	Suicide Risk	DCFS
1/13/2009	Suicide Risk	DCFS
1/20/2009	Suicide Risk	DCFS
2/3/2009	Suicide Risk	DCFS
11/10/2008	Disparities in Access	MHSA
11/17/2008	Disparities in Access	Genesis
12/8/2008	Disparities in Access	Genesis

DATE	TYPE	PLACE
1/13/2009	Suicide Risk	DCFS
1/20/2009	Suicide Risk	DCFS
2/3/2009	Suicide Risk	DCFS
11/10/2008	Disparities in Access	MHSA
11/17/2008	Disparities in Access	Genesis
12/8/2008	Disparities in Access	Genesis
12/15/2008	Disparities in Access	Genesis
12/22/2008	Disparities in Access	Genesis
12/29/2008	Disparities in Access	Genesis
1/5/2009	Disparities in Access	Genesis
1/12/2009	Disparities in Access	Genesis
1/26/2009	Disparities in Access	Genesis
2/2/2009	Disparities in Access	Genesis
12/19/2008	First Onset of Mental Illness	Blue Sky
12/26/2008	First Onset of Mental Illness	Blue Sky
1/2/2009	First Onset of Mental Illness	Blue Sky
1/9/2009	First Onset of Mental Illness	Blue Sky
1/16/2009	First Onset of Mental Illness	Blue Sky
1/22/2009	First Onset of Mental Illness	Blue Sky
11/13/2008	Stigma and Discrimination	MHSA
11/20/2008	Stigma and Discrimination	Blue Sky
12/4/2008	Stigma and Discrimination	Blue Sky
12/11/2008	Stigma and Discrimination	Blue Sky
12/23/2008	Stigma and Discrimination	Blue Sky
12/30/2008	Stigma and Discrimination	Blue Sky
1/6/2009	Stigma and Discrimination	Blue Sky
1/13/2009	Stigma and Discrimination	Blue Sky
1/20/2009	Stigma and Discrimination	Blue Sky
1/27/2009	Stigma and Discrimination	Blue Sky
2/3/2009	Stigma and Discrimination	Blue Sky

Considerations and foci of the working groups were based on factors such as these. Specifically, the working groups reviewed, analyzed and discussed the results of the data collected in the first phase of the PEI planning. Local strategies were developed as a result of the experiences of consumers and families, experiences of representatives from un-served and underserved communities and/or expertise of advocates for these groups, and the expertise of various providers, organizations, community groups, and lay individuals who were part of each Working Group. These working groups presented strategy narrative and program descriptions to the larger Planning Panel for their feedback.

Table 1.6 Planning Panel Composition

Full Name	Organization
Barry Chong	Alliant
Debra Bekerian	Alliant
Laura Wass	American Indian Movement
Matthew West	Big Sandy Rancheria
Billie Hughes	Blue Sky
Donna Nunes-Croteau	Blue Sky
Jeff Gorski	Blue Sky
Karen Scott	Blue Sky
Cassandra Joubert	California State University at Fresno
Kabeljit Atwal	California State University at Fresno
Laura Tanner-McBrien	California State University at Fresno
Gary Easley	Carathurs Unified
Bao Thao	Central Cal Legal
Monica Blanco-Etheridge	Central Cal Legal
Bob Solis	Centro la Familia
Estela Lara	Centro la Familia
Margarita Rocha	Centro la Familia
Kevin D Hamilton	Clinca Sierra Vista
Naomi Sosa	Clinca Sierra Vista
Barbie Hansen	Clovis Unified
Janet Cooper	Clovis Unified
Mary Lou Brauti-Minkler	CMC
Alberto Casias	Community Member
Amber Benton	Community Member
Ana Meinzo	Community Member

Araceli Sanabria	Community Member
Carmen Pascual	Community Member
Catalina Leon	Community Member
Cormen Pascual	Community Member
Estrella Hernandez	Community Member
Gary L Clark	Community Member
Gayle Jamie Leland	Community Member
Gloria Barajas	Community Member
Gregory Fischer	Community Member
Guadalupe Leon	Community Member
Guadalupe Puentes	Community Member
Guillermina Buaista	Community Member
Guillermina Perez	Community Member
Ines Garcia	Community Member
Joy Lewis	Community Member
Kaye Fredrickson	Community Member
Luz Maria Gonzalez	Community Member
Mairselay Maravilla	Community Member
Maria Gonazalez	Community Member
Maria Mahzo	Community Member
Marisela Maravilla	Community Member
Mary Cervantes	Community Member
Matra Ponce	Community Member
Mayia Mahzo	Community Member
Michelle Torez	Community Member
Miley Hernandez	Community Member
Monica Ethel	Community Member
Norma Ventura	Community Member
Rose Ward	Community Member
Sarah McAcie	Community Member
Violeta Matinez	Community Member
Jacque Smith	Comprehensive Youth Services
Kathleen Mancebo	Comprehensive Youth Services
Colleen Gregg	DBH
Giang Nguyen	DBH
Tom Burket	DBH
Diana Barrera	DBH
Dennis Koch	DBH-SAS
Natasha Hagaman	DBH-SAS

Cathy Charvez	DCFS
David Miller	DCFS
Donna Taylor	DCFS
Francisco Escobedo	DCFS
Jeanie Cox	DCFS
Kris Wallace	DCFS
Monica Dhillon	DCFS
Nancy McCart	DCFS
Preet Sanghera	DCFS
Rachel Ebrahimzadeh	DCFS
Shanna Wilson	DCFS
Tricia Gonzalez	DCFS
Yuleen Al-Saoudi	DCFS
Laurie Misahi	DPH
Lisa Cardoza	DPH
Sandra Arakelian	DPH
Barbara Swan	Exceptional Parents Unlimited
Gladys Prado	Exceptional Parents Unlimited
Marilyn Brantford	Families First
Curt Thornton	Family member
David Swain	FCOE
Steve Gonzales	FCOE - SELPA
Melanie Y Vang	FIRM
Sophia DeWitt	FIRM
Lilith Assadourian	First 5
Nancy Pressley	Focus Forward
Paul Bezerra	Focus Forward
Erika Ireland	Fresno American Indian Health Project
Ger Thao	Fresno Center for New Americans
Ghia Xiong	Fresno Center for New Americans
Jeff H Xiong	Fresno Center for New Americans
Tom Thao	Fresno Center for New Americans
Cheryl Chancellor-Freeland	Fresno County EOC
Darla Beesom	Fresno County EOC

David Smith	Fresno County EOC
Steve Gonzalez	Fresno County EOC
Susan Bechara	Fresno County Mental Health Board
David Ruin	Fresno County Probation
Gorden Dahlberg	Fresno County Probation
Philip Kader	Fresno County Probation
Allisa Vasquez	FUSD
Bee Xiong	FUSD
Boun Xiong	FUSD
Lissa Vasquez	FUSD
Brian Conway	Genesis
Judith Calvo	Genesis
Hilary Chittick	Judge, Superior Court
Amy Tillery	Juvenile Behavioral Health Court
Alberto Ramirez	Kingsview
Bear Alexander	Kingsview
Elizabeth Gonzalez	Kingsview
Erica Ochoa	Kingsview
Irlanda Guzman	Kingsview
John Yang	Kingsview
Nicole Barksdale	Kingsview
Rebeca Rangel	Kingsview
Tou Moua	Kingsview
Yolanda Fernandez	Kingsview
Katie Quinn-Crask	Marjoree Mason Center
Christina Alejo	Mental Health America, The Rios Company
David Weikel	Mental Health America
Helen Siporin	Mental Health America and UACF
Juanita Fiorello	MHB
Ricky Miller	MHB-ADAB
David Tijerina	MHSA
Geoff Smith	MHSA
Gilda Zarate-Gonzalez	MHSA
James Ritchie	MHSA
Jim Ritchie	MHSA
Karen Markland	MHSA
Cynthia Wells	NAMI

Philip Traynor	Radio Bilingue
Kim Hazelton	Sierra Peoples' Action Network
Richard Cain	Sierra Peoples' Action Network
Leann Gouveia	SOS-Fresno
Tonya Archie	Vassar Home for Women
Cheryl Washington	West Fresno Healthcare Coalition
Darlene Holland	West Fresno Healthcare Coalition
Pat Mendoza	West Fresno Healthcare Coalition
Yolanda Randles	West Fresno Healthcare Coalition
Frank A. Torrez	Westcare
Suzanne Moineau	Westcare/Genesis
Albert Maldonado	Youth Leadership Institute

Planning Phase III: Strategy Prioritization

The draft strategy recommendations from the working groups were presented to the larger Planning Panel through a PowerPoint presentation. The strategy recommendations were fully explained and a significant amount of time was devoted to addressing questions from the Planning Panel members. After the Planning Panel members agreed to close the question and answer period at the Planning Panel meeting, the members were then provided four chits or lots that they could caste for their four highest priorities from the list of draft strategy recommendations for budgeting purposes. The rules were that 4 chits or lots could be caste any way a member chose. For example, a member could choose to place one chit or lot on four separate strategy recommendations or they could place all of them on one, or some other combination.

The draft strategy recommendations were prioritized by the sheer number of chits or lots caste for each project, which were then summed. A computerized graph was developed in real time showing the prioritized list of draft strategy recommendations, which was presented to the Planning Panel. For those Planning Panel members who were unable to attend the Planning Panel Meeting, an additional outreach effort was made via email and through community partners and contracted vendors for the purpose of providing these Planning Panel members an opportunity to caste their chits or lots for their four highest priorities. All Planning Panel members received notification of the finalized list.

Once the prioritized draft strategy recommendations were finalized, further programming details and draft budgets were developed. Some strategies, such as the CIT Training, were developed in the working groups under the assumption that specific additional funding was identified through DMH Information Notice 08-37, related to training, technical assistance and capacity building. The Planning Panel members were given a choice to either be allowed to caste their

chits for this project, among all the others, or to agree unanimously by voice vote that CIT Training is a priority community need. Since separate funding was identified for this program, it was overwhelmingly agreed that no chits should be caste for this program in view of that funding. Additionally, it was agreed unanimously with no objections that those programs or components of programs within the CSS plan that are prevention and early intervention by definition, should be moved out of CSS and funded through PEI in order to free up service funding in the CSS plan.

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.

According to the 2006 Census data, Fresno County has over 891,000 individuals. Fresno County is also geographically disperse with only one large metropolitan area, the City of Fresno. Fresno is also one of the poorest counties in the State and in the Nation. The primary regions of Fresno County are: The City of Fresno, the City of Clovis immediately northwest of Fresno, the western agricultural regions that include the Cities of Kerman, Mendota and Firebaugh in the northwest, the Cities of Coalinga and Huron in the southwest, the eastern foothills and mountains of the Sierra Nevada Range, including Tollhouse and Prather in the northeast and Squaw Valley in the southeast. The central region of Fresno County includes the Cities of Reedley, Selma, Fowler, Sanger, Kingsburg, Orange cove and Parlier. There are several unincorporated areas in western Fresno County, including Dos Palos, Del Rio, Biola, Tranquility, San Joaquin, Cantua Creek, Caruthers, Raisin City, and one unincorporated area, Pinedale, that exists immediately north of the City of Fresno. Approximately half the population of Fresno County resides within the City of Fresno.

Table 1.7 Populations of People of Color in Fresno County

	Latinos	Hmong/Lao	African American	Native American	White
Percent of Population	47.6%	8.5%	4.9%	0.6%	36.4%

Table 1.8 Poverty Rates for Ethnic Groups

	Latinos	Hmong/Lao	African American	Native American	White
Percent of	30.6%	38.5%	34%	34.3%	20.3%

Population					
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Table 1.9 Fresno County Age Demographics

Total population	886,074	100%
Male	446,024	50.3%
Female	440,050	49.7%
Under 5 years	76,605	8.6%
5 to 9 years	70,473	8.0%
10 to 14 years	73,619	8.3%
15 to 19 years	75,190	8.5%
20 to 24 years	74,671	8.4%
25 to 34 years	130,021	14.7%
35 to 44 years	117,713	13.3%
45 to 54 years	108,237	12.2%
55 to 59 years	40,866	4.6%
60 to 64 years	32,870	3.7%
65 to 74 years	43,085	4.9%
75 to 84 years	30,680	3.5%
85 years and over	12,044	1.4%
Median age (years)	30.1	

Table 1.10 Education Rates for Fresno County

Population 25 years and over	515,516	100%
Less than 9th grade	84,731	16.4%
9th to 12th grade, no diploma	59,063	11.5%
High school graduate (includes equivalency)	124,643	24.2%
Some college, no degree	112,408	21.8%
Associate's degree	37,747	7.3%
Bachelor's degree	66,708	12.9%

Graduate or professional degree	30,216	5.9%
Percent high school graduate or higher	72.1%	(X)
Percent bachelor's degree or higher	18.8%	(X)

Planning Phase 1: Community Input Phase

The PEI Community Input Phase, including surveys, focus groups, and stakeholder meetings engaged over 1600 individuals from diverse ethnic, age and geographical backgrounds. The engagement process closely resembled Fresno County’s demographics and attempted to represent the community at large. The Community Input Process was made up of approximately 45% Caucasians, 35% Latinos, 11% African American, 4% Native Americans and 4% Southeast Asian and Pacific Islander. In terms of age, 12 of the 26 focus groups were on topics that address gestation/birth through age 18, with five of those focus groups gathering responses directly from youth. The process was also geographically diverse; three meetings (2 focus groups and 1 Stakeholder Meeting) were held in the rural foothills of eastern Fresno County, seven meetings (3 focus groups, 3 Stakeholder Meetings, and 1 Community Meeting) held in rural west Fresno County, four meetings (2 focus groups, 1 Stakeholder Meeting, and 1 Community Meeting) in the rural south central area of Fresno County, and the remaining twenty-six meetings (18 focus groups, 2 Stakeholder Meetings, and 6 Community Meetings) in the metropolitan area around the City of Fresno and Clovis. One focus group was designed to specifically gather responses from older adults. Three focus groups were designed to specifically gather responses from consumers. Please note that sign-in sheets were explicitly prohibited as a condition of engaging the consumers at these focus groups, although the numbers of individuals who identified themselves as consumers at these focus groups was made available. In terms of gender, about 55% of the participants were female, 35% were male and 10% declined to state their gender.

In addition, the Community Input Process was made up of approximately 35% consumers, 30% providers of mental health services, 10% educators, 10% family members, 3% faith-based, and 1% law enforcement.

Planning Phase II: Strategy Development

The strategy recommendations developed in Phase II were the result of the outreach and engagement efforts to include participation of un-served and underserved populations who worked as full partners with other members of the Planning Panel working groups, which included representatives from the required community sectors. In terms of ethnicity, the Planning Panel working groups engaged members from various un-served or underserved communities as well as advocacy groups, community-based and/or faith-based organizations that specifically work with these populations. The un-served and underserved populations who participated in the Strategy Development Phase include Latinos, including

documented, undocumented, and naturalized and/or native English speaking, Hmong and other Southeast Asians, Native Americans, African Americans and LGBTQ. For the Latino communities, various community representatives and consumers, as well as representatives from advocacy groups such as Centro La Familia, Central California Legal Services, Radio Bilingue and Kings View Outreach and Engagement made up approximately 45% of the Planning Panel. For Hmong and other Southeast Asian communities, several community representatives, including representatives from advocacy groups, community- and faith-based groups, and public school officials, such as FIRM, Fresno Center for New Americans, Lao Family Center, Hmong Radios KQEQ and KBIF made up approximately 10% of the Planning Panel members. For the African American community, various representatives from the community and community-based organizations, including West Fresno Health Care Coalition made up only approximately 2% of the Planning Panel members. Significant trust issues between the African American community and government officials presented obstacles to greater participation. Specific outreach efforts were made to provide incentives for participation, establish connections through the advocacy of West Fresno Health Care Coalition, including several person to person meetings to establish that relationship. Additional unsuccessful efforts were repeatedly made to develop focus groups through faith-based organizations in the African American community. For the Native American communities, various tribal representatives and representatives from advocacy groups such as American Indian Movement, Fresno American Indian Health Project, Big Sandy Rancheria, Spirit Walk, Spiritual Leaders and Owens Valley Career Development Center made up approximately 5% of the Planning Panel members. The number of individuals who were from the LGBTQ community is not known since individuals were not required to disclose their sexual orientation. Several advocacy groups from the LGBTQ community were continuously invited to participate, including PFLAG, Central California Alliance, Breaking the Silence, and Project Male. Other members of the Planning Panel included individuals from the Sikh community, representatives from Islamic community, including representatives from the Islamic Cultural Center, and representatives for the First Americans from Mexico, namely Mixteco and Zapoteco, including representatives from the advocacy group Binacional and Radio Bilingue. All of the Planning Panel participants were adults. In terms of gender, approximately 65% of the Panel Members were female and 35% were male.

Planning Phase III: Strategy Prioritization

The Planning Panel included representatives from all County regions and all genders. The Planning Panel was also comprised of participants with expertise across all ages, including 0-5, grade-school age, middle-school age, high-school age, TAY, Adults and older Adults.

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

Fresno County proactively responded to the MHSA's mandate to involve consumers in all aspects of the MHSA, and in particular with the PEI planning. Participants in the Planning Process included; NAMI, Kings View, Mental Health America, United Advocates for Children and individual consumer advocates. Consumers and family members made up at least 30% of the Planning Panel. Moreover, 50% or three of the six weekly Working Group meetings held over the course of ten weeks were held at consumer centers, including Blue Sky Wellness Center and Genesis Family Center. Because of the geographic size of Fresno County and the need to hold consistent Working Group meetings, all of the Working Group meetings were scheduled to meet in the metropolitan area of the city of Fresno. Consumers and family members were transported to meetings through a contracted vendor (Kings View) and given incentives for participating in those meetings (including food, refreshments, and stipends). Moreover, the strategy recommendations that were drafted in the Planning Panel were consistently informed by consumers and family members. Many of the actual ideas originated from consumers. For example, one consumer, Mike, helped non-consumers in the Working Group on the First Onset of Serious Mental Illness understand specific post-crisis obstacles that negatively affected his recovery. Mike helped the Working Group develop a strategy recommendation for First Onset Consumer Support and he added specific language to address his concerns and experiences with the system. Similar consumer experiences were instrumental in developing other projects.

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

- a. Participation of stakeholders as defined in Title 9, California Code of Regulations (CCR), Chapter 14, Article 2, Section 3200.270, including, but not limited to:***
- Individuals with serious mental illness and/or serious emotional disturbance and/or their families***
 - Providers of mental health and/or related services such as physical health care and/or social services***
 - Educators and/or representatives of education***
 - Representatives of law enforcement***
 - Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families***

Please refer to Table 1.6 Planning Panel Composition, which includes detailed information about the diverse stakeholders involved in the process.

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

In an effort to educate the community regarding PEI guidelines and regulations, a series of educational sessions were planned and held (see Table 1.11). The goal of these was to educate the public about the community planning process and all of the MHSOAC PEI definitions, guidelines and regulations regarding PEI plan development and allowable uses of funding.

Table 1.11. PEI Educational Meetings

Prevention and Early Intervention	
Date/Time	Discussion Topic
1/10/08 @ 3:30 pm	MHSA Regulations
1/24/08 @ 3:30 pm	P&EI Guidelines
2/14/08 @ 3:30 pm	Needs Assessments
2/28/08 @ 3:30 pm	Evidence Based Practices
3/13/08 @ 3:30 pm	Planning Strategies/ Q & A
3/27/08 @ 3:30 pm	Planning Strategies/ Q & A

Additional training and education updates on the PEI planning guidelines were provided to stakeholders at each Planning Phase. The broad community received an overview of the planning guidelines during each of the seven Community Input Meetings, plus at all of the Community Meetings and at the 26 focus group discussions. The members of the Planning Panel and working groups received periodic overviews and discussions of the guidelines in their work on the Panel.

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 following paragraphs are provided through the CSS planning process de-briefing that was contracted out with Mental Health America. The de-briefing was used as a foundation for improving the community input and overall planning process for the three-year PEI plan. The following areas are highlighted in the de-briefing and re-introduced here:

Meaningful participation requires a common “language.”

It takes more than one meeting to communicate the complicated information about mental health services and new mental health programs to groups that are unfamiliar with mental health services and concepts. One of the first steps in mental health services outreach and engagement is assessing the level and depth of knowledge about these subjects that the target audience has. There is an inverse relationship between the level of knowledge of a target group and the amount of contact needed to convey adequate information that will establish a working knowledge base from which people can make informed choices. A common language between the party giving the information and the party receiving it needs to be developed. This is more involved than language translation (e.g. English to Spanish). It involves developing a relationship between people that can act as the medium by which information can be exchanged and understood.

Unserved and underserved populations have been disappointed by past efforts.

Many traditionally unserved and underserved populations feel disenfranchised. This is an important issue to acknowledge and discuss with target populations. In addition, discussing past community engagement efforts is important. These populations have been studied for decades and in some cases hundreds of years. People and organizations have come to them promising great things and then leave to either never be heard from again or they use only feedback that serve their own agendas. This is important to acknowledge and discuss because this is often where the greatest resistance to new projects comes from. Often, groups want to know the length of the project commitment or want to know how the populations they serve will benefit from the agency/organization allocating resources and time to your project. Project staff should be willing to discuss any concerns raised openly and honestly. It is also important that the people that make the initial contact with the target group should continue to be the primary contacts or, at least continue to have regular contact with them.

Building trusting relationships takes time.

Allowing time for consistent relationship building is essential. If an effort is not going to be a long term commitment, there needs to be a dialogue with target community representatives regarding balancing the cost and benefit of those they represent being involved in the effort, as the cost to them may outweigh the benefit. If the cost outweighs the benefit, it may be better to not pursue the project, to not undermine future efforts. It may take several meetings to develop a mutual understanding of complex topics and issues to a point where people are able to move forward on project development and implementation. Allow time for Briefing or Debriefing, venting regarding past negative experiences and report what was done with the information that stakeholders gave.

Specific Lessons Learned from Target Groups

1. Consumers and family members may be frustrated by service cut backs.

As County Behavioral Health Departments are facing and implementing service cut backs due to funding short falls, consumers and their families may be fearful, frustrated or angry due to the loss and uncertainty of services. All of this may lead to resistance in participating in the MHSA stakeholder process, as consumers and families may not see the value in this long-term process, given the loss of immediate services. This might also be the case for consumers and family members who participated in the 2005 CPP process, as there have been those that have stated that their ideas and feedback were not captured or reflected in the services that were implemented for the CSS Plan.

2. Older adults may have difficulty participating due to physical barriers.

Many of the older adults who participated in the community briefing were 70-80 years old. Some of these older adult participants were dealing with multiple health issues that made participation a bit more difficult. Some of the challenges included auditory impairments that were not aided by the use of a microphone. Others had visual impairments that may or may not have been aided by materials in large print. Others had some difficulty with memory and tracking basic information.

3. Native American communities may require additional considerations.

Key informants stated that there may be “infighting” between various groups, which makes for special considerations. It is important to make sure that the people that are the key informants and cultural brokers into the community are respected and positioned to be able to speak for the target community. Meeting on a reservation or Rancheria may alienate some Native American groups and may be seen as favoring one group over another. Outreach organizations should be aware of this and hold meetings at a site that is considered neutral ground. Time should be allocated for opening and closing ceremonies. Be prepared to modify presentations to a Talking Circle format. Food is essential at any meeting as a sign of respect and honor.

Transportation is a huge issue as many natives have been isolated from mainstream America on Reservations and Rancherias due to government relocation. This is a source of tension for natives. In addition, for government entities, it may take quite a bit of time to build a sense of trust with Native Americans as they have the history of centuries of broken

promises from many different types of government entities. Another source of tension is initiatives such as Child Welfare's removal of children from reservations for adoption to non-native families.

4. Non-English speaking groups may require more time.

Meetings with non-English speaking groups required more time. Many of the participants had difficulty completing sign-in sheets and evaluation forms. In these situations, participants provided the information orally, while a facilitator or translator recorded the information given by the participant. More time is also needed to accommodate the time it takes to translate information which is not directly translatable. For example, in the Southeast Asian community there is no word equivalent for "mental health". The same is true for other MHSA concepts such as "stakeholders." For example, when we told the Southeast Asian group, via translators, there were consumers and family member stipends available and they should see the facilitators after the presentation, everyone in the group formed a line. We attempted to clarify what was meant by "consumer or family member" explaining that these were terms for people receiving mental health services or their families. An elaborate explanation was given in both Hmong and Laos but resulted in no change in the line.

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.

Engagement of diverse stakeholders

As described above, a large number of diverse stakeholders, including TAY and their advocates, were involved in all three components of the community planning process. Many of the stakeholders were from underserved and inappropriately served groups. Additionally, participants included advocates from all age-groups and all geographic regions of the County. Very many of the participants were consumers and family members.

Feedback through public comment

Table 1.12 . Feedback from Public Hearing

Overall Plan Comments	
Name	Comment
Lisa Rankins-individual	Department of Behavioral Health is doing great things. They have helped me immensely. I would love to see them be able to continue to do what they are doing, providing help for those who want it. Thank you.
Helen Siporin-individual	Will this commentary at today's hearing be added to the plan? Can the public get a written copy of the questions asked and the answers?
Helen Siporin-for MHA	MHA asks for more family/consumer people to be employed and provided with adequate training and clinical supervision for these para-professionals. Administrative oversight is also critical.
Karen Scott-individual	I was part of the planning process and found it to be intriguing and interesting. I believe that Prevention and Early Intervention should always be focused on first. Why are we waiting until a crisis happens before helping? Consumers' voices need to be heard and served.
Curt Thornton-MHB member	I don't think the plan reflects the priorities we should have given the current funding issues. The planning process/meetings ended in February it is now almost June and funding issues have arisen that were not their then. The County's redesign does not provide for a CRT to visit homes and this is a priority need. We need to stop and re-examine and rework the plan to reflect today.
Jill Shepard-DBH	Things change all the time. The economy goes up and down- we cannot continue to wait. For all we know tomorrow will be even worse. We need to move ahead on this. Fresno can do this now.
Susan Bechara-MHB member	We all know we need more money. The reality is there will never be enough money. This plan identifies a lot of needs. I want to advise the community to do some self searching with awareness to realistic available funding and then unite for those truly un/underserved populations. They are the neediest consumers. We need to be realistic with our limited funds and stretch it as far as we can.
Ricky Miller-MHB member	I was extremely active in this process. The amount of work that was done was extensive and the community spoke and was heard during the process. Prop. 63 was designed to transform the system. It was specifically written so that funds cannot be used to supplement existing programs. The idea of holding back approval to pass the plan through won't work. Maybe we can combine a few programs or pass with a few modifications (stigma, suicide) and divert those dollars but we should go ahead and pass it through. Over half of the counties in California have already implemented their PEI programs. We need to stop dragging our feet.

Table 1.13 Feedback from public hearing per PEI Plan project

Project #1-Integration of Primary Care and Mental Health	
Name	Comment
Naomi Sousa-Clinica Sierra Vista	I believe this project is the perfect avenue for prevention. I know first hand that people who are starting to get overwhelmed with everyday stressors first go to their Dr. with their symptoms. (Nervous, can't sleep etc). With Mental Health being right there in the same building doctors can immediately refer the patient and start to alleviate their symptoms right away. That is an excellent way to intervene and prevent before becoming more serious. I applaud this component.
Dr Bekerian-MHB	There is lots of evidence that this is one of the most effective ways to treat mental health issues. It is a progressive program and I applaud it.
Project #2-Cultural-based Access and Navigation/Peer Support	
Name	Comment
Yolanda Randles-WHC	I applaud the whole PEI process, we were involved and so was the community we serve. I love this project. It works elsewhere and it will work here.
Tom Thao-FCNA	Will transportation be part of the CHW's oversight? Can they help people get to where the CHW sends them?
Project #3-Peri-Natal P&EI for Pregnant/Parenting Women and their Infants	
Name	Comment
Patty Neufeld-LMFT & RN	I am a strong advocate of this program. At a conference recently held there were over 40 MD's there and they were all on board for this type of screening and short term group type therapy. It is very effective and money well spent. Depressed moms' equal depressed kids.
Peggy Thompson-LMFT	Remember to co-locate and work with existing infant mental health specialists both county and private providers.
Laurie Misaki-EPU	I really like the home visitation component of this project.
Mimi Mott-Smith-NP	Exclusion of treatment for those with pre-existing conditions (depression) is bad. Pregnancy exasperates and amplifies prior depressions or anxiety to crisis type breaking points. CSS does not have the capacity to treat consumers with depression. I would like wording to be carefully structured to prevent exclusion of those with prior existing conditions that may or may not be already in the system and allow for much needed short term therapy.
Dr. Bekerian-MHB	Where are we going to get these culturally and linguistically appropriate specialists? We should focus on 'homegrown' people; they are the ones who will stay here. No imports.
Curt Thornton-MHB	I would like to see final language reflect ability to serve those with pre-existing conditions.

Project #4-Parent-Child Interaction Support in Natural Settings	
<i>There were no comments from the public on this project</i>	

Project #5-School-based Prevention and Early Intervention for K-8	
Name	Comment
Mike Motter & Ms. Jiminez CUSD	Coalinga is a prime example of un/underserved community. Our kids spend the majority of their day at school; there is no other place for them to go. We need services <i>there</i> not in Fresno. Our parents can't afford to take a whole day off to go all the way there, they lose income and have high gas costs. We would really love to see this out there.
Helen Siporin-United Advocates	Written comment submitted. "We should cull this project out of the plan and rewrite it to reflect the process the community wanted and thought it would be when they voted on it"
Steve Gonzalez-SELPA	This project is an approach that incorporates parts of <u>several</u> different programs. That way this will work for all the different schools and kids. Using various components of evidence-based models that work. It will be customizable by the communities that it serves and create protective factors for our children.
Susan Bechara-MHB	Mandated service for the unincorporated areas to be included. These are our most un/underserved people.
Curt Thornton-MHB	This will give individual districts flexibility?

Project #6a-Suicide Risk and Para-Suicide Behavior Project	
Name	Comment
Curt Thornton-MHB	The language is too specific. I would change it to include the phrasing "such as those who deliberately self-harm"

Project #7-Community Gardens	
Name	Comment
Dr. Bekerian-MHB	I think this is a great project. Will we have the water to run these gardens? I would like see us formally endorse the use of drought resistant plants. They could also be used as exhibition sites for water conservation and/or "Going Green".
Youa-FCNA	Our communities are really looking forward to these, we applaud this project. How will the breakdown be for CBO's that have clients from several different ethnicities?

Project #8-First-Onset Consumer and Family Support	
Name	Comment
Curt Thornton & Susan Bechara-MHB	Family buy-in is especially crucial in the rural areas
Tou Moua-Kings View	How will we know if its 'first onset'?

Project #9-CIT Training	
Name	Comment
Dr. Bekerian-MHB	Fully support
Tom Thao-FCNA	Will the call center be equipped to handle all different languages?

Project #10-Stigma	
Name	Comment
Cassandra Joubert	I want to thank Jim for all his work in this process. And recommend that committees partner with MH professionals. Think the assessment should have clear distinction between 'stigma' versus 'knowledge level/awareness of'
Brian Conway-MHB	This seems like a natural partner for project #5. Start in the schools, they have shown to be effective in educating kids in new ways of thinking (going green etc)
Curt Thornton	Is this where we should be focusing our PEI dollars? Especially when there is an upcoming statewide project addressing this?
Ricky Miller-MHB	It is still unknown from state about the release of those specific funds- if ever. The assessment is critical. Our prejudices are within the community but more within ourselves. Self-stigma and stigma from our families is worse. Consumers repeatedly bring this up; they feel the state project would not address the self-stigma.
Susan Bechara-MHB	Its not discrimination, stigma is more about lack of knowledge

Project #11-Treatment for Men with Children Residential Co-Occurring Treatment	
<i>There were no comments from the public on this project</i>	

Project #12-Funding components of existing CSS programs that are PEI	
Curt Thornton- MHB	I approve this redirect of funding

Table 1.14 Overall PEI Plan Comments during 30 Plan Review

Individual	Comment on:	Comment and Response: (Some of the project and page numbers have changed since these comments were made. All un-funded projects have been removed from the plan.)
Trevor Hanes (Individual)	Overall Plan	Please have enough administrative positions similar to CSS from the start to make sure projects are success. Key to have good oversight. Response: Over 13% of entire PEI Planning Estimates are allocated for administrative purposes for each project
Nancy Chavez, MCAH	Perinatal Prevention and Early Intervention	<ul style="list-style-type: none"> • Targets underserved population • provides services in the communities and clinics where clients are located • Truly preventative for the children of these women (a chance at a better outcome). <p>I currently do field work with this population and have little or no resources for these women. South East Asian and monolingual Spanish women are the most difficult to find services for. Many of the women are “trauma exposed” and have been victims of sexual molest or abuse.</p> <p>Response: This project is the PEI Planning Panel’s highest priority project, in part, for the reasons specified in this comment</p>
Katherine Martindale (DCFS)	Perinatal Prevention and Early Intervention	Brief Therapy for women suffering an early stage manifestation of mental illness (perinatal/postpartum depression, anxiety and mood disorders) needs to be part of the plan. This intervention will address the earliest opportunity to prevent a mental health issue developing with the fetus/newborn. As part of the child welfare system, we often see families after all their support systems and resources have been depleted stemming from early developing mental health issues in connection with their pregnancy. The children are needlessly traumatized by a lack of early intervention resources. I am hopeful this plan will address that gap in our continuum of care. <p>Response: The MHSOAC guidelines for PEI allow for short-term treatment (less than one year) for individuals early in the manifestation of mental illness and is included in this project</p>
Toni Hanson, (LMFT, Substance Abuse)	Perinatal Prevention and Early Intervention	It is a plus that the perinatal program is included
Noelle Coppola, (California Health Collaborative	Perinatal Prevention and Early Intervention	It meets a need that Fresno County may not have been able to address before with limited funding in mental health. The focus groups have pinpointed the needs within the community, one being the mental health of prenatal and postpartum women. This is a population that has been underserved in the past in terms of mental health screening and treatment. I would like to address my concerns about the lack of “treatment” used within this proposed plan. It is essential to meet the need of screening and detecting mental health issues, yet without treatment measures in place this would be in vain. Fresno County has limited resources to refer these women to currently to treat mental health issues. My hope is that therapy can be included in the plan as an intervention strategy. If the wording within the document could support this, it will make it easier to apply this once the funding is available. Response: The MHSOAC guidelines for PEI allow for short-term treatment (less than one year) for individuals early in the manifestation of mental illness and is included in this project

<p>Noelle Coppola, (California Health Collaborative)</p>	<p>Perinatal Prevention and Early Intervention</p>	<p>I would also like to see the wording changed from “first time onset” to “minor mental health issues”, or some other categorical phrase that would specify the treatment of women with less severe disorders. It is common knowledge within the field of psychology that many illnesses, such as depression, are cyclical and manifest with triggers throughout the life span. I understand that this program is not focusing on major psychological issues such as schizophrenia, and I agree that it would not be feasible to treat these issues with short-term therapy. Yet, I would like to help women who have experienced depression previously, and could possibly be triggered by her pregnancy and experiencing depression again. Research shows that more and more children are being diagnosed with depression and anxiety in grade school. If we limit the wording to “first time onset”, we would be ignorant of what research is finding as well as what the diagnostic criteria of the DSM-IV-TR is telling us today. Mental illness is rarely diagnosed as a “first time onset”, it is more of a cycle that manifests at different stages within the individuals life. Response: The MHSOAC guidelines define the parameters of PEI funding. PEI funds can only be used for preventative activities and short-term early intervention for individuals early in the manifestation of a mental illness. The single exception to this for first onset of a serious mental illness with psychotic features. It is not within Fresno County MHSAs ability to change these guidelines</p>
<p>Miriam Mott-Smith FNP MPH (UCSF Fresno Family Medicine Residency Program)</p>	<p>Perinatal Prevention and Early Intervention</p>	<p>Exclusion from treatment of women with a pre-existing mental illness, particularly depression. A personal HISTORY of depression is THE MAJOR RISK FACTOR for post-partum/perinatal depression. In the perinatal setting, depression tends to be worse than previously. Consequences include impaired maternal judgment, self-medication with alcohol, tobacco, and/or drugs, decreased appetite and poor weight gain during pregnancy, insomnia, anxiety, suicidal ideation, suicide completion, and impaired mother-infant bonding. If we screen women, then deny them treatment based on past history of depression (an often chronic or recurrent disorder), the goals of prevention and EARLY INTERVENTION will not be achieved. Response: The MHSOAC guidelines for PEI allow for short-term treatment (less than one year) for individuals early in the manifestation of mental illness and is included in this project</p>
<p>Curt Thornton (Mental Health Board)</p>	<p>Overall Plan</p>	<p>I don't think the PEI plan developed reflects the priorities we should have-taking into account the current overall funding situation for mental health services. We know realignment funding is dropping substantially. MHSAs revenue projections are going down. And, now because of the failure of the various budgetary propositions this week, we don't know what further cuts the legislature might impose on us. We need to carefully review our situation before proceeding with a PEI plan that has not taken these things into account. Even without considering the funding situation, there are things not taken into account by this plan—like the expansion of the crisis response teams to include visits to homes upon the request of families in the midst of a crisis—a need clearly identified when the 5-prong effort related to the closing of CSI was rolled out. There are details about the various items included in the plan that I could comment on, but I think the big picture is the most important thing to address. Response: The PEI Plan was developed using the Stakeholder process, which necessarily takes time. PEI funding cannot be used to supplant or to fill in gaps in shortfalls in realignment funds</p>

<p>Laurie Misaki, RN (Fresno County Department of Public Health)</p>	<p>Projects 1,3 and 10</p>	<p>Project 3 can truly be a prevention and early intervention project because it begins as new life begins. This early intervention program for infants and children can improve outcomes for the children when mothers are suffering from perinatal mood, anxiety and other mental illnesses are screened, assessed and linked to early intervention and therapeutic services. A mother's mental illness, including depression and anxiety, has been shown to affect the developing brain of the fetus in utero. In addition, a mother's mental illness effects her ability to mother and care for her child after birth resulting in mother/infant attachment issues, and poor infant mental health effecting the long term functioning of the child. This project aims to reduce the toll and costs in human suffering and resources for long-term treatment and services. We need to create an early intervention project that targets the needs of the unborn infant and newborn infants by identifying the pregnant and post-partum mothers suffering from a mental illness and are in need of early intervention services.</p> <p>On page 4 of project 3 it is written that the project is based on the evidence based Nurse-Family Partnership program, home visitation program for first-time moms who have never parented before. Project 3 should not be restricted to serve only first-time moms. Response: This project is not restricted to first-time mothers</p> <p>Project (10 removed) is stigma reduction. I recommend that stigma reduction includes an effort to combat the "you're a bad mother" stigma when a mother is experiencing depression or anxiety while she is a pregnant or post-partum mother. Society's message is that she should be happy she is going to have a baby or that she has a baby. That stigma too often prevents women from letting anyone know she is depressed or anxious. Response: The Stigma Reduction project is unfunded as a result of the potential for a Statewide Project on Stigma Reduction</p> <p>Project 1 is Integration of primary care and mental health in Federally Qualified Health Clinics (FQHCs). Rural Health Clinics (RHC) (located in rural sites only) and FQHCs sites (located in urban underserved and rural sites) throughout the county provide OB care to low income pregnant women who qualify for Medi-Cal. I would like to see PEI perinatal services for pregnant/parenting women and their infants be incorporated into Project 1. It would make sense if you are already training people at FQHCs sites to provide early mental health intervention that they also be the resource for pregnant women in primarily rural communities. An illustration of the need in Project 1 is a teen mother in a rural site, but she was previously a pregnant teen who could not access mental health services. Response: One of the main reasons for integrating primary care and mental health prevention and early intervention in community clinics is to reduce barriers in access to mental health services. Project 1 is inclusive of perinatal mental health concerns.</p>
<p>Laura Wass (American Indian Movement)</p>		<p>Breaking down the walls between the American Indian Community and the Dept. of Social Services through active participation from each towards the wellness of the whole. The proposed plan holds opportunity for providing a means of much needed mental health resources to be</p>

		<p>delivered by those who have been sensitivity trained to know the Indian community. The only concern is that those delivering the resources are indeed aware of the American Indian and are provided complete training of said community. We are highly excited to see this proposal become a reality. It will add huge steps towards the wellness we are seeking for all our families and this proposal has been needed for many, many years. We appreciate the careful thought and complete structure which has been put into the plan. Response: Cultural competency is the cornerstone of this three-year PEI plan. All reasonable efforts will be made to ensure appropriate training and sensitivity to all traditionally underserved communities</p>
<p>Wellness Coalition (c/o Mental Health America of the Central Valley)</p>	<p>Community Planning Process</p>	<p>Appendix A. Abbreviations and Table 1.6 Planning Panel Composition</p> <ul style="list-style-type: none"> • Question: Are any of the people on lists beginning on Page 24* of the plan, clients or family members who would require releases of information? Response: Consumers, if noted, have self identified • Addition: Appendix A., pg. iii: add UACF–United Advocates for Children and Families • Correction: Table 1.6: Add The Rios Company to Mental Health America of the Central Valley in Christina Alejo’s identifying info • Correction: Table 1.6: Spell out Mental Health America of the Central Valley and United Advocates for Children and Families in Helen Siporin’s identifying info <p>Response: These changes have been incorporated</p>
<p>10. Wellness Coalition (c/o Mental Health America of the Central Valley)</p>	<p>Integration of Primary Care and Mental Health in Federally Funded Clinics</p>	<p>1) Billing: How does this project address the issue of Primary Care not being able to bill for a health service on the same day as a mental health service? Response: This project must observe federal guidelines. The current system does not support the ability to bill for two services on one day.</p> <p>2) Staffing: This appears to be a lot of staffing for the amount of funding being allocated to this program. Response: Staffing is in line with funding allocations</p> <p>3) Indigent Care: Page 43 says FQHC’s have no means to pay for consumers who have no insurance coverage. This may be incorrect, as FQHC’s are mandated and funded to provide indigent care. Response: This is in reference to undocumented individuals who traditionally are not covered by insurance or other healthcare plans for mental health services. One of the target populations will indeed be these individuals who are in need of mental health services, but otherwise have no means by which to receive these services.</p> <p>4) “Linguistically accessible community mental health programs” Page 49 mentions referring people who “...do not qualify for county services” to “<i>linguistically accessible community mental health programs</i> (italics added)” What “programs” is this statement referring to? Response: It is anticipated that some individuals seeking county services will have private insurance to pay for their mental health care. The line referenced refers to these individuals and implies that those who can seek treatment within their health insurance policies will be required to utilize this resource</p> <p>5) Administration Budget: Page (?) states, “Fiscal and program monitors will be assigned to the program at start-up. Progress reports and follow-up will be scheduled quarterly to address any</p>

		<p>emergent problems. Program, evaluation will address sustainability and progress in achieving goals. Program success will be sustained through the positive outcomes of this project.” This level of program administration is a good idea; however is not reflected in a budget for program administration. Response: Over 13% of the entire PEI budget is allocated to administration of these projects</p> <p>6) Leveraging Resources: The discussion on page 50 regarding leveraging resources and utilizing support staff from Primary Care clinics is great. Has BHS engaged in any preliminary verbal agreements with representative from these clinics regarding how resources can be leveraged, and budgeting for services based on their existing costs? Response: This project has not yet been approved by the State DMH, and will ultimately go out to an RFP. It is anticipated that MOUs will be developed</p>
<p>10. Wellness Coalition (c/o Mental Health America of the Central Valley)</p>	<p>Cultural-based Access and Navigation Specialists) and Community-based Peer Support</p>	<p>1) Job Titles: a) The difference between a CHW and a PSS is not clearly delineated. b) On Page 56, Bullet #7 refers to a “MH Liaison for underserved communities . . .” Is this a third position, or just another term for the CHW or PSS? Response: Under “Use of Funds” for this project, the following is stated: “For example, CHWs can provide linkages, education and outreach at Horticultural Therapeutic Community Centers, community clinics, and in other natural community settings. Peer support can be provided through the Horticultural Therapeutic Community Centers, community clinics, and in other natural community settings.” Also, as indicated in the CHW description, part of their function is to serve as a liaison between providers and the community they represent. The CHW will function as a mental health liaison.</p> <p>2) Cultural Competency: the Plan has identified cultural-based disparities to access and treatment, with 34% licensed mental health staff being white/Caucasian (resulting in cultural and linguistic disparities). Will the CHW and PSS positions be required to proportionately reflect the needed threshold populations? Will testing of CHW and PSS be conducted prior to and after hiring to assure cultural and linguistically competent staff? Response: “This project is modeled significantly on evidence-based community based health models, utilizing community healthcare outreach workers (CHW) employed by community organizations. The CHW model is used because CHWs are effective disseminators of information, and act as the bridge between governmental and non-governmental systems and the communities they serve. Community health workers also act as change agents within their naturally occurring social networks. Moreover, top-down and bottom-up outreach and engagement efforts are less effective than “horizontal” collaborations between professionals and residents in underserved communities. Direct, local involvement can generate creative and dynamic efforts to address disparities to mental health services in these areas and for these groups. The project would also feature the addition of a peer support component which is culture-specific and tailored to help bridge cultural and language divides through advocacy, education, and short term peer-support for</p>

		<p>non-SMI intervention for individuals and families dealing with economic and immigration-related challenges in a de-stigmatizing and culturally appropriate manner.”</p> <p>CHWs will be selected from within the communities, hence identified from within underserved communities for cultural and linguistic competence.</p> <p>3) Populations Served: a) Staffing for CHW’s and PSS’s to provide outreach, education, support and linkage and brokerage services to targeted populations is greatly needed and appreciated. However, given the extremely low penetration rate of public (or other) mental health services into these communities, and historical disparities in access, it is likely, that these staff will encounter severely mentally ill persons who-having never been served by mental health services-will need immediate intensive and/or acute crisis intervention services. Response: These individuals will be linked to appropriate care. CHWs and PSSs will be trained to address these concerns.</p> <p>b) Page 57 states that this “project is designed to serve <u>all</u> underserved communities in Fresno county...” but then defines 4 specific populations. How do these positions tie to these populations and how will that be determined? For example, on Page 52, 4 different types of Latinos are described, each with their specific needs/concerns. Would there be a peer specialist for each of these? Response: The word “all” has been removed</p> <p>4) Clinical Support to Staff: Will the hiring of Community Health Workers (CHW) and Peer Support Specialists (PSS) be supervised or monitored by licensed Clinicians? If not, who will provide such oversight? Response: Peer Support will be appropriately supervised. Community Health Workers do not need clinical supervision, since they will not provide treatment, although CHWs will also be appropriately supervised</p> <p>5) Confidentiality: What steps will be taken to assure the CHW and PSS will adhere to HIPAA rules and guidelines? Should violations of confidentiality occur, what grievance procedures will be provided to the consumer? Response: Training will be provided. All HIPAA laws will be strictly enforced. Grievance procedures and other specific contract requirements are typically described in the RFP</p> <p>6) Duplication of services. In this Project, specific needs have been identified and strategies for each of the targeted cultural populations, yet Project #10 talks about conducting an assessment to establish a baseline for these same populations. Hasn’t this already been completed based on all of the work completed as part of the CSS and the PEI planning processes? How will existing information that has been collected through MHSA and other efforts feed into this project? (Communities feel like they have been “assessed to death”.) Response: The assessment of Project 10 is specifically designed to assess stigma and discrimination. No such assessment has been completed and therefore is not considered a duplication of service</p>
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<p>10. Wellness Coalition (c/o Mental Health America of the Central Valley)</p>	<p>Peri-Natal Prevention and Early Intervention Program for Pregnant/Parenting Women and their Infants</p>	<p><u>Parent-Child Interaction Support in Natural Settings Project</u></p> <p>1) Resource Suggested: The Parent-Child Interaction Support in Natural Settings Project describes utilizing paraprofessional staff in a way that fits with the RAICES Promotores program out of Florida. RAICES utilizes a multidisciplinary team that includes the Promotores. Response: Plan narrative describes collaboration across many PEI projects, including between CHWs and Parent-Child Interaction Support projects, although the latter is currently unfunded in this plan</p>
<p>10. Wellness Coalition (c/o Mental Health America of the Central Valley)</p>	<p>School-based Prevention and Early Intervention Program for Kindergarten through Eighth Grade</p>	<p>1) Primary Intervention Plan (PIP): PIP, the SAMHSA endorsed program referred to in this Project, was ranked by the community as one of the top 5 projects (during the final general PEI General Session). However, only Tier I type interventions (screening and outside expert consultations) are actually funded. The Tier II early intervention component of PIP-<i>para-professional training and ongoing weekly direct service w/ selected at-risk K-3 children</i>-is not budgeted for. Response: The Planning Panel clearly identified the need for a school-based prevention and early intervention project, which has Tier 1 and Tier 2 prevention and early intervention supports. The language of this project specifically references PIP, but also allows participants to develop a program in a particular school or district that extends up to the eighth grade. This project description also allows for the possibility that other schools or districts may create a program that more closely fits their needs. The project description clearly describes Tier 2 interventions are therefore implicitly budgeted for</p> <p>2) Technical Assistance: The technical assistance part of the program is unnecessarily costly. Several local and neighboring districts are utilizing PIP (Fresno, Sanger and Visalia USD’s) and could provide low cost technical assistance as needed to implement PIP, BESS or SSBD screening, interventions and evaluation. Free or low-cost State conferences for the EMHI (Early Mental Health Initiative) PIP program directors/staff are also available. Response: We have made changes to the language in the project narrative to reflect this concern</p> <p>4) Staffing: It is not clear why funded “Professional Learning Committees” of 6 members at each site are necessary as opposed to one project manager per school or several schools as required by PIP.</p> <ul style="list-style-type: none"> • PEI trainings can be incorporated into faculty staff meetings and district “buy back days”. Screenings require little training and are easy to implement. • Tier II interventions are provided by para-professionals, not teachers yet paraprofessionals are

		<p>not funded. Response: We envision leveraging many of the local mental health educational settings. Student interns from mental health programs, such as Fresno State and Alliant University, among others, need practicum and clinical hours that can be provided in the schools for these positions</p>
<p>10. Wellness Coalition (c/o Mental Health America of the Central Valley)</p>	<p>Suicide Risk and Para-Suicide Behavior Project</p>	<p>1) Community Input to this Project a) If “suicide risk did not register as a major local mental health concern through the extensive Community Input Phase...” and “...underlying stigma and discrimination may have likely contributed to the low recognition of it as a major mental health concern,” then why is it a separate program from the stigma program? b) It seems like access disparities and stigma, which are addressed by two other Projects (#2 and #10) in the plan, are the issues this Project seeks to address. c) This Project seems to also address issues stemming from general lack of access to mental health care. Response: This project directly addresses individuals who are specifically at risk for suicide. The Stigma Reduction project is much broader in scope 2) State Level Suicide Prevention Initiative: How will this Project tie into the State Level Suicide Prevention program and 10-year plan? It is likely that the state will use Fresno County as a focus point in our region for the 10-year plan, as it has the greatest population density in the region. Response: This project is unfunded due to the potential for Statewide Project on Suicide Prevention. In the event that Statewide Project funding will be used for local purposes, this project will be implemented</p>
<p>10. Wellness Coalition (c/o Mental Health America of the Central Valley)</p>	<p>Community Gardens as Neighborhood Resource Center and Community Site for Delivery of Prevention and Early Intervention Activities</p>	<p>1) Multiple Benefits: This seems like a really great program; similar to the Clubhouse model in some ways. This program will address lack of access to services while at the same time; provide access to neighborhood land to raise healthy food. The economic support to families may provide additional benefit in reducing psychological distress related to the economy. Response: This project has been very well received 2) Need for Clinical Support: Again, clinical support for the paraprofessional staff appears to be lacking. Given the access disparities of the target populations and the higher prevalence rate of severe mental illness in these populations due to socioeconomic and other variables, clinical support would be wise. Response: CHWs working at these and other community settings will be able to communicate resources to their communities</p>
<p>10. Wellness Coalition (c/o Mental Health America of the Central Valley)</p>	<p>First-Onset Consumer and Family Support</p>	<p>1) Terms: Phrase “short-term bridges across systems” is not defined (bullet #4 p.132) Response: The following clarifying language was added: “Bridges across systems (DBH/DCFS/School/Law Enforcement/Courts/Primary care) for consumers in recovery to help them function in their natural daily lives within the systems that they otherwise function, such as schools, places of employment, or other setting. These bridges will be voluntary and can be refused by the consumer.” 2) Training: Project #8c identifies a one-time cost for the Education and Clinical Training Workshop on Prevention and Recovery of Psychosis project for primary care practitioners, mental</p>

		<p>health practitioners, school psychologists, and other stakeholders and professionals. Training in new area such as mental health prevention, early intervention and relapse prevention takes more than one time training session. It is likely that everyone that would need to/like to attend the training will not be able to do so. How will the benefits of this Project be sustained and repeated over time? Response: This one-time workshop to address clinicians and others in early phases of psychosis is a sub-part of the overall First Onset Project, which is designed to intensively treat first onset consumers. The evidence suggests that providing the types of intensive services to individuals early in their psychotic illness is very effective in reducing recovery time. Given positive outcomes along these lines, this project will continue to receive funding support and will thus be sustainable. This one-time workshop will offer an opportunity to the community to learn about the prodromal phases of psychosis and is viewed as one component of the larger project on First Onset</p> <p>3) Number Served: a. Plan states that 66 consumers will be provided wrap-around services but does not indicate what types of providers, how many of each and what costs are associated. Response: This is based on the cost of the level of care described in this project and based on the EPPIC model implemented elsewhere at a cost of around \$10,000 per consumer. This is only an estimate b. Are provided wrap-around services for individuals and 66 families discrete or overlapping? Clarify same for Consumer/Family Advocates serving 200 individuals and 200 families. Response: Consumer Family Support is designed to deliver education and strategies to family members of these first onset individuals to reduce stigma and to leverage the care during recovery that families are in a position to provide. It is anticipated that more than one family member may receive such resources. Again, this is only an estimate</p> <p>4) Job Duties: Consumer/family advocates can and should be providing some case management (linkages, advocacy & navigating systems, as well as family education and support). Two advocates is too few in relation to the numbers of children and adults hospitalized yearly</p> <p>5) Training & Supervision: Training for consumer/family advocates is neither mentioned nor budgeted for and is critical. With the severity of symptoms and high potential for relapse, ongoing clinical supervision is needed. Response: Clinical supervision and case management are integral to this project and referenced in the narrative</p> <p>6) Cultural Competency: Plan mentions that bid applicants “must demonstrate bona fide cultural and linguistic competency for the communities identified . . .” but does not state which languages/cultures should receive top priority given current consumer/advocate positions already existing. Response: Competency in the threshold languages will receive the highest priority</p>
<p>10. Wellness Coalition (c/o Mental Health America of the Central Valley)</p>	<p>CIT Training for Law Enforcement and First Responders, including Emergency Room Personnel, and Urgent</p>	<p>1) Target Population: How will staff differentiate between people experiencing First Onset of mental illness and ongoing severe mental illness? This is an issue because non-SMI people in crisis often access mental health crisis services because it is the only service available. How will non-SMI crises be handled? Response: This project provides stigma-reducing training that will reduce the overall discriminatory practices against individuals suffering from a</p>

	<p>Mental Health Care PEI Call Center Expansion</p>	<p>psychiatric crisis. Direct services are not provided for in this project</p> <p>2) Sustainability: Several county mental health crisis units have come and gone over the past few decades. What distinguishes this mobile unit and marks it for success, where the others have not succeeded? Response: This project does not create a mobile unit. This project is about training and stigma and discrimination reduction of first responders against those they must confront in the operations of their job duties, including transporting individuals who are in psychiatric crisis</p> <p>3) Volunteers: Page 166 says that this project will be sustained "...through mostly volunteer efforts." It is difficult to understand how volunteer services could sustain crisis services coverage on a 24/7 basis. Response: A more careful reading of the whole sentence will allow that CIT is by definition a collaboration across several organizations, thus the sentence: "Because CIT is developed through community collaborations, it can be accomplished at low cost, through mostly volunteer efforts." Many individuals involved in the curriculum are indeed volunteers. Many individual law enforcement officers will volunteer to participate in CIT and agencies must contribute (i.e. volunteer) the time required for law enforcement personnel to attend this training. The way CIT works is through robust collaborative relationships between law enforcement agencies, consumer advocacy groups, and county mental health services.</p> <p>3) Leveraging Resources: It is great that Fresno BHS is leveraging the Statewide Training and Technical Assistance funds to maximize available resources. What is the plan for sustainability for these services after the 4 years of funding provided by this funding source? Is Fresno considering using these resources as part of a regional effort? What other funding sources (e.g. law enforcement-training funds) will be leveraged for this program? Response: We anticipate a well developed CIT program that results in law enforcement owning the training, as it ultimately provides law enforcement the necessary professional tools. Slow start-up and a three year reversion may result in seven years of fully funded CIT. After that, there is ample evidence to show that costs savings to law enforcement, in terms of reduction in number of officer injuries, liability costs, and other costs associated with a poorly handled psychiatric crisis will provide considerable motivation to continue funding CIT, as evidenced in several counties within the State of California and beyond</p>
<p>10. Wellness Coalition (c/o Mental Health America of the Central Valley)</p>	<p>Project 9b</p>	<p>1) Staffing: Project #9b has only 1 clinician assigned to it. Will this person be part of a larger effort? How many hours will s/he be working? Response: The provision of one clinician, plus one Peer Support Specialist is deemed to be a prudent resource component of the Urgent Care Wellness Center. Outcomes measurements may indicate a greater need in the future.</p>
<p>10. Wellness Coalition (c/o Mental Health America of the Central Valley)</p>	<p>Reducing Culture-based Stigma and Discrimination of Mental Illness and Individuals who have</p>	<p>1) Scope of Work:</p> <p>a) <u>Comprehensive Assessment:</u> Page 171 states that "...a one size fits all approach is wholly inappropriate for dealing with stigma over the rich tapestry of diverse cultural, ethnic, and linguistic communities of Fresno County". Page. 172 it states that a comprehensive stigma assessment will be conducted with..."all underserved cultural, ethnic, linguistic, racial, and geographically disperse</p>

	<p>Mental Illness</p>	<p>communities of Fresno County...” Other than saying this will be done in partnership with a university or college, it does not suggest any methodology, nor why/how it has been determined that the university or college is the best means for assessing the underserved communities.</p> <p>b) Focus: The project would benefit from a narrower focus. On Page 176 it states, “no natural setting should be ignored and every conceivable community partner should be brought on board in the development of stigma-busting campaigns...” Though this ideally is true, we know we can’t reach everyone in every setting. How will settings and communities be determined/prioritized?</p> <p>Response: It is the view of the department that local colleges and/or universities are appropriately suited to a county-wide assessment of stigmas associated with mental illness. The goal of the assessment is to highlight areas where targeted approaches to busting these stigmas can be implemented for maximum effect. Indeed, this project is designed to uncover stigmas within our communities regarding mental illness, which ultimately requires engaging individuals in as many natural settings as possible. It stands to reason that natural settings are where un-served individuals who feel stigmatized are. Natural settings are also where stigmas and discrimination are propagated</p> <p>2) Terminology: <i>“First Americans from Mexico;”</i> (Page 173) does not seem to be widely understood in Latino communities. Ask representatives of these communities what term might be preferred. Response: As these individuals are not by definition Latinos, there is no need to ask Latinos what we should call First Americans from Mexico. Moreover, Binacional representatives who took part in the Stigma Reduction Working Group provided this term to the working group</p> <p>4) State-Level Initiative: How will this program tie into the State Level Stigma and Discrimination program and 10-year plan? It is likely that the state will use Fresno County as a focus point in our region for the 10-year plan, as it has the greatest population density in the region. Response: This project is unfunded due to the potential additional funding for a Statewide Project on Stigma Reduction</p>
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<p>10. Wellness Coalition (c/o Mental Health America of the Central Valley)</p>	<p>General Comments for the Whole Plan</p>	<p>1) The English version of the plan is well written. It was easy to read, well structured and easily accessible via Internet except for a short period. The Executive Summary was helpful as well as the funding chart for all projects.</p> <p>2) The plan identifies valid community needs that can be met through programming developed using the MHSA Prevention and Early Intervention funding.</p> <p>Duplication: Many components of the Projects address the same issues. These components could be consolidated to reduce the number of programs and/or components. This, in turn, will result in better funding, more cohesive use of funding, and reduction of potential duplication and gaps.</p> <p>Examples: 1) Programs #2, #6, #7, and #10 all describe linkage and brokerage, community education, supportive services and outreach and engagement services with a strong emphasis on underserved populations. Response: Indeed, many projects will work collaboratively as described in the narratives</p> <p>2) Many projects require basic training in early signs and symptoms. This training could be provided by a few mental health education teams utilizing the same or similar training curricula, adapted for cultural and linguistic competency. Response: The one-time Workshop on early signs and symptoms of Project 8c is partially designed for this purpose</p> <p>3) Projects #1 and #3 might be consolidated, as they would likely be provided out of a medical setting such as primary care, FQHC's. Response: Project #3 is specifically designed to fund perinatal mental health care, which includes in-home visitation by nurses and mental health specialists. Project #1 is designed to expand mental health prevention and early intervention at community clinics. While there may be a similar primary care-mental health care connection to both projects, the scope of each is specific to targeted populations</p> <p>4) Projects #4 and #5 might also be consolidated to provide a broader range of staffing. Over all this will help lower the program administrative costs due to lowering the amount of outcome tracking, contract monitoring, etc. Response: Project #4 is for children under school age, while project #5 is designed for Kindergarten through Eighth Grade. Different target populations are addressed by each project</p>
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First 5 Task Group on Infant-Family and Early Childhood Mental Health
Nancy Richardson, Chair
First 5 Task Group on Infant-Family and Early Childhood Mental Health:
Kendra Rogers, Deputy Director, First 5 Fresno County of Fresno
Cassandra Joubert, Sc.D., Director, Central California Children’s Institute
Shanna Wilson, MFT, Infant Mental Health Clinician
Martha Moore, Ph.D., Infant Mental Health Clinician
Peggy Thompson, MFT,

Congratulations on the completion of a proposed plan for the Fresno County Prevention and Early Intervention Component of the Mental Health Services Act. It has been a monumental undertaking involving many dozens of people from throughout Fresno County. The Plan reflects authentically the community wishes, which were solicited and expressed, it displays laudable creativity, and it is imbued with great hope and optimism. Many people will benefit from this work. Thanks go to the staff and to the legions of people who contributed to the development of this plan.

The First 5 Task Group on Infant-Family and Early Childhood Mental Health, in partnership with the Central California Children’s Institute at CSU, Fresno, hopes to engage in a year-long series of activities which will increase the understanding and use of up-to-date information about infant-family and early childhood mental health across a wide-range of child-serving providers. It is in that context that we offer the following general comments, none of which are in any way critical of the Plan. Rather, they are crafted to expand on some of the elements of the Plan:

- 1) It will be important to integrate infant-family and early childhood mental health into the following PEI Plan projects:
 - a) Integration of primary care and mental health prevention and early intervention at federally funded clinics
 - b) Culturally based access and navigation specialists and community-based peer support.
 - c) Perinatal prevention and early intervention program for pregnant/parenting women and their infants
 - d) Parent-child interaction support in natural settings project
 - e) School-based prevention and early intervention program for kindergarten through eighth grade
 - f) Reducing culturally-based stigma and discrimination of mental illness and individuals who have mental illness
 - g) Prevention and early intervention for children of men in co-occurring treatment
- 2) PEI programs will be far more effective if adequate time is devoted to close consultation with community stakeholders and current service providers to close gaps in mental health services for children birth to three.
- 3) In order to ensure adequate staffing and sustainability, pertinent PEI programs can work in tandem with First 5 Fresno County and the Central California Children’s Institute, who are working on capacity building efforts in infant-family and early childhood mental health.
- 4) It is important to note that infant-family mental health is founded upon a wellness model that when provided by qualified, culturally competent professionals under appropriate circumstances can strategically “promote positive cognitive, social, and emotional development,” to use a phrase from the PEI website.
- 5) In order to prevent problems from getting worse and to reduce the need for extensive mental health treatment, it is critical that early intervention be joined together with ongoing services. This will allow for the best use of expertise in the overlapping fields of knowledge and practice. Brief interventions may be useless if not linked effectively to ongoing treatment when needed.

<p>12. Suzanne Moineau (Genesis)</p>		<p>This plan appears to provide a great bang for the buck. The service plan addresses a wide variety of issues that allow for many different people to have access to help and training that would otherwise not occur. Of course the biggest concern would be sustainability. Also, as the programs are put in place, people will be identified with bigger issues than can be taken care of with these programs. The lack of places to send these identified folks is a major concern. Response: We have addressed sustainability by de-funding four (4) of the projects of the original plan. Recent budget notices indicate a significantly reduced set of planning estimates for PEI and MHSA in general, which differ dramatically from original planning estimates. We therefore de-funded the two lowest priority projects (Projects #4 and #11) , as well as the two projects for which funding has been identified for Statewide Projects that address Stigma Reduction and Suicide Prevention (Projects #6 and #10)</p>
<p>Carol Sadoian-Meisner (Sanger School District)</p>		<p>My concern relates to Item 5 regarding the School Based Intervention programs. As I understood it, PIP was the program which was selected as a result of the community input. There is some reference to PIP in the program components section. However, when the funding and use of funds are described, it is clear that these costs are not for implementing PIP. The training, technical assistance and materials described appear to refer to SWIS and PBIS, as well as the Restorative Justice program. To implement a PIP program, a program coordinator (who could oversee multiple sites), some school-based professional support, paraprofessional staff and materials to establish a playroom would be required. The screening instrument used for the currently funded PIP programs is the Walker Screening Instrument. The pre and post measures of the Walker Mc Connell Scale are used to assess progress for the students participating in the program. This evaluation component of the students served in the program would fulfill the requirement for one of the twelve projects to include quantifiable measures to document desired outcomes. For more specific information on implementing the PIP program, a description is outlined in the 2009 Early Mental Health Initiative RFA, which can be accessed at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EMHI.asp. As a result of the May 19th election, the funds designated for this RFA are in jeopardy. Thus, this component of the Mental Health Services Act for Prevention and Early Intervention in the schools becomes even more critical. Response: The description of this project clearly describes a two-tiered prevention and early intervention program (with Tier 3 being referred to CSS or other services, as appropriate) to be implemented in the schools for grades K-8. Because PIP specifically addresses K-3 only, we reference PIP as well as other evidence-based practices that will make it possible to address K-8. Furthermore, the PEI guidelines require every age group to be addressed in this PEI plan. Project #5 addresses the prevention and early intervention needs of both children and youth. Moreover, no funding is provided for Restorative Justice in this plan. The reference in this plan clearly describes this as an example of the types of community partners with whom this project may collaborate and/or leverage for additional resources, as mandated by the OAC guidelines for developing the PEI plan and implementation of PEI projects.</p>

<p>Michael Reiser, MSW, Program Manager, E&TA</p>		<p>The PEI plan does not provide for treatment, however by definition intervention is some level of service or treatment. One of the at risk and underserved populations in Fresno County are women and men who experience Perinatal Depression, beyond the “baby blues.” These expectant mothers especially need intervention services in the form of treatment during and after delivery for best possible outcomes, and the ability of the parent(s), specifically the mother, to bond with her new child. Research (Dr. S. Misri), has demonstrated a higher rate of poor or inadequate bonding with perinatal depression, which also gives rise to higher levels of depression for the infant as they grow into childhood and adolescence. Additionally, failure to bond and attach to a baby, puts the mother/parents at greater risk of neglecting or abusing their infant child, which subsequently will impact the legal and child welfare systems as well as the mental health system. I strongly encourage that the provision of treatment, even if time limited, be included in the PEI section, as by definition intervention is some level of treatment. Response: This plan provides for short-term early interventions, which may include short-term treatment for a mental illness early in its manifestation per OAC guidelines</p>
<p>Rev Natalie Chamberlain, United Christian Church (Disciples of Christ)</p>		<p>There are many places, in most parts of the plan, that include community and faith based organizations involved. My concern is that these roles are not articulated. It seems that these outside organizations are vital to this plan reaching all the people who need to be reached. There was minimal contact with the faith community in the meetings leading up to the formulation of this plan. It is difficult for any community to come on board after the fact. The faith community seems to have been given responsibilities but no real voice and no authority. Response: We disagree with the statement that there was “minimal contact with the faith community”. We held a focus group specifically for the faith-based community to learn about their needs and expectations. PEI Planning Panel communications, invitations, and requests for participation during all phases of plan development were delivered to faith-based organizations and to specific individuals from the faith community who participated in the focus group. Additional phone calls were made and educational/outreach meetings were scheduled and conducted with many faith-based groups, including many of Native American, Muslim, Christian, and Southeast Asian communities. On September 18, 2008, we also presented at a Roundtable at Metro Ministries specifically on the PEI planning process and at that time made our initial requests for participation. Also, no specific responsibilities have been presumed by this plan to any specific faith-based organization. We hope for and do anticipate participation by many faith-based groups, as well as by other community organizations in the implementation of our County’s three-year prevention and early intervention activities</p>
<p>16. Monica Blanco- Etheridge (Central California Legal</p>		<p>Proposal was well written given the short frame to write it. The addition of a table of content made locating certain sections easier. Use of technology to post the plan was beneficial but not with out its limitations. Initial concerns over technical problems in accessing the plan fully may not have allowed additional public input. Concerns regarding the limited number of consumers who had input in the development of the plan remain an issue. Of the 891,000 people residing in Fresno</p>

<p>Services)</p>		<p>County, only 1600 contacts were made by County staff. This resulted in .18% of the population being reached to assist in the development of projects. Response: Indeed, 1600 community members participated in the PEI planning process, while very many more individuals and groups were invited to participate. The number of contacts made during the MHSA CSS and PEI planning processes should not be confused with the number of individuals who actually participated in the PEI planning process. Thousands of individuals from throughout the County were engaged and given opportunities to participate. Very many chose not to participate. We are confident that our outreach and engagement efforts are significant, are in good faith, and authentically represent the needs of our County and our un-served/underserved communities</p> <p>The plan lacks adequate clinical supervision and there is a need to increase the use of clinical support or paraprofessionals for the outreach staff. Additional clarity is needed on how the cultural and linguistic needs of rural consumers will be met. Possible duplication or overlap of services in various sections such as in: 1 and 5. Response: We do not believe that Projects 1 and 5 in any way overlap or provide duplication of services. Project 1 is intended to integrate mental health prevention and early intervention at community primary care clinics, while Project 5 is a school-based project. We also believe that there is adequate clinical supervision. Project 2 specifically describes and is focused on implementation of the kinds of cultural and linguistic needs defined by individual underserved communities.</p> <p>Rural consumers will not be able to utilize an urban place based social environment and face transportation barriers. Providing urban place based social environment does not meet the needs of the rural consumer. Provide quantifiable measures within the plan and not just outcomes. Response: There is significant activity throughout the PEI plan that will take place in rural settings. Project 1 in particular is designed to be in the rural areas, as is the work of CHWs and Peer Support Specialists, among other project components</p> <p>Assure section 9 is implemented Countywide and not limited to the City of Fresno. Assure the availability of call centers or drop-in centers in rural locations. Centers should be staffed with cultural and linguistically trained competent staff. Since many crisis centers have come and gone within Fresno County, what is the plan to sustain or expand this project? Expectations to have volunteers sustain the project 24/7 are unrealistic and will ultimately leave the residents without services and further loss of faith in the behavioral health system. Response: Project 9 seeks to train first responders in psychiatric crisis response. This training is being developed with law enforcement agencies from throughout the County, including rural agencies, and Fresno County Sheriff's Office</p> <p>Response: Re: volunteers. A more careful reading of the whole sentence will allow that CIT is by definition a collaboration across several organizations, thus the sentence: "Because CIT is developed through community collaborations, it can be accomplished at low cost, through mostly volunteer efforts." Many individuals involved in the curriculum are indeed volunteers.</p>
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		<p>Many individual law enforcement officers will volunteer to participate in CIT and agencies must contribute (i.e. volunteer) the time required for law enforcement personnel to attend this training. The way CIT works is through robust collaborative relationships between law enforcement agencies, consumer advocacy groups, and county mental health services. This necessarily requires volunteer efforts</p> <p>Section 10 is unclear on how the diverse cultural population will be reached or involved in the assessment process. This has to be done from the community perspective versus the academic arena. Recommendation to provide financial compensation for the Mental Health Education Council. Provide more information on the make-up and selection process to assure cultural diversity and in both rural/urban representation. Response: The academic community involvement is intended to provide expertise in developing a multicultural assessment of mental illness stigmas, so that communities can be given tools to address these barriers to mental health services and treatment. As described in the PEI plan narrative, the Mental Health Education Council members would receive stipends for their work that is commensurate with a wage. The Council members would be selected to authentically reflect the diversity of the County</p> <p>Post program administrative costs with the plan during the 30-day review process. This would have been helpful to review and would allow for full transparency of the plan. Response: Administrative costs were posted along with the plan. They were also discussed at the Public Hearing and an excel sheet detailing administrative costs was attached to the Executive Summary</p>
<p>Marion M. Karian, Executive Director, Exceptional Parents Unlimited</p>		<p>The following responses relate to the Project 4: Parent-Child Interaction Support in Natural Settings:</p> <p>1. The proposed program describes short-term activities which do not allow for long term interventions other than referral to long term clinical interventions. The problems identified are most often multi-generational and in order to have long term outcomes require long-term intensive interventions. The plan should allow for programs to work with families over at least a one-year period to achieve the desired outcomes. There tends to be a belief in the child welfare system that short term interventions such as parenting and anger management classes have long term impact, when in reality, after many years of working with hundreds of families, is that those interventions which are individualized, are family driven in ways that allow families to set their own goals, and are based on strong relationships between the family and the home visitor are most effective. Short term “fixes” don’t work for long term problems. Response: There are no time limitations on prevention activities. However, any intervention activities in this PEI plan are limited to short-term, usually less than one-year, per OAC guidelines on MHSA PEI funding allowances</p> <p>2. The program proposes to use an LVN but does not adequately describe the role of this level of nurse in the program. LVN’s are trained to provide technical hands on care for patients—most often in hospital or home based care. Most do not have child development, psychology, health</p>

		<p>education training or other educational backgrounds to enable them to provide knowledgeable supports to families in crisis. If nursing is to be represented on these teams, nurses with bachelor level education should be employed. Response: LVNs were included as a potential resource. This project identifies child-development specialists and supervised mental health specialists, as well</p> <p>3. The projected numbers are too high. Work with the described high-risk populations requires that home visitors carry caseloads of no more than 15-20 families and work with them over a one or more year period of time to help families turn around chaotic lifestyles. Over the course of one year, a team of 5 home visitors and 1 mental health clinician would typically see around 110-120 families. The fact that much of the focus of this project is rural would require travel time for staff. 300 families are too many for one year.</p> <p>2. The proposed use of volunteers is of concern. In smaller communities, there can be confidentiality issues surrounding the use of volunteers. Volunteers tend to come in and out for brief periods of time and because of this cannot be counted upon for consistent reliable help in programs that meet children and families each day. In addition, volunteers who work with children require background checks at the same level as staff to assure that they are safe to be working with children. Volunteers must be managed in the same ways that staff must be managed. The budget would need to provide for this level of supervision. Response: The use of volunteers is noted in the narrative to encourage sustainability and community participation. The use of volunteers is noted in the “collaborations” section of the narrative and volunteers or volunteer organizations (such as donated meeting space for center-based activities) are crucial to program success. The project narrative reads:</p> <p>Volunteers may be an important part of this project and will play a variety of roles. Volunteers can assist with the groups and child enrichment in the center based components of the program. They can carry out administrative tasks, such as scheduling transportation and registering participants in the center based groups. Volunteers can also work with a home visitor to offer additional support in the home to families who require more intensive contact. Other roles that volunteers might play include sharing specialized expertise in recreation, crafts, education, and other areas. Funding for some of the proposed activities is very limited. In my opinion, it is better to create programs that are deeper in impact. When funds are spread too thinly, there is limited opportunity for long-term outcomes. First 5 had some early experiences with parenting classes offered in rural areas with basically no long-term outcomes. These short-term interventions do not have life altering outcomes. Response: There are many evidence-based programs, such as PCIT, that are found in the OAC PEI Resource Guide and that demonstrate positive outcomes</p>
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5. Provide the following information about the required county public hearing:***a. The date of the public hearing:***

The 30-day review period ended with an official public hearing conducted by the Fresno County Mental Health Board:

Date: May 27, 2009
Location: Blue Sky Wellness Center
Address: 1617 E. Saginaw Avenue
Fresno, CA 93704

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 draft plan and executive summary of the draft plan were made available on the Fresno County MHSA/PEI webpage with copies distributed at the main public libraries in each of the large cities throughout the County.

Copies of the PEI plan draft were mailed and hand delivered to individuals and organizations that work in all areas of the county. The plan draft and all budget information were posted to the Fresno County MHSA PEI webpage. In addition, presentations were made at various locations throughout the County and copies of the plan draft and executive summaries were distributed. The plan was also presented on Hmong Radio and listeners were given opportunities to call in and ask questions and provide commentary.

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

Table 1.12 displays an overview of the substantive public comments received during the public hearings and the Fresno County MHSA response to each substantive theme or topic of interest. Substantive comments were defined as suggestions that would result in a concrete change in funding or program design. Please note that as there is overlap in the populations being addressed by these projects and that costs vary depending on the nature of a particular intervention. As such, the budgets are not meant to be proportional to a particular age or ethnic group's percentage of the total County population. **It is also important to note that the portfolio of PEI projects is not meant to stand alone; it is meant to complement and expand the network of existing local programs and the new programs that are now**

being developed through other MHSA funding streams, including Community Services and Supports (CSS) and Workforce Education and Training (WET).

d. The estimated number of participants:

A total of 144 individuals were active during Phase IV. Individuals engaged by attending the meetings, providing written and spoken comment or both. 144 individuals attended the public comment meetings; 57 individuals emailed feedback; and 40 attended the final Mental Health Board meeting.

Note: County mental health programs will report actual PEI Community Program Planning expenditures separately on the annual MHSA Revenue and Expenditure Report.

PEI PROJECTS INTRODUCTORY NOTES

The following is a list of the PEI projects that are included in Fresno County's three-year plan. Brief descriptions of these projects are also included in the paragraphs following this list. The brief descriptions will describe the main priority populations and key mental health needs that each project seeks to address. These descriptions are introductory and are intended as a broad overview. Complete details are provided in Form 3 for each project. Due to the nature of several of these projects, more than one priority population or key mental health need may be targeted. In general, significant efforts have been made to ensure that the un-served and underserved communities of Fresno County are targeted along with other priority populations. Based on the tremendous participation of consumers and their family members, we have also ensured that several projects focus on first onset of serious mental illness. Every age group is addressed through one or more of these projects. Please note that Project 8 includes already approved projects through the CSS plan. The purpose of their inclusion here is to fund these prevention and early intervention programs through PEI in order to free up CSS funds for enhanced coordination with the PEI plan.

1. Integration of Primary Care and Mental Health Prevention and Early Intervention at Federally Funded Clinics
2. Cultural-based Access and Navigation Specialists (CHW) and Community-based Peer Support
3. Peri-Natal Prevention and Early Intervention Program for Pregnant/Parenting Women and their Infants
4. School-based Prevention and Early Intervention Program for Kindergarten through Eighth Grade
5. Horticultural Therapeutic Community Centers as Neighborhood Resource Center and Community Site for Delivery of Prevention and Early Intervention Activities
6. First-Onset Consumer and Family Support
7. CIT Training for Law Enforcement and First Responders, including Emergency Room Personnel, and Urgent Mental Health Care PEI Call Center Expansion
8. Fund existing projects or components of projects within the CSS plan through the PEI three-year plan.

Projects 1 and 2 are specifically designed to reduce disparities in access to mental health services as a result of cultural, linguistic, or geographic isolation by providing mental health access in community clinics and other natural, culturally appropriate community settings for prevention efforts and short-term early interventions. Referrals and linkages will be made where appropriate. The priority population therefore is the un-served and underserved communities.

Projects 3 is specifically designed to help un-served and underserved pregnant or parenting women and their infant and children age 0-2. The primary priority population addressed is children and youth in stressed families. This project also potentially addresses trauma exposed individuals through prevention and early intervention activities. First onset of serious mental illness is also a primary focus of project 3, in that pregnant and mothering women will be quickly identified and linked to appropriate services, as needed.

Project 4 is specifically designed for school age children and youth, in particular for those at risk of school failure. **Project 4** will be primarily based in the un-served and underserved regions of the county to ensure increased access to services.

Projects 5 is specifically designed to address the needs of TAY, Adults and Older Adults from un-served and underserved communities. **Project 5** is designed to provide a culturally appropriate and sensitive site for delivery of mental health prevention and early intervention activities, namely to address immigrant-related trauma and PTSD or other growing mental health concerns of the specific community.

Project 6 is specifically designed to address the needs of individuals experiencing the first onset of serious mental illness. Activities in this project will begin at the crisis access point and provide post-crisis recovery assistance for consumers and their families or support persons. **Project 6** includes an in-home family-centered outreach and early intervention support that will facilitate appropriate consumer-family interaction and skill-building. This project will also facilitate a back-up plan of action in the event of decompensation during recovery in order to appropriately get the consumer to psychiatric triage. **Project 6** also includes a workshop that will provide training to County mental health and primary care providers for early identification of the prodromal phase of early psychosis to facilitate the earliest possible identification of individuals who need treatment.

Project 7 specifically address stigma and discrimination against mental illness and individuals experiencing mental illness. **Project 7** will address new mental health concerns as a result of the growing impact of the economic crisis on mental health in Fresno County. This project is an expansion of the urgent mental health care call center to include prevention and early intervention services for individuals seeking help with depression, anxiety, and adjustment disorders as a result of economic stressors resulting from the economic downturn.

Project 8 includes four projects that are currently implemented and funded under the Community Supports and Services plan, but are prevention and early intervention activities that would be more appropriately funded under the PEI plan. They

are included under one heading for ease of reading. These projects have already received prior approval for MHSA funding.

Fresno County is unique in the number of large immigrant communities who do not have access to mental health services either as a result of culture-based barriers and subsequently inappropriately designed existing mental health services to meet the cultural needs of those individuals or because of the undocumented immigration status of a large segment which precludes these individuals from receiving most core service benefits, including mental health and primary care treatment that are otherwise available to those who meet need requirements. Moreover, Fresno County has a significant proportion of its population living at or under the poverty level. The consequences of this include financial barriers to mental health services, increased stressors, increased trauma, and decreased information about mental health and mental illness. The intent of the PEI projects described in this plan is to address the un-served and underserved cultural groups in sensitive and competent ways; to provide increased awareness of mental health and mental illness; to provide prevention and early intervention activities that address the community described needs; and ultimately through these efforts, to reduce the unnecessary burdens on the service side of mental health in order to provide a more efficient mental health system of care.

Many of the projects are expected to be contracted out to the community through the RFP process, while others are more suited to fit within an existing County agency. Fresno County will include language in any RFP and contracts that require that vendors must be in compliance with the approved Fresno County and MHSAOAC PEI plans and requirements related to unique needs of un-served and underserved communities in Fresno County and the specific actions to be carried out for the PEI projects. Contracts shall be awarded, where appropriate, to multiple providers who demonstrate their expertise in meeting the unique needs of the targeted cultural and ethnic communities and in their ability to carry out the specific provisions of the given PEI project. Culturally competent services shall be a primary focus in *all* RFP's and awarded contracts.

County: Fresno **PEI Project Name:** 1. Integration of Primary Care and Mental Health Prevention and Early Intervention Services at Federally Funded Clinics

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

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

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

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

The PEI Community Planning Process for Fresno County found that the highest priority population was the underserved cultural populations. Survey data also identified individuals who are poor as a high priority underserved population. The geographically disperse area of western Fresno County is predominately populated by migrant Latino farm workers, many of whom are undocumented, and who do not have access to mental health services. Native Americans in the eastern foothills and south central areas of Fresno County and the African American, Hmong and Southeast Asian populations in the metropolitan areas of the City of Fresno also experience disproportionately high rates of poverty. In numerous focus groups, interviews and community meetings throughout Fresno County, stakeholders discussed the importance of primary care facilities in mental health prevention and early intervention, in particular in the rural and underserved areas of the county. For a number of reasons, including culture-based stigma and transportation, many of Fresno County's immigrant families are unable to address mental health concerns in a timely manner. As a result, first contact with mental health services is often after a mental health concern has progressed to a crisis level. It is critical that primary care centers that are Rural Clinics, FQHCs, and Tribal Clinics have an integrated mental health prevention and early intervention services component that can serve as a non-stigmatizing, warm site for identification of and, if necessary, entry to mental health services funded through CSS or other County/private agencies, as appropriate. Integrating mental health prevention and early intervention services at community-based primary care facilities that currently provide services to underserved rural families will in part also address transportation concerns as one of the major barriers to accessing services as a result of the geographic size of Fresno County and the location of existing mental health services mostly within the metropolitan area of the City of Fresno.

Integrating primary care and mental health prevention and early intervention services will also provide much needed opportunities across all ages for addressing trauma-exposed individuals, including culturally based, intergenerational PTSD and trauma associated with an individual's immigration status or new life in a foreign and often unwelcoming host culture. This project may also address children and youth in stressed families whose undocumented immigration status and poverty are causes of significant stress, especially in the absence of mental health services. This project will also be particularly advantageous to older adults who may have less personal difficulty seeking mental health advice and outreach at a primary care facility.

- *One resident at a Stakeholder Meeting in Coalinga responded that what was needed most to help families is "Services of all kinds—MH professionals and other para-professionals do not like coming up here, and when they do, they operate within the times of 8:00-5:00, which means that they come from Fresno and arrive in Coalinga/Huron at 10:00, go to lunch at noon for an hour, and leave by 3:00. People who work have no access to any such services. There is no sense of urgency for county staff to travel out to west Fresno County."*

- *One teen mother from a focus group reported that she cannot drive even if she could afford it because she cannot get a drivers license since she is undocumented, having been born in Mexico but raised entirely in the US. Moreover, since she has to take the bus (for mental health services) with her baby, the distance she has to walk from the bus stop to her home in a very poor neighborhood makes her afraid. She has been repeatedly approached and harassed and once even experienced a nearby shooting, with the shooter running past her, while she walked with her baby in a stroller.*
- *Another respondent from a rural focus group noted that “Other than district services, our community has no mental health resources to deal with the school-age child (with exception of New Paths Mediation). Not to sound too flippant, ANY services would be appreciated if they were provided within our community.”*

3. PEI Project Description: (attach additional pages, if necessary)

a. Description of proposed PEI Intervention.

This project provides the funding for mental health prevention and early intervention services in primary care settings. The short term early intervention treatment that may be provided in these community clinic settings cannot exceed one year. This Project will expand the capacity of community health care clinics to provide mental health screenings as indicated (e.g. PHQ-9), care coordination, and short term early interventions. Clinic providers will receive training on delivering short-term services to individuals who present early in the manifestation of mental health concerns, including depression, anxiety disorder, and other non-SMI (SMI consumers will be referred to appropriate services, and in the event that the illness is a first onset, they will be referred to PEI Project 9, below). Clinic administrators will work to implement policies that support best practices for mental health integration. Training needs will be ascertained in collaboration with the MHSA WET plan.

It is anticipated that up to 10 (0.5 FTE) licensed clinicians, plus 10 (1.0 FTE) peer support specialists will be funded to provide screening, direct mental health prevention and short term early intervention services for individuals who present with symptoms early in the manifestation of a mental illness in community clinic settings across the county. Mental health professionals will work with patients to help identify resources and supports to eliminate or reduce stressors in their lives. Mental health professionals, working in tandem with cultural brokers (see PEI Project 2, below) will help culturally and linguistically isolated individuals identify the services and supports necessary to stabilize their mental well being. As appropriate, care coordinators will help transition patients to more extensive existing mental health services both within clinic practices and as funded through MHSA community services and supports.

Providing mental health prevention and early intervention at federally funded clinics is designed to integrate and/or build capacity specifically at FQHCs, Rural Clinics, and Tribal Clinics. This Project focuses on primary care centers as the

nexus of care in un-served and underserved communities throughout Fresno County. It seeks to augment the existing health care services available at primary care centers to help ensure that they are more able to provide prevention and short term early intervention for mental health issues such as depression, anxiety, and other mental health concerns. The project will fund capacity building by funding care managers and LCSWs within clinics to provide assessments and short term early interventions, such as teaching coping skills and linking participants to more extensive services as needed outside of PEI. The project will include a special focus on Latino populations in the western part of Fresno County, Native American populations in the foothills of eastern Fresno County and south central Fresno County, African American populations in West Fresno metropolitan area, homeless individuals, and Hmong and Southeast Asians in the central metropolitan area of Fresno. By providing mental health prevention activities and short-term early interventions at community clinics within Fresno County, many of the barriers to access that exist for the n-served and underserved cultural and linguistic groups noted above will be directly addressed. Furthermore, this project envisions strong collaboration with Project 2 (the Community Health Worker and Peer Support Project) to ensure that barriers to access for all cultural communities in Fresno County will be significantly reduced. Furthermore, we anticipate significantly improved penetration rates for early interventions for ethnic, cultural and linguistic communities as a result of the de-stigmatizing nature of the ability to receive short term early interventions at a site that is principally primary care in nature.

Provider: To be identified through one or more RFPs or County Agencies. Collaborative proposals, if applicable, are strongly encouraged. Bid applicant(s), if applicable, must demonstrate bona fide cultural and linguistic competency for the communities identified in this project narrative.

Use of Funds:

- Provide funding for contracting LCSWs within primary care clinics to provide prevention and early intervention services in community clinics for individuals to resolve mental health issues through short-term early intervention and to provide linkages for those individuals who need more extensive services.
- Incorporate best practices for integrated primary care and mental health care services so that prevention and early intervention activities, including assessment, short term treatment, and linkages to other appropriate projects within the PEI plan can increase access and reduce the need for long term mental health treatment by identifying mental health problems or concerns early and providing early intervention treatment over a short duration, where appropriate. Individuals identified as needing more extensive mental health treatment will be linked to appropriate CSS or other County or private mental health services outside the scope of PEI.

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

By far, the highest identified need of the Community Input Phase in Fresno County is the need to address the disparities in access to mental health services. Providing easily accessible, on-site assessment of mental health, consultation and short term early interventions for mental health concerns and problems, such as depression, anxiety, and PTSD at community primary care clinics directly addresses that need. At the same time, underserved cultural, ethnic, linguistic and rural communities make up the highest priority population as identified through focus groups, survey responses, and stakeholder meetings.

This Project has been developed to address some of the largest disparities in access related to income, geography, language and/or cultural background. The funding provision of the mental health clinician at the LCSW level at these community clinics will provide short term prevention and early intervention for hundreds of poor and working poor residents of Fresno County who would otherwise forego treatment due to the cost of private help. As stated in the program summary and through the affirmation of the MHSA Planning Panel, this project is also intended to be spread throughout the county with an estimate of six to ten clinics in diverse locations. The west, the eastern foothills, and the south central areas of the county have been specially noted in this planning process as requiring services. In conjunction with other PEI projects (see Project 2 below), the cultural access and navigation specialists will ensure that linguistically and culturally isolated Hmong and Spanish speakers will have greater awareness of and be more comfortable with accessing mental health prevention and early intervention services in the non-stigmatizing environment of a primary care facility.

The Latino Population

According to the California Mexican Health Initiative Mental Health Fact Sheet 2005:

- Among Latino Americans with a mental disorder, fewer than one in eleven contact Mental Health Specialists and less than one in five contact general health care providers. The utilization rates are even lower among Latino immigrants
- While the percentage of mental health professionals who speak Spanish is not known, only about 1% of licensed psychologists, who are members of the American Psychological Association, identify themselves as Latino. Moreover, there are only 29 Latino Mental Health professionals for every 100,000 Latinos in the United States, compared to 173 non-Latino White providers per 100,000 non-Latino Whites

The Asian/Pacific-Islander (API) Population

According to the Surgeon General's 2001 Report:

- Nearly half of APIs have problems with availability of mental health services due to limited English proficiency and lack of providers who have appropriate language skills

- It has been estimated that about 21% of APIs lack health insurance. The rate of public health insurance for API's with low income, which are likely to qualify for Medicaid, is well below that of Whites from the same income bracket.
- API's have lower rates of utilization when compared to Whites. This under-representation in care is characteristic of most API groups, regardless of gender, age and geographic location. Among those who use services, the severity of their condition is high, suggesting that they delay using services until issues become very serious. Stigma and shame are major deterrents to their utilization of services.

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

This project will occur in primary care settings and assessment; short-term early interventions and linkages will be provided by a licensed clinician at the LCSW level, in order to match federal Medi-care requirements for billing purposes, as appropriate. The primary care physician and mid-level staff, including registered nurses, nurse practitioners, and front-end staff will be trained in mental illness warning signs and precursors as well as sensitivity and privacy issues, in order to facilitate capacity building and communication with on-site mental health providers. Primary care staff and mental health staff will need to work collaboratively to achieve the desired outcomes of identifying signs and symptoms of mental illness and directing these individuals to the most appropriate service provider, including the on-site LCSW for short term services and assessments.

Integrating mental health prevention and early intervention services with primary care at community primary care clinics will greatly improve access to services for thousands of underserved individuals in the western rural areas, foothills and tribal areas, and underserved metropolitan communities where services are currently difficult to access.

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

This project is designed to provide short term mental health preventions and early interventions to underserved and indigent Latino communities in west Fresno County, where there are currently few mental health service options. The population in west Fresno County is predominately Latino, with many undocumented farm workers who live in severe poverty and have few resources or access to mental health services, as learned through focus groups and community meetings in Mendota, Stakeholder Meetings in Coalinga and Huron, and through surveys and Planning Panel participation from Latinos from west Fresno. Native Americans and other indigent rural communities in the eastern foothills of Fresno County also lack access to mental health services, as learned through focus groups at the Native American Gathering at Haslett, focus groups at Big Sandy Rancheria, and a Stakeholder Meeting in Tollhouse. Tribal Clinics and rural clinics in these areas are vital to reducing these disparities in access to mental health services. Similarly, south central Fresno

County and the Fresno metropolitan areas have FQHCs that serve indigent Latinos, African Americans, and Hmong and Southeast Asian communities.

e. Highlights of new or expanded programs.

This project serves to initiate new mental health prevention activities and early interventions within Fresno County. As stated previously, there is an absence of adequate prevention and early intervention of mental health needs in the underserved and rural communities, particularly in west Fresno County, the eastern foothills, and in the south central and metropolitan areas of the County. The proposed interventions will link individuals who can benefit from early intervention services with mental health providers on site for short term treatment, for the purpose of reducing the need for more extensive mental health treatment. Those with SMI/SED or who need more extensive mental health treatment can be linked with a warm hand-off to appropriate County mental health or private mental health services outside of the community clinic.

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

To carry out this project, MHSA/PEI will identify federally funded community clinics, possibly through the RFP process, that will participate in the integration of primary care and mental health prevention and early intervention services. Once identified, these community clinics will be required to train primary care practitioners, mid-level and front-end staff on mental health issues, medications, sensitivity, mental health resources (including the urgent mental health care facility) and HIPAA/mental health record keeping, as appropriate. Participating clinics will also either hire or contract LCSWs for the purposes of prevention and early intervention services; including assessment and identification of mental health concerns or illness; provide quick-access, short-term early intervention treatment; provide linkages to prevention and early intervention activities from the PEI plan in the community that are culturally and linguistically appropriate; and provide warm hand-offs to more extensive mental health services within CSS, or other County or private mental health agencies.

Bid applicants, if applicable, will be encouraged to develop innovative collaborations and partnerships to meet the prevention and early intervention needs at these community clinics. This project will fund LCSWs for screening, short term intervention treatment for indigents and ultimately warm hand-offs for those who need mental health treatment that is not short term at FQHCs, Rural Clinics, Tribal Clinics or any federally funded clinic for the purpose of increasing access in the rural and other un-served and underserved communities in Fresno County. Under existing federal law, FQHC, rural and tribal health clinics can provide and bill for mental health service for Medi-Cal beneficiaries but have no way of paying for consumers who have no insurance coverage. The FQHC, rural and tribal clinics already have bi-cultural and bi-lingual staff. It will also collaborate closely with the MHSA WET plan for the purposes of training primary care physicians, mid-level staff and front-end staff so that they will be able to communicate with the LCSW and other preventative and early intervention mental health staff in order to facilitate capacity building to intervene in cases of mental illnesses that are in

the early manifestation, including depression, PTSD, and anxiety disorders, among others, while referring individuals assessed for SMI/SED or more extensive mental illness to appropriate services, or in the case of first onset consumers, referrals to the PEI first onset consumer project services or through CSS or other appropriate County/private mental health providers. This project creates access, provides crucial early intervention, and reduces stigma by providing a neutral site for services within the community. This project also leverages existing site resources. There is also a billable component if federal requirements are met, thereby providing long term sustainability.

g. Key milestones and anticipated timeline for each milestone.

- Month 1 – Approval from OAC
- Month 2-3 -- Procurement process to solicit proposals for programs and identify the primary care facilities
- Month 4-6 -- Program start-up, which would include recruitment, hiring and training of staff and program/infrastructure development
- Month 6-8 --Program implementation

4. Programs

Program Title:	Proposed number of individuals or families to be served through June 2010 by type:		Number of months in operation through June 2010
	Prevention	Early Intervention	
Integration of primary care and Mental Health Services at Rural, Native American or Community Clinics for Indigent Care	Individuals: 780	Individuals: 260	9
Total PEI project estimated unduplicated count of individuals to be served	Individuals: 780	Individuals: 260	9

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

Underserved individuals whose assessed mental health concerns are of such a magnitude that short term early interventions are insufficient through the Rural Clinics, FQHCs, and Tribal Clinics, will be linked through a warm hand-off to the most appropriate county mental health or appropriate private mental health services as indicated by the LCSW and other supporting mental health and primary care staff. Individuals treated for mental health services in primary care facilities, in particular those who have suffered trauma, such as sexual abuse or domestic violence, or are at risk for trauma, such as living in homes with substance abuse problems, will be linked with appropriate community partners, as indicated. Existing site resources as provided by the community clinics will be leveraged for the purpose of building capacity at these clinics to serve the short-term non-SMI mental health needs of the underserved communities throughout Fresno County.

The mental health specialists at these clinics will refer those who are eligible for county mental health services and the referring practitioner will follow-up with the patient to ensure that the patient was able to receive the needed services. Any problems will be followed-up by the mental health specialists at these clinics. Those who need mental health services and do not qualify for county services will be referred to linguistically accessible community mental health programs. Those who need primary care services will be referred to appropriate County or CBO programs in the community.

6. Collaboration and System Enhancements

It is anticipated that Fresno County Mental Health will work collaboratively with primary care personnel in the rural areas and underserved metropolitan areas of Fresno County to build capacity at federally funded community clinics. Funding for LCSWs (and support staff), *and* training of primary care personnel, (including Physicians, Mid-Level Staff, and front-end Staff) will foster an environment in which prevention and short term early intervention can be provided in a non-stigmatizing and culturally appropriate way, while also respecting the privacy rights of individuals. County Mental Health staff will work closely with these clinics to ensure that properly assessed individuals with SMI/SED or other extensive mental health needs will be received through a warm hand-off from the community clinics and that culturally-based access and navigation specialists (See Project 2 below) will work in collaboration with the County Mental Health and primary care staff when appropriate.

The primary goal of this PEI project is to integrate mental health prevention and short term early intervention with primary care at Rural Clinics, FQHCs, and Tribal Clinics. The goal is to provide short term interventions at these community clinics and provide warm hand-offs for those individuals who need more extensive treatment. By meeting federal guidelines and requirements, including providing LCSWs at these clinics, mental health treatment through the LCSW will be billable through Medi-Care and thus provide some degree of sustainability for short term early intervention services for a variety of mental health concerns. Initial start-up training and hiring will present initially higher funding requirements, but over time, these funding levels should subside as service revenues increase.

This project will be sustained by licensed mental health clinicians and/ or psychiatrists supervising direct mental

health specialists at federally funded clinics, who have the ability to reimburse a portion of their costs and return visits of clients to the clinics. Other costs in this PEI project will be sustained through MHSA funding, which is a cost-cutting measure to provide short-term early interventions to individuals --prior to their developing a more extensive mental illness and thus need for more extensive services. As part of implementation, Fresno County MHSA will assess potential providers' management and capability to fiscally manage and sustain this program. Fiscal and program monitors will be assigned to the program at start-up. Progress reports and follow-up will be scheduled quarterly to address any emergent problems. Program evaluation will address sustainability and progress in achieving goals. Program success will be sustained through the positive outcomes of this project.

Much of the infrastructure is currently in place for this service. Community health centers have an established location, which minimizes space costs. Clerical staff time will also be leveraged. Additionally, the mental health specialists will utilize existing waiting room areas, medical records expenses and referral processes and health education staff. The established data management system will also be leveraged to gather patient demographic and utilization data. There will be no costs related to project promotion for clinics, as there are existing patients to whom screening will be available. Through the procurement process, agencies will be asked to describe their plan for leveraging additional resources and/or funding.

7. Intended Outcomes

Individual	System/Program/Community	Proposed Methods/ Measures of Success
<ul style="list-style-type: none"> • Appropriate and early identification of mental health issues in underserved cultural and linguistic populations who frequently use targeted community clinics • More appropriate and timely mental health services that prevent more disabling conditions • Increase in culturally and linguistically appropriate services for the individual • Linkages to appropriate PEI 	<ul style="list-style-type: none"> • Increase awareness and recognition of mental health issues amongst primary care professionals • Increase non-stigmatizing screenings for mental health issues and timely referrals by primary care staff • Reduction in stigma of mental health services utilization by older adults • Increase appropriate use of services so that allocation of resources is more cost-effective 	<ul style="list-style-type: none"> • Tracking logs to measure number of mental health screenings per client • Increase in penetration rates for mental health services at community clinics • Community surveys to determine the degree to which integrated mental health care at community clinics is deemed to be effective

<p>activities throughout the underserved communities</p> <ul style="list-style-type: none"> • Linkages to appropriate long term mental health services outside the scope of PEI 	<ul style="list-style-type: none"> • Increase in penetration rates for underserved cultural and linguistic communities 	
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8. Coordination with Other MHSA Components

MHSA CSS components include FSPs whose contracts require collaborative outreach to primary health care providers. In particular, the outreach and engagement project currently in the CSS plan will provide engagement with children and families at primary care facilities. The MHSA CSS FY08/09 update includes a re-design of the crisis intervention services that includes an urgent mental health care center for psychiatric triage. Integrating prevention and early intervention assessment and short-term services in community clinics will require collaboration with both existing FSPs and activities within CSS and the re-design of the crisis intervention services that include the urgent mental health care center.

Fresno County’s MHSA Workforce, Education and Training (WET) Planning Panel has developed a series of Career Pathways strategies to diversify the mental health workforce to more closely reflect the community in which we serve. PEI and WET programs will partner in areas of staff recruitment and training. This is particularly important for the integration of mental health and primary care at community clinics. In particular, Fresno County’s WET plan includes Action Item no. 6, which provides on-going training to primary care providers in mental health and MHSA.

At this time, no Capital Facilities funds have been identified for this project. It is possible that IT computer labs may be located at some of the community clinics. Please refer to the Fresno County MHSA IT plan.

9. Additional Comments (optional)

N/A

County: Fresno **PEI Project Name:** 2. Cultural-based Access-Navigation Specialists (CHW) and Peer Support

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

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Stigma and Discrimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. PEI Priority Population(s) Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
B. 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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Children and Youth in Stressed Families	<input type="checkbox"/>	<input type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input type="checkbox"/>	<input type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input type="checkbox"/>	<input type="checkbox"/>		
6. Underserved Cultural Populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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

The PEI Community Planning Process for Fresno County found that the highest priority population identified was underserved cultural populations. Fresno County is unique in its rich cultural make-up, with many diverse immigrant, ethnic and linguistic groups. As an example, and as informed through focus groups, one must be careful and avoid over generalizing the Latino population in Fresno County, since there are diverse Latino communities in the county, each with its own features. The **undocumented migrant Latino farm workers in west Fresno County** face specific problems as a result of their immigration status and the cycle of seasonal work and poverty. Their stresses are also compounded by an extended drought which threatens to completely shut down the water supply to the area and to employment prospects. As a result, their needs differ from those of other Latino communities. **Legally documented Latinos** also do not necessarily speak English and also deal with cultural and linguistic barriers to access, but they do not have the level of fear of authorities and legal concerns that undocumented individuals have. It is also important to note that many of the incoming migrant workers are **First Americans from Mexico**, who do not speak Spanish or English. These groups are comprised of indigenous individuals who are Mixteco and Zapoteco from southern Mexico. Many of their needs will likely coincide with the needs of Native Americans, as described below. Yet another Latino community is **the English-speaking Latino-American community**, whose families have lived in the United States for several generations, but who also have specific culture-based needs. The following are some of the concerns expressed by migrant Latinos in Mendota:

- *Because of my legal status, I can't apply for public assistance*
- *We have no programs to deal with depression*
- *We have no idea where to go for talking about our problems*
- *Stressed families who do they call?*
- *I can't go talk to neighbors because I am embarrassed. I have no one to talk to*

Focus groups for **Hmong and Southeast Asian communities** highlighted the need for trust building and engagement. Southeast Asian communities are highly self-reliant, but experience fundamental stressors and barriers to access including linguistic barriers, culture-based stigma, daily living issues, and trust issues, given their experiences with governments from their homelands and with experiences of mistreatment by many in the host culture where they now live. Problems include basic daily life challenges, such as employment, transportation, and places for socialization. The following are some of the responses gathered at a focus group for Hmong families:

- *My son wants to commit suicide because it is very hard to live in this country*
- *I cannot get around without a driver's license. I can't get driver's license because no one speaks Hmong at DMV*

- *Financial issues in my home. My family has left me because I cannot provide. I am stressed by this. I have suicidal thoughts.*
- *We need a consultant to address mental health, laws, and suicide—for both Hmong and Western cultures*
- *Programs that help us fill out job applications and other forms to help us become self sufficient*
- *More Hmong county staff*
- *Cultural sensitivity training at the schools so teachers can communicate with Hmong parents to help them understand the school curriculum*

For the **Native American community**, lack of services and cultural insensitivity have left the communities highly distrustful and concerned with being subjected anew to broken promises and superficial engagement. At a talking circle of an annual gathering of Native Americans from the area, several communities reported their experiences of being lied to, being left out of the loop, and being discouraged, even by this prospect for prevention and early intervention activities that address Native American concerns. One specific idea that was developed was the need for a liaison to facilitate trusted, authentic two-way communication between the communities and various systems, including mental health care. Some of the concerns expressed by representatives from the Native American community include the following:

- *suicide (in the family and among friends, one suicide in particular was by intentional methamphetamine injection overdose) as a result of extraordinary poverty, sense of loneliness and isolation, and hopelessness*
- *specific experiences with depression related to multigenerational PTSD*
- *depression related to feelings of loneliness and a sense of lack of belonging to the wider community, and unemployment*
- *experiences with the MH system and the inappropriate/inauthentic past attempts to placate Native American customs (compounded by lack of outdoor space in which to provide any opportunity for Native American customs to take place)*
- *deep mistrust of the “white man” and “new” programs or promises of new programs*

The **African American community** in the metropolitan area west of the City of Fresno will also be served. In a key informant interview with the West Fresno Health Care Coalition, Ms. Yolanda Randles, Executive Director, described the scope of the work of the West Fresno health Care Coalition, and explained some of the difficulties that the African American community has experienced with Fresno County and other local government agencies. These challenges included lack of consistent message from government organizations to the West Fresno community, lack of authentic outreach by those agencies, and breaking perceived promises. In particular, Ms. Randles described the consequences of these experiences as the challenges we now face in getting continued feedback from the community. They do not come out to help, because they believe that nothing substantial ever comes from it.

3. PEI Project Description: (attach additional pages, if necessary)***a. Description of proposed PEI Intervention.***

The CHW model is based on previous research and pilot interventions that establish the validity of this model. Examples in the United States of successful community health worker models are the Navajo Community Health Representatives and the migrant farm worker programs of the 1950s and 1960s, respectively. Internationally, the World Health Organization's (WHO) Declaration of Alma-Ata, in 1978, stated a key strategy for the delivery of basic health care services is the use of community health workers. The community based CHW Program will help eliminate the stigma that groups and/or individuals have about mental health and its services, and thus improve individuals' knowledge of mental health and availability of services designed to meet their psychological and emotional needs. The CHWs will outreach to the community in order to provide a personal contact or liaison to mental health resources and programs within the community so that individuals will not have to visit a traditional mental health treatment site. The Culture-based Access and Navigation Specialist will also assist in the developing peer support groups to help individuals with mental health concerns receive short term treatment early in the manifestation of a mental health concern in natural community settings that are culturally sensitive and linguistically appropriate. The CHWs will actively pursue the feedback of community stakeholders, monitor the number of service contacts through sign-in procedures, and evaluate the effectiveness of contacts/presentations through pre-and post-feedback worksheets.

This project is modeled significantly on evidence-based community based health models, utilizing community healthcare outreach workers (CHW) employed by community organizations. The CHW model is used because CHWs are effective disseminators of information, and act as the bridge between governmental and non-governmental systems and the communities they serve. Community health workers also act as change agents within their naturally occurring social networks. Moreover, top-down and bottom-up outreach and engagement efforts are less effective than "horizontal" collaborations between professionals and residents in underserved communities. Direct, local involvement can generate creative and dynamic efforts to address disparities to mental health services in these areas and for these groups. The project would also feature the addition of a peer support component which is culture-specific and tailored to help bridge cultural and language divides through advocacy, education, and short term peer-support for non-SMI intervention for individuals and families dealing with economic and immigration-related challenges in a de-stigmatizing and culturally appropriate manner. CHWs who serve the Latino communities are primarily *Promotores*, while this cultural-based CHW project will serve each underserved cultural, ethnic, and racial community. This project envisions that individuals of relatively high importance for a given cultural community may act as the CHW (including Hmong Shaman and Native American Spiritual Leaders, for example). CHW services are delivered, for the most part, through community settings, home visits and group presentations, and also specifically include mental health promotion strategies that impact knowledge, attitudes, and practices on a community level. To reach the unreachable, the CHWs go where people

congregate. This could be at events such as health fairs, church and neighborhood meetings, factories, laundromats, gas stations, and grocery stores, among other locations. Trusted experts from within each of the un-served and underserved communities of Fresno County will provide information about resources and linkages to those communities through advocacy, engagement, education, and knowledge about mental health services, including the array of prevention and early intervention activities in the community. For example, short term peer support interventions can be used for addressing coping skills to deal with immigration-related traumas and can be accomplished at natural community sites that are trusted and culturally appropriate. For example, the potential PEI project “Culture-based Horticultural Therapeutic Community Center as Neighborhood Resource Center” (See project 7. below) could be a site at which short-term mental health peer-support interventions can be delivered in a culturally and linguistically sensitive and appropriate way, as informed by the community needs and communicated through the access and navigation specialists from each underserved cultural, linguistic, racial and ethnic community.

Individual un-served and underserved communities will be identified, possibly through the RFP process, in order to develop a robust Culture-based Access and Navigation Specialists program within the community that will provide educational outreach (up to 50 educational session multiplied by an average of 25 unique individuals from the community) at natural community settings. The CHW will identify at least two peer support specialists from within each of the un-served and underserved cultural and linguistic communities (Latino, Hmong, Southeast Asian, Native American, African American) to work with them. In collaboration with County mental health, the organizations that are awarded contracts or County Agencies, as appropriate, for the CHWs and peer support specialists must provide training in mental health illness, signs and symptoms, features of medication, sensitivity, and mental health resources of the County and private providers/agencies. The peer support specialists will provide prevention and short term early intervention within the community at natural community settings.

The CHWs and peer support persons must be carefully recruited for cultural and linguistic competency in order to participate in the program. Faith-based organizations of all denominations may assist with recruitment and dissemination of information as focus group data shows that many underserved groups within Fresno County trust these organizations. Each CHW will receive extensive training that teaches knowledge of relevant mental health topics. They will be trained to identify and recognize early signs and symptoms of substance abuse and mental health disorders, work with resource center staff in delivery of prevention and early intervention psycho-social educational programs, development of culturally relevant materials, and assist in ensuring services are delivered in a culturally sensitive manner. They will also be trained in ways they can participate in mental health coalition building to strengthen their communities’ capacity to increase resilience and wellness.

This project must include the following components:

- Training of staff on the CHW/Promotoras model;

- Identification and effective recruitment strategies of leaders in communities to become CHW/Promotoras/es;
- Interview tools for identifying effective candidates to become CHW/Promotores;
- Bi-cultural and bi-lingual MH specialist or CHW for underserved communities as informed by respected leaders/representatives from those communities (Hmong, Southeast Asian, Latino, Native American, African American);
- Warm linkages to more intensive mental health services, as indicated;
- Collaboration with primary care clinics with integrated mental health services that receive MHSA PEI funding;
- MH collaboration, education and promotion that is inclusive of culture-specific resources, such as curanderos, traditional healers, spiritual leaders, and shamans;
- Function as a MH liaison for underserved communities to help provide consistent message and communication stream between MH systems and individual communities;
- Train-the-trainer approach for sustainability and capacity building.

Provider: To be identified through one or more RFPs or County Agencies. Collaborative proposals, if applicable, are strongly encouraged. Bid applicant(s), if applicable, must demonstrate bona fide cultural and linguistic competency for the communities identified in this project narrative.

Use of Funds:

Funding will include salaries/stipends for Community Health Workers and Peer Support Specialists, training, consumer incentives, design of an outreach plan and reasonable operating costs. At least five (4) CHWs and at least ten (9) Peer Support Specialists will be funded. The Community Health Workers and Peer Support Specialists are expected to work collaboratively with other components and projects in the PEI plan. For example, CHWs can provide linkages, education and outreach at Horticultural Therapeutic Community Centers, community clinics, and in other natural community settings. Peer support can be provided through the Horticultural Therapeutic Community Centers, community clinics, and in other natural community settings. The CHWs must be from within the various cultural, linguistic, ethnic, and/or racial communities, and must be linguistically and culturally competent of those cultures, ethnicities, and the language of the community.

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

Community Input data has identified several significant barriers to access to mental health services that are based on cultural, ethnic and linguistic needs. Further highlighting this problem, data from the Fresno County Mental Health Plan illustrate culture-based disparities to access and treatment:

- 62% of consumers of public mental health services are Latino
- 11.17% of consumers of public mental health services are Southeast Asian or Pacific Islander
- 8% of consumers of public mental health services are African American
- Fresno County also has large Middle Eastern, Indian/Punjabi populations
- 34% of licensed mental health staff is white/Caucasian, resulting in linguistic and cultural disparities for consumers

By developing a culturally informed access and navigation specialist and community-based peer support at neighborhood resource centers, faith-based and community-based organizations, many in the immigrant and culturally marginalized communities will be empowered through their own trusted key social leaders and their representatives to develop culture- and language-specific prevention strategies, and intervene in a culturally sensitive and linguistically appropriate way at the earliest possible juncture of a more serious mental health problem, thereby reducing many of the culturally determined disparities in access to mental health information and the mental health system.

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

This project will take place in natural community settings, such as neighborhood resource centers, Horticultural Therapeutic Community Centers, faith-based, and community-based organizations. Additionally, this project will also work in collaboration with community primary care clinics that receive PEI funding for the integration of mental health services. As needed, the culturally-based access and navigation specialist may provide culturally appropriate advocacy and educational services at a mental health facility in the event that an individual from the community is experiencing a first break with SMI. The CHW is a community member and is able to relate with the population they serve, to understand community values, beliefs, and language. The program is selected because it is sufficiently developed to be carried out with fidelity and its strong likelihood of achieving the desired PEI outcomes. Furthermore, the approach is rooted in cultural assets as it embraces positive traits among community members, while it builds leadership and trust. This approach of raising awareness of mental health needs, namely prevention and early intervention is consistent with PEI Key Mental Health Needs, and Priority Populations.

A review of health literature confirms that the Community Health Worker (CHW) model has been implemented successfully in a variety of settings, both urban and rural, and to address a myriad of mental health concerns within

communities. Additionally, research confirms that a promoter-based community health program is a culturally appropriate model, which can be successfully implemented in community settings among various ethnic populations with limited or no English proficiency.

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

This project is designed to serve underserved communities in Fresno County. The geographic areas and corresponding underserved populations include:

1. Underserved Latino communities in west Fresno County, where there are very limited mental health services. The population in west Fresno County is predominately Latino, with many undocumented farm workers who live in severe poverty and have few resources or access to mental health services, as learned through focus groups and community meetings in Mendota, Stakeholder Meetings in Coalinga and Huron, and through surveys and Planning Panel participation from Latinos from west Fresno
2. Native Americans and other rural communities in the eastern foothills of Fresno County also lack access to mental health services, as learned through focus groups at the Native American Gathering at Haslett, focus groups at Big Sandy Rancheria, and a Stakeholder Meeting in Tollhouse. Leveraging existing neighborhood resource centers, community-gardens, faith-based, and community-based organizations is vital to serving these populations and providing the type of advocacy and two-way communication that is necessary to help reduce disparities in access to mental health services. In addition, it is expected that several Rural Clinics, FQHCs, and Tribal Clinics will have funding to integrate mental health services at their facilities. It is expected that the Culturally-based Access and Navigation Specialist will collaborate with these community clinics
3. Hmong and Southeast Asians in the central Fresno metropolitan area are underserved in that cultural and language barriers to access are profound and pervasive. As informed through two focus groups, one with Hmong families and the other of at risk Hmong and Southeast Asian youth at the Lao Family Center, the Southeast Asian populations suffer from immigration-based trauma as well as PTSD resulting from their experiences in their homelands, as survivors of war and/or totalitarian governments. Moreover, these communities often lack transportation or a western understanding of mental illness, often defining such illness as fate or spiritual retribution for some past transgression in the family or clan. Many of the Southeast Asian languages lack the nomenclature for mental illness and describe, for example, anxiety disorder as “being nervous” or depression as “sadness”

4. African American communities in the west Fresno metropolitan area are distrustful of outsiders, especially those from government agencies, as recorded in a key informant interview with the advocacy organization, West Fresno Health Care Coalition, which has developed a very close relationship with the African American community

e. Highlights of new or expanded programs.

This project serves to initiate new services within Fresno County. As stated previously, there is an absence of adequate culturally-based and culturally-sensitive preventative mental health care in the underserved and rural communities, particularly in west Fresno County, the eastern foothills, and in the south central and metropolitan areas of the County. The proposed interventions will include culturally appropriate community-based peer support for many of the non-SMI mental health concerns in the underserved communities, including trauma that is based on status as a new American, or multigenerational PTSD, and depression. Those with signs and symptoms of SMI can be linked through a warm hand-off to appropriate services at an appropriate facility. With this program we will train identified community leaders to provide a personal contact or liaison to mental health resources and programs within the community, so that participants can receive assistance without having to visit a traditional mental health service site.

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

In coordination with project partners, the contractor/provider will develop and implement training for all program staff. Integrated Care Managers will receive the following training: coordination and integration of mental health and primary care services to older adults; mental health and the aging process; clinical practice guidelines for treatment of depression; screening; assessment protocols for mental health, alcohol, substance abuse and domestic violence screening; medical necessity criteria for referral to specialty mental health; cultural competence and evidence-based interventions for integrated treatment of medical and mental health conditions; Problem Solving Therapy and Chronic Disease Self-Management. In coordination with DBH and other community partners, contractor will provide 40 hours of initial training to promotoras/health educators. The training curricula will include, but will not be limited to, role of CHWs/promotores, work environment, cultural issues, aging and mental health, culturally competent outreach, chronic disease self-management, senior peer counseling and support, medications use and misuse, alcohol use and abuse, community resources, wellness, rehabilitation and recovery, care management and record keeping.

The training should empower CHWs to design their own plan of action, based on the perceived mental health needs of the particular cultural community they represent. After they are provided with knowledge and skills, they will be encouraged to identify the mental health priorities in their community and develop a plan of action on how they will address these priorities (in addition to dissemination of health information and health care access facilitation).

The CHW will disseminate information in several ways. The strategies bulleted below will ultimately provide data regarding the effectiveness of the Culture-based Access and Navigation Specialists project with additional follow-up information obtained through random phone and/or paper surveys. These surveys would indicate the degree of individual/family mental health, whether or not further resources were accessed and the success of the program objectives.

Necessary activities for project success include:

- Frequent (e.g. monthly) educational presentations to faith-based groups, community groups, and school groups (such as the Parent Teacher Association (PTA))
- Regularly scheduled (e.g. quarterly) “Knock and talk” sessions where they target relevant neighborhoods to provide outreach, education and support
- Follow-up community meetings to enhance all outreach and engagement activities
- Maintain contact lists and other evidence of CHW activities
- Peer Support services to be provided monthly and in the various communities that are traditionally un-served, underserved, and inappropriately served.
- Provide information at various community cultural events and fairs
- Meet with local agencies, as opportunities exist, to advocate for policy changes that can include, but are not limited to, primary care facilities, government agencies, and local businesses
- Each CHW will help develop, and update county-wide resource manual filled with local resources, information regarding health care topics, human services, and other culturally specific resources that serve the communities in which they function.

g. Key milestones and anticipated timeline for each milestone.

- Month 1 --OAC approval
- Month 2 -- Identification of community partners through RFP, if applicable, or through County Agencies for funding 5 CHWs and 10 Peer Support Specialists
- Month 3-5 -- Training of 5 of CHWs
- Months 6 -- CHWs begin outreach activities
- Month 4-6 -- Peer Support Specialists trained
- Month 7 -- Peer Support activities begin
- Months 6-12 -- 50 educational presentations given
- Months 6-12 -- In-home education “knock and talk” sessions delivered
- Month 1-12 -- Program monitoring

- Month 6-12 -- Program evaluation

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	
Culture-based Access and Navigation Specialist Community Health Worker (CHW)	Individuals: 1,500 or Families: 1,500	Individuals:1,500 or Families: 1,500	9
Peer Support in Natural Settings	Individuals: 500	Individuals: 500	
Total PEI project estimated <i>unduplicated</i> count of individuals to be served	Individuals: 2000 or Families: 1,600	Individuals: 2000 or Families: 1,600	9

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

The CHW would link all individual participants, from all ethnicities and age groups, who are perceived to need assessment of extended treatment for mental illness or emotional disturbance to County Mental Health, primary care providers, or other appropriate mental health service providers by being subject matter experts and having the resources readily available for those that are in need of the information. Further, the CHWs would be able to educate families and individuals to prevent and/or provide early intervention to the underserved and unserved populations in culturally appropriate ways. PEI education and resource efforts that would be provided by the CHWs would include prevention and short term early intervention on:

- Out-of-home placement
- Prevention/ reduction of homelessness
- Prevention/early intervention of incarceration, hospitalization, emergency room care, involuntary mental health care

- Prevent or provide short term early intervention to those that are frequent users of acute psychiatric hospitalization and/or who are caught in the cycle of arrest for minor crimes-jailed-released-reoffend-jailed again, homeless, co-occurring disorders
- Un-served, underserved individuals with history of repeated emergency health services, several admissions to inpatient services or at risk for institutionalization, been homeless or at risk of homelessness

Referrals will be made to include substance abuse prevention and treatment, community and domestic violence, and sexual abuse prevention and intervention. Linkages with human services would also be provided to assist with basic needs (food, housing and employment). Partnerships that have been formed as a result of the CSS planning process have resulted in agreement by Fresno County MHSA to include outreach and engagement of underserved and un-served children and youth. Fresno County MHSA and its community partners will also provide on-site consultation and technical assistance on best practices to link families to more extensive services as indicated.

6. Collaboration and System Enhancements

Through the Culture-based Access and Navigation Specialists project, there will be extensive collaboration with existing partners, such as local schools and district offices, faith-based organizations, primary care centers, various health offices, natural gathering sites, social services offices and local law enforcement offices. Additional efforts will be made to reach and partner with community based organizations in underserved/un-served populations to include community/family resource centers, private and public employment offices, collaboration with local media outlets throughout Fresno County. The CHW model should leverage community volunteers who can be trained to work with professional and para-professionals in the delivery of services. In-kind contributions in terms of building costs, donations, incentives, computer usage, electricity, printing, clerical support staff, etc. will be leveraged. We will develop new partnerships and deliver services in faith-based centers, in homes and other natural settings that are culturally sensitive, linguistically appropriate and non-threatening/non-stigmatizing locations for participants. Formal agreements, either MOUs or interagency agreements, will be developed and used as a model for future collaborative efforts.

7. Intended Outcomes

Individual	Program/System	Long Term Community
<ul style="list-style-type: none"> • Increased knowledge of risk and resilience/protective factors • Increase overall mental health 	<ul style="list-style-type: none"> • Increase in number of prevention programs and EI activities that are directed at un- 	<ul style="list-style-type: none"> • Increase in cultural competency and in the understanding that there is no one-size-fits-all

<p>awareness in the community</p> <ul style="list-style-type: none"> • Overcome individual culture-based stigmas against mental illness and mental health concerns • Develop coping skills and build resiliency for immigration-related and historical trauma • To facilitate identification of early signs of mental illness for linkages to timely interventions and treatment 	<p>served and underserved cultural, ethnic, racial, and linguistic communities</p> <ul style="list-style-type: none"> • Increase in number of individuals/families who receive prevention programs and EI services and who are from un-served and underserved cultural, ethnic, racial, and linguistic communities, including rural areas of Fresno County • Increase early onset interventions and treatment to prevent a problem from getting worse and thereby requiring more extensive services from the system 	<p>model for delivery of prevention and early intervention strategies for mental health illness</p> <ul style="list-style-type: none"> • Reduction in stigmatizing attitudes towards mental health illness • Reduction in discrimination against those with mental illness within and across diverse cultural populations • Earlier access to MH treatment and services for un-served and underserved cultural, ethnic, racial, and linguistic communities • Shorter duration of untreated mental illness
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8. Coordination with Other MHSA Components

The Culture-based Access and Navigation Specialist Project will coordinate and partner with the Workforce Education and Training Component of MHSA to provide resource development and access to education, training and workforce development programs and activities. This will allow us to develop and maintain a culturally competent workforce and to include consumers and family members who can provide client and family-driven services in order to promote wellness, recovery and resiliency, which will result in measurable outcomes. In particular, Fresno County’s WET plan includes Action Item no. 4, which provides cultural awareness training for staff, consumers, and families with the objective of improving cultural awareness and sensitivity in the delivery of mental health services, including short-term prevention and early intervention activities.

The Culture-based Access and Navigation Specialist project will provide educational presentations that could include information on training and counseling programs designed to prepare and recruit individuals for entry into a career in the public mental health system through the Workforce Education and Training Component of MHSA. The Culture-based Access and Navigation Specialist project can assist the Workforce Education and Training Component in addressing the lack of equal opportunities and access to the public mental health workforce to underrepresented

racial/ethnic, cultural and/or linguistic groups and help to prepare community members, consumers and family members. Through collaboration with WET, these individuals can be linked to careers in public mental health. CHW staff will meet monthly with Department of Behavioral Health/Department of Children and Family Services staff members who are currently involved in the implementation of other MHSA components such as PEI and CSS coordinators. This meeting will be used for updates about each component's progress during implementation. It will also be an opportunity to educate, inform and support families and individuals who might qualify for on-going services such as Community Services and Support.

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

At this time, no Capital Facilities funds have been identified for this project. It is likely that IT computer labs will be located a sites in un-served and underserved communities.

9. Additional Comments (optional)

N/A

County: Fresno **PEI Project Name:** 3. Peri-Natal Prevention and Early Intervention Program for Pregnant/Parenting Women and their Infants

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

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

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

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

The PEI Community Planning Process for Fresno County found that when the responses from the focus groups were coded for the three separate priority populations that address children and youth populations, the sum of the data coding indicates that the highest priority population is the at risk children, youth, and young adults. At risk children, youth and young adults also represent the second highest key mental health need for Fresno County. Survey results also identify children and youth in stressed families as the population with the highest need. Moreover, Both Survey and focus group data indicate that co-occurring disorder in parents that affects children and youth in stressed families, ranks as the highest at-risk concern for that population. Perhaps most importantly, the PEI Planning Panel ranked this project as the highest priority project in the 3-Year PEI Plan.

- Conrad Chao, MD, Chief of Obstetrics and Gynecology at UCSF-Fresno, noted at a focus group for SART membership that the fundamental concern is prenatal and postpartum mood disorders (depression, anxiety disorder, OCD) and their effects on infant brain development
- There are less than 10 qualified professionals to address mental health issues for all age 0-3 who are trained in infant mental health for Fresno County
- There are approximately 16,000 births in Fresno County each year; approximately 10,000 are to mothers who are on Medi-Cal

The following citation is quoted from a letter dated February 3, 2009, addressed to MHSA on letterhead from the County of Fresno, Department of Public Health. It was written by the Chairperson for the Babies First SART (Screening, Assessment, Referral and Treatment) Leadership Group representing 22 members, with additional signatures from 16 prominent community professionals who work in the area of maternal and child health who support the SART Leadership Group's efforts to secure funding to provide prevention and early intervention services for pregnant and parenting women.

“Childbearing women suffering from prenatal and postpartum mood disorders have been unserved and sorely underserved; many gaps in services have been identified, including lack of community funded services and an insufficient number of skilled private practitioners willing to accept public funding. As you are aware, the lack of services and inadequate access to the minimal treatment options in Fresno County increase the risk of suicide, maltreatment and early onset of mental health issues in the children they bear. Treatment of the mother has direct impact on the newborn and reduces the potential for abuse, neglect, and even death. We request that special consideration be

given to prevention and early intervention to this high-risk population in order to address this alarming trend.”

3. PEI Project Description: (attach additional pages, if necessary)

a. Description of proposed PEI Intervention.

This program includes outreach, early identification through screening, assessment, and referral to treatment. Short-term mental health services will be provided for pregnant and parenting women and their infants. Infant brain studies show that infant brain development is negatively affected by mental illness of the mother. The screening component will identify perinatal depression, anxiety disorders, psychosis, or other mental health illnesses. Short-term mental health early interventions should begin at the earliest sign of mental health concern for mother as an intervention for the mother and a prevention strategy for the fetus/infant's brain development. The purpose of this program is to provide the best possible mental health outcome for the newborn child and his/her mother. This program places strong emphasis on providing treatment primarily to low-income, underserved populations, including rural populations in western Fresno County and in the foothills of eastern Fresno County.

Some key components of the program include:

- Develop capacity to identify and treat perinatal depression
- Early screening, identification, and intervention for maternal depression during perinatal care (early prenatal through postpartum) at primary care/obstetrical care facilities, including the community clinics referenced in Project 1.
- Specialty team home visitation by a nurse and mental health clinician when prenatal screening is positive for a perinatal mental health concern early in its manifestation.
- Linkage made to other mental health services (e.g. therapy, medications)
- Assessment of the newborn by a trained professional to identify need for early intervention and linkages to other 0-5 services
- Community partners that are active participants, including providers who are actively screening and treating pregnant/parenting women
- Provides services to low-income, underserved populations, especially in rural areas
- Partnerships with evidenced-based programs serving perinatal women and their infants.
- May include billable services for sustainability

Provider: Project may be provided through County agency or through an agency or contract provider identified through the RFP process.

Use of Funds

Funding to include Nurses (who may be LVN, RN, or PHN) plus other licensed and unlicensed mental health clinicians to support health care providers at hospitals and primary care clinics in Fresno County that are rural, Federally Qualified Health Centers, and/or Tribal Clinics in working with prenatal, pregnant, and postpartum women and their children to identify perinatal depression, anxiety disorders, psychosis, or other mental health illnesses and to provide treatment at the earliest possible juncture for the best possible outcome for mother and child. Funding can include reasonable operating expenses, such as travel, training, and other reasonable costs.

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

The Perinatal Prevention and Early Intervention for Pregnant/Parenting Women and Their Infants project will address the key community needs of at-risk children, youth and young adult populations by providing identification and treatment of a mental health problem early in its manifestation. In addition, the program will address underserved populations by providing early interventions that will address the early stages of a mental illness in the mother, reduce the effects of child neglect and mother-child bonding problems, and other constraints on an infant's mental well being. The project is based on an evidence-based home visitation model (such as Nurse Family Partnership, Welcome Every Baby, and others) but adapted to the special needs of Fresno County's un-served and underserved communities in order to improve the health, well-being and self-sufficiency of low-income parents. It enhances the model by adding a critically needed mental health component. Research data indicates that for those children whose mothers participated in an NFP program, there are fewer arrests, fewer incidents of child abuse, sizable reductions in alcohol and tobacco use, and fewer convictions and probation violations.

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

In close partnership with a variety of community partners, this project will require leveraging significant resources. The initial point of contact with prenatal or pregnant women will likely be at a health care provider office or community clinic. Once identified for need, other treatment sites will include community settings or the home. The project will require a high level of coordination of resources.

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

1. Underserved Latino communities in west Fresno County, where there are no mental health services
2. Native Americans and other rural communities in the eastern foothills of Fresno County
3. Hmong and Southeast Asians in the central and southwest Fresno metropolitan area
4. African American communities in the west Fresno metropolitan area

e. Highlights of new or expanded programs.

The Nurse Family Partnership Model, upon which the *Perinatal Prevention and Early Intervention for Pregnant/Parenting Women and Their Infants* project was loosely based, is an evidence-based model that engages, assesses, and provides linkages and education for women from gestation through nine months postpartum. Since this program will target those geographic regions in which un-served and underserved populations receive perinatal services, it is anticipated that the vast majority of those being served will be un-served and underserved women and their infant children. In collaboration with our community partners and existing vendors through the CSS component, in particular through the Outreach and Engagement project, we will be able to solicit consumer, family and community feedback. Data will be collected for all components of the project to evaluate outcomes.

- The Perinatal Prevention and Early Intervention for Pregnant/Parenting Women and Their Infants project is a new program in Fresno County for mothers and their children
- Services are provided in clinics, the home or other community setting
- Program services will be based on best practices

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

The Perinatal Prevention and Early Intervention for Pregnant/Parenting Women and Their Infants project will be delivered in the homes and/or community settings serving mothers and their infants. Implementation partners include perinatal providers (in the target geographic areas) and collaboration between County Departments (DBH, DCFS and DPH).

Activities:

- Nurses and clinicians will have contact with 480 perinatal women who screen positive for mental health issues
- Mental Health Clinicians will treat pregnant/parenting women to promote healthy mother/infant bonding and attachment. Client contact will be based on the treatment plan
- Infant Mental Health Specialists will help mother and infant bond and attach

- Outreach and education will occur to promote screening of pregnant/parenting women and referral to treatment once treatment resources are in place in the targeted geographic regions of Fresno County
- Services are voluntary and will ideally begin early in pregnancy. During home visits, the nurse coordinates the mental health and primary health care of mother and infant
- Visits/services will occur at least monthly and more frequently, as needed
- The mother and infant will be engaged in this project regularly up through nine months, with follow-up screening and referrals through age two, or beyond, as needed, of the infant.

In the service of these goals the nurses will link families with needed health, mental health, and human services and attempt to involve other family members and friends in the pregnancy, birth and early care of the infant. The nurses utilize detailed assessments, record keeping, and protocols to guide their work with families, but adapt the content of their home visits to the individual needs of each family. Mental health clinicians will be trained to provide infant mental health services. The clinicians offering Infant Mental Health Specialty services will provide a comprehensive educational program designed to promote parents' and other family members' effective physical and emotional care of their children.

g. Key milestones and anticipated timeline for each milestone.

- Month 1 – OAC approval
- Month 2-3 (and ongoing) -- Recruit nurses, Mental Health Clinicians w/Infant Mental Health training, a case manager and part time psychiatrist with expertise in working with pregnant women
- Month 2-3 (ongoing) -- Inform local health care providers of program
- Month 4 (ongoing) – Begin prevention activities by screening mothers
- Month 4 (ongoing) -- Deliver short term early interventions
- Month 2 (ongoing) – Program monitoring
- Month 6-12 – Program evaluation

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	
Peri-Natal Prevention and Early Intervention for Pregnant/Parenting Women and Their Infants	Individuals: 360 Families: 100	Individuals: 360 Families: 100	9
Total PEI project estimated <i>unduplicated</i> count of individuals to be served	Individuals: 310 Families: 50	Individuals: 310 Families: 50	9

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

- Women who are identified as needing more extensive mental health services will be immediately referred by the nurse to an appropriate provider. Referrals will be made, including substance abuse prevention and treatment, community and domestic violence, and/or sexual abuse prevention and intervention. Additional linkages may be provided to meet basic needs, such as food, housing and employment
- Children who are identified through the Ages and Stages Questionnaire/Social Emotional (ASQ/SE) screening and developmental assessments will be referred to Fresno County’s children’s Screening, Decision Making, Assessment, Referral, and Treatment (SMART) Program.
- Children who are in need of general or specialty medical care will be referred by their nurse and follow-up will ensure that appointments are not missed due to transportation and other barriers, such as inappropriate linguistic or culturally-based barriers
- Whenever childcare is needed, referrals to local Early Head Start, Children’s Services Network, and Child Care Health Linkages programs will be provided

Key community partners and service providers include Fresno County alcohol and drug prevention and treatment providers, community clinics, and contracted Fresno County providers. Fresno County MHSA, Public Health providers, DBH, and DCFS 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

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

The *Perinatal Prevention and Early Intervention for Pregnant/Parenting Women and Their Infants* project will develop new partnerships and deliver short term interventions in the home and other natural community settings, including community clinics in order to reduce the stigma of mental health for women experiencing perinatal mood disorders. The potential for collaboration and leveraging of dollars with this project is very strong. Many perinatal service programs currently collaborate with numerous physicians in the community for the purpose of screening pregnant women, for example for alcohol/drug use during pregnancy and providing preventative services. In addition, First 5 Fresno funds perinatal and prevention programs in collaboration with other community agencies. The continuation of such funding would provide an opportunity to build on the existing physician and mental health provider relationships throughout this project.

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

The primary goal of this PEI project is to identify and provide short term interventions and/or linkages for pregnant and/or parenting women and their infant children to ensure the best possible mental health outcome for child and mother. Perinatal treatment at community clinics is the primary access point for contact with these women. The goal is to provide short term mental health early interventions for these women at community clinics and provide a warm hand-off for those who need more extensive mental health treatment. Community clinics will provide non-stigmatizing identification and short term interventions for women who need mental health services while they are pregnant and/or mothering. When indicated, home visitation with mental health specialists, nurses, and child development specialists also supports the community-based system of care of this PEI plan.

c. Leveraging and Sustainability

The majority of the recipients of mental health services are eligible for Medi-Cal. In addition, funding (which could be in-kind contributions, staffing, among other things) should be sought to help sustain this project. Prevention and short term early intervention services provided through this project include providing Clinicians, Public Health Nurses, Psychiatrist and Community Mental Health Specialists for short-term early intervention of pregnant and parenting women, and

prevention services for infants and children. Some of these services are billable to Medi-Cal. Short term case management and psychiatric interventions are also services which can also be billed to Medi-Cal. Additional in-kind resources may include office space, administrative staff and equipment, and transportation services.

7. Intended Outcomes

Individual	Program/System	Long-Term Community
<p>Mother</p> <ul style="list-style-type: none"> • Improved prenatal health and mental health • Improved bonding and attachment with infant/child • Fewer incidences of maternal child abuse or neglect • Reduction in maternal risk behaviors including alcohol and drug abuse <p>Child</p> <ul style="list-style-type: none"> • Improved physical, social, and emotional health of the infant • Decreased neurobehavioral vulnerability and neurological damage in the child, expressed as problems with self regulation, impulsiveness, distractibility, aggression and a lack of responsiveness to ordinary disciplinary and socialization guidance • Decreased rates of childhood depression 	<ul style="list-style-type: none"> • Increase in the number of prevention programs and early intervention(EI) activities • Increase in the number of individual/families who receive prevention and EI services • Increase in the number of individual/families from underserved populations who received prevention and EI services • Improved access to perinatal mental health services • Reduction in the number of children in out-of-home placements 	<ul style="list-style-type: none"> • Reduction in stigma toward perinatal mental illness. • Improved access to perinatal mental health services • Reduction in the numbers of children with developmental and behavioral problems • Reduction in child abuse and neglect • Reduction in need for mental health services for infants and children

8. Coordination with Other MHSA Components

The *Perinatal Prevention and Early Intervention for Pregnant/Parenting Women and Their Infants* project staff will meet monthly with MHSA/DCFS staff members who are currently involved in the implementation of other MHSA components such as PEI and CSS coordinators. This meeting will be used for updates about each component's progress during implementation. It will also be an opportunity to educate, inform and support families and individuals that might qualify for on-going services such as Community Services and Support. Program staff will have access to and benefit from Workforce Education & Training funds for professional development.

MHSA CSS components include FSPs whose contracts require collaborative outreach to primary health care providers. The MHSA CSS FY08/09 update includes a re-design of the crisis intervention services that includes an urgent mental health care center for psychiatric triage. Integrating prevention and early intervention assessment and short-term services in community clinics will require collaboration with both existing FSPs and activities within CSS and the re-design of the crisis intervention services that include the urgent mental health care center.

Fresno County's MHSA Workforce, Education and Training (WET) Planning Panel has developed a series of Career Pathways strategies to diversify the mental health workforce to more closely reflect the community in which we serve. PEI and WET programs will partner in areas of staff recruitment and training. This is particularly important for the integration of mental health and primary care at community clinics. In particular, Fresno County's WET plan includes Action Item no. 6, which provides on-going training to primary care providers in mental health and MHSA. At this time, no Capital Facilities funds have been identified for this project. It is possible that IT computer labs may be located at some of the community clinics. Please refer to the Fresno County MHSA IT plan.

9. Additional Comments

N/A

County: Fresno **PEI Project Name:** 4. School-Based Prevention and Intervention Program for Kindergarten through Eighth Grade

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

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

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

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

According to an analysis of the data collected from the Community Input Phase in Fresno County, the highest at risk conditions for school failure for children and youth include severe emotional and behavioral problems, abuse, neglect, trauma resulting from co-occurring substance abuse, and gangs. The data express similar findings for children and youth at risk of juvenile justice involvement. Below are listed some representative comments quoted from the community input process and, in particular from the focus group held at the Fresno County Office of Education.

- *Services need to be available for students and families with problems at home*
- *We need mental health professionals. As a school psychologist, I can do the majority of school based support at school, but I am not a therapist*
- *Tulare has a good program. Tulare's program offered support in each community as well as at school sites. County mental health personnel were an active part of each site, with district and county mental health services working together as one. Each site's Special Friends Program would work proactively with mild mental health needs, the school psychologist would work with individual, small group and whole classrooms regarding social skills and county mental health would deal with more intense mental health needs (along with family issues)*
- *Make services accessible through school to reduce transportation issues*
- *We need Student Assistance Programs providing targeted, short-term intervention strategies and support services for students at school*

Additional comments from several rural school districts are found in Table 4a. Among them, lack of mental health services, anger issues and other behavior issues, and co-occurring substance abuse support the conclusions drawn from the community data collected through surveys and focus groups outside the field of education. There is also ample coordinate data to support these comments as found in Tables 4b, 4c, and 4d. Table 4b displays the drop-out rates for several rural school districts in Fresno County for the ninth through twelfth grades. The numbers reflected in these tables' point to a tremendous need to reach children and youth early with the prevention and early intervention project described here. Note that Central Unified School District has a 1-year 9.1% school drop-out rate! Tables 5c and 5d are comparisons of truancy and suspension rates for State and County, and across several rural school districts within Fresno County, respectively. Truancy and suspension rates are significantly higher for Fresno County than the California statewide average. It is common to see truancy rates over 25% and suspension rates over 20% throughout Fresno County!

More importantly, in 14 out of 25 Focus Groups, schools were selected as the top site for delivery of PEI programs as a natural community setting. Examples of other sites include, e.g. *"wherever the children are"* and *"where people go normally"*, which is certainly also inclusive of schools. This project will address the un-served and underserved

County: Fresno

Form No. 3

Date: 7/7/09

populations, and children and youth in stressed families, at risk for school failure and juvenile justice involvement through school-based prevention and early intervention strategies to meet this identified need.

Table 4a Representative Comments from Educators in Fresno County Rural School Districts

District	School	Needs
Kerman Unified School District	Liberty Intermediate School	Emotionally disturbed. Better understanding diagnosed disabilities. Behavioral Issues. Social Skills. Dysfunctional Families. Dealing with identity issues.
	Nova High School	Grief loss issues; anger management; substance abuse; sexual abuse/activity; abandonment; behavioral issues ranging from defiance toward adults to physical confrontations among students; family issues; peer issues.
	Sun Empire Elementary	We have a great need for mental health services at our school site. A number of students are in need of social skills and behavioral assistance. We also have students in need of counseling for depression, anger, parental incarceration, divorce, neglect, death, and other types of emotional distress.
Sierra Unified School District	Sierra Elementary	Small group/one-on-one counseling, family services.
	Foothill	We have students from dysfunctional families; split families; families that are rippled w/alcohol, drug, violence, poverty. They are becoming unaware how out-of-balance their lives are and acting out.
	Sierra High School	We will be losing our ability to provide group counseling services due to the reduction of [staff]. We are interested in having you help us with our groups such as: grief counseling, anger management and drug and alcohol counseling.
	Auberry Elementary	Rural location prevents many families from utilizing/receiving Mental Health services. School based services would enable students to receive services recommended through IEP/504/School Plan/etc.
	Foothill Middle/High School	Alcohol/Drug Prevention groups; Managing peer pressure; providing support for the family system; conflict resolution groups; individual counseling
Fresno County Office of Education	Sutherland Center	On a case by case basis my school site including off-site classrooms for moderately to severely disabled children may have student that could benefit by mental health services. I have two primary school psychologists who would be main contacts interfacing with any mental health professionals.
Raisin City	Raisin City	As a rural school with little access to mental health services, we have students with social, emotional and behavioral problems who could benefit by having services come to them. Our parents would be very open to receipt of student services, but often their financial and travel difficulties prevent them from seeking/accessing such services.

Table 4b Drop-Out Rates for Fresno County

District	Total Drop (9-12)	Total Enroll (9-12)	4 Yr Derived Rate (9-12)	1 Yr Rate (9-12)
CENTRAL UNIFIED	342	3,742	32.1	9.1
KINGS CANYON JOINT UNIFIED	82	2,769	11.7	3
MENDOTA UNIFIED	79	1,193	23.5	6.6
COALINGA-HURON JOINT UNIFIED	51	1,283	15.3	4
SANGER UNIFIED	41	2,786	7.3	1.5
PARLIER UNIFIED	39	1,319	11.3	3
WASHINGTON UNION HIGH	37	1,184	12.5	3.1
KERMAN UNIFIED	22	1,119	7.5	2
SELMA UNIFIED	22	1,853	4.8	1.2
FIREBAUGH-LAS DELTAS JOINT UNIFIED	18	752	10.5	2.4

Table 4c Comparison of State and County Truancy and Suspension Rates

Comparison of State and Fresno County					
Expulsions, Suspension, and Truancy Information 2007-08					
	Enrollment	Truancy Rate	Overall Total Expulsions	Overall Total Suspensions	Suspension %
Fresno County	192,726	36.75%	1,073	46,442	24%
California State	6,181,417	25.84%	21,418	823,614	13%

Table 4d. Comparison of Truancy and Suspension Rates in Rural Schools of Fresno County

Fresno County Office of Education					
Expulsions, Suspension, and Truancy Information 2007-08					
District	Enrollment	Truancy Rate	Overall Total Expulsions	Overall Total Suspensions	Suspension %
Fresno County Office of Education	1,985	23.53%		888	45%
Coalinga-Huron Joint Unified	4,416	51.56%	35	1,627	37%
Fresno Unified	75,690	39.38%	633	26,549	35%
Washington Union High	1,245	34.38%	4	377	30%
Selma Unified	6,480	35.82%	15	1,949	30%
Parlier Unified	3,957	25.07%	15	805	20%
Kerman Unified	4,245	26.74%	29	743	18%
Sierra Unified	1,819	20.23%	21	283	16%
Caruthers Unified	1,416	26.06%	7	209	15%
Sanger Unified	10,129	36.65%	89	1,200	12%
Raisin City Elementary	306	29.74%	22		0%
West Fresno Elementary	1,205	10.21%	1		0%

3. PEI Project Description: (attach additional pages, if necessary)

a. Description of proposed PEI Intervention.

The school-based prevention model will incorporate a three-tiered integrated approach emphasizing Primary Prevention, Secondary Prevention, and linking to Tertiary interventions (specialized, individualized systems for students with high-risk behavior). The Primary Prevention focuses on preventing the development of new cases of problem behavior by focusing on all students and staff, across all settings (i.e., school-wide, classroom, and nonclassroom/noninstructional settings). The Primary Tier will be designed to create positive school social cultures that promote social and academic success and thus build protective factors in the child to deal with social and emotional challenges. Secondary Prevention focuses on reducing the number of existing cases of problem behaviors, including emotional and behavioral problems, by establishing efficient and rapid responses to problem behavior. Within the Secondary Tier, an early identification screening system can be implemented to allow for early delivery of timely prevention and intervention supports and programs to children, schools, and their families (e.g., Systematic Screening for Behavior Disorders, Behavioral, Emotional Screening System

and Evidenced Based PEI programs). This model will be designed to promote both academic and social success, to build a continuum of integrated systems of support between schools and community agencies, and provide social, emotional, and behavioral supports for children as a preventative activity and intervene early when problem behaviors are identified in the school setting.

Specific components include:

- Identification of school districts and specific schools that are likely to support such a program
- Training program on how to screen and coordinate the intervention programs and projects
- Early classroom screening
- Weekly sessions with supervised staff
- Based on evidence-based models, such as the Positive Behavioral Supports and Prevention of Mental Illness (PBS), Primary Intervention Program (PIP) and the Behavior Education program, among others to be determined as best fits the needs of each school.
- A mentoring component should be added if possible
- An example of Second Tier programs includes PIP, which is SAMHSA endorsed
- Tertiary interventions can be coordinated through MHSA CSS and DCFS

Provider: To be identified through RFP or County Agencies. Collaborative proposals, if applicable, are strongly encouraged. Bid applicant(s), if applicable, must demonstrate bona fide cultural and linguistic competency for the communities identified in this project narrative.

Use of Funds: (see Form 4 and Budget Narrative)

Funding will provide for cost such as:

- Staffing
- Training costs
- Technical assistance
- In-State Travel expenses
- Materials for each school

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

For children and youth at risk of school failure, survey results suggest that severe emotional and behavioral problems are identified as the highest at risk condition. Child abuse and neglect, gang activity and school violence were also highly

ranked. Substance abuse, aggression, gang activity, and emotional and behavioral problems are the greatest at risk conditions for juvenile justice involvement. This school-based project will have three essential tiers designed to mitigate school failure and, secondarily, juvenile justice involvement, by addressing poor social skills and behavior problems that are in their early stages and thus affect a child's overall mental well-being. The Primary Tier prevention strategies that are school-wide will specifically address the underserved children and youth in communities where mental health services are known to be lacking. Through the promotion of social and academic success, many individual children and youth with identified at risk conditions will be identified for more extensive Secondary preventative measures. Secondary Prevention will develop strategies to respond rapidly and efficiently to individuals with behavioral concerns. Early identification will allow for timely prevention and intervention supports for children, schools, and their families (e.g., Systematic Screening for Behavior Disorders, Behavioral and Emotional Screening System). When indicated, a child in need of more extensive Tertiary support will be linked to appropriate services through Department of Children and Family Services (DCFS) or related provider.

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

This project will take place in schools that are kindergarten through eighth grade. In particular, programs in the schools will be a mixture of school-wide, classroom, and non-classroom or non-instructional settings. Professionals involved in various aspects of these programs will include school officials, teachers, and school psychologists in addition to personnel from outside a particular school, including behavioral health staff, interns and residents, who may be leveraged through local colleges and universities for capacity building and sustainability. Alliant University, for example, has a need for providing opportunities for behavioral health activities free of charge for students of the school.

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

This project will primarily target rural schools, especially those with un-served and underserved populations. Table 5e reflects the ethnic demographics of several rural schools in Fresno County. For example, in the eastern foothills of Fresno County, Sierra Unified has a higher percentage of Native Americans, while western agricultural areas, such as Kerman, Caruthers, and Raisin City, have high percentages of Latinos. The metropolitan area of West Fresno has a high percentage of African Americans, while Central Unified has a higher percentage of Hmong and Southeast Asians. Table 5f shows the first language of those who require instruction of English as a second language in the schools. The vast majority are Spanish speaking, while Hmong, Mixteco and Punjabi make up a significantly high number of first languages.

e. Highlights of new or expanded programs.

Traditionally, schools have not been defined as mental health providers. However, individuals within schools can and do make a significant, positive impact on the mental health of children. While the primary responsibility of the schools is to educate, schools also recognize the need to deliver extra-educational services to individuals in order to facilitate the learning process. The School Lunch program and Special Education are just two of the many powerful examples of this. This school-based project will utilize preventative strategies at the Primary and Secondary Tiers and provide early interventions when problem behaviors are identified and provide linkages when more extensive mental health services are indicated in order to reduce the impact of potentially serious mental health issues and create the best possible education outcomes for the individual. Selected bidder will work in collaboration with a variety of community supports to promote wellness and foster resiliency through this program. These community supports will include Social Services, MHSA/DCFS, alcohol and other drug prevention and treatment programs for youth (and families), violence prevention programs, mentoring programs, and after-school recreation and enrichment. This project will also maximize educational resources by training teachers and administrators through a train-the-trainer model on mental health indicators and positive classroom management.

There are many new and expanded programs within Fresno County. Some of the school-based models are known as Response to Instruction and Intervention (RtI²) are just now being proposed in schools. According to the California Department of Education, RtI² when implemented with fidelity in general education, can reduce the disproportionate representation of student subgroups identified as needing special education services. Another multi-tiered prevention model currently being discussed in Fresno County schools is Positive Behavior Intervention and Supports (PBIS), an evidence-based model that establishes school-wide primary interventions for all students. At the secondary tier, interventions are targeted for students not responding to school-wide interventions. The third tier, known as the tertiary tier, is the stage at which point CSS interventions and intensive individualized supports are accessed. Another new model that Fresno County can take advantage of is the use of collaboratives between the Universities. Fresno Pacific University currently has initiated a Restorative Justice (RJ) community initiative that can be an alternative for schools to use as an alternative to suspension and expulsions. Colorado Public Schools is currently using RJ in schools to assist them in keeping students in school. Peer to peer mentoring programs from California State University, Fresno are also expanding in Fresno County schools with positive results.

In addition to the new programs being proposed above, Fresno County Schools is also proactively building capacity to implement “expanded school-based mental health” with in the multi-tiered model. In this framework, clinician’s learn how to integrate in school systems by providing support at the primary level, secondary level, and be a link to services in the tertiary level. In order to integrate all of the resources in schools under this framework, school-based teams will need to learn how to use data and map out resources in order to integrate school and community systems. Under the multi-tiered model, approximately 20 schools shall receive PEI services, with a population up to 5,000 students receiving protective factors to assist in building resiliency in children and youth.

Table 4e Fresno County Students by Ethnicity in Rural Schools

Students by Ethnicity 2007-08									
	School Districts								
	Caruthers Unified	Central Unified	Kerman Unified	Kingsburg Elementary Charter Unified	Parlier Unified	Raisin City Elementary	Sanger Unified	Sierra Unified	West Fresno Elementary
American Indian	0.3%	0.8%	0.2%	0.7%	0.4%	0.7%	0.5%	13.4%	0.3%
Asian	8.8%	13.6%	5.9%	3.8%	1.0%	1.6%	11.0%	1.0%	11.5%
Pacific Islander	0.1%	0.3%	0.0%	0.2%	0.1%	0.0%	0.1%	0.2%	0.0%
Filipino	0.0%	1.5%	0.1%	0.3%	0.2%	0.7%	0.5%	0.2%	0.0%
Latino	69.4%	45.9%	79.4%	49.8%	92.6%	88.2%	68.7%	6.8%	55.6%
African American	1.2%	11.0%	0.5%	0.9%	0.9%	0.3%	1.9%	1.3%	30.1%
White	19.7%	22.9%	13.2%	41.3%	3.0%	8.5%	17.1%	76.6%	1.9%
Multiple/No Response	0.5%	4.0%	0.7%	3.0%	1.7%	0.0%	0.1%	0.5%	0.6%
Total:	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 4f English Learners in Schools

Languages of English Learner Students 2007-08								
	School Districts							
	Caruthers Unified	Central Unified	Kerman Unified	Kingsburg Elementary Charter Unified	Parlier Unified	Raisin City Elementary	Sanger Unified	Sierra Unified
Spanish	46.5%	9.6%	29.9%	10.7%	50.7%	56.2%	20.8%	0.4%
Punjabi	3.8%	2.3%	2.0%	0.5%	0.1%	1.0%	0.6%	
Arabic	0.6%	0.4%	0.3%					
Hmong	0.5%	2.9%			0.1%	0.7%	3.7%	
Mixteco	0.5%		0.3%			3.3%		
Russian			0.0%					0.1%
Lao		0.2%			0.1%		0.2%	
Cantonese				0.2%				
Khmer (Cambodian)					0.2%		0.2%	
Portuguese						1.0%		
Thai								0.1%
Italian								0.1%
Urdu								0.1%
All Other	0.3%	0.9%	0.0%		0.0%		0.6%	
Total:	52.2%	16.3%	32.5%	11.4%	51.2%	62.2%	26.1%	0.8%

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

It is anticipated that the MHS/PEI will collaborate closely with county agencies that are in a position to be able to identify target school districts and populations, including agencies such as Fresno County Office of Education/SELPA. Once schools have been identified, action plans for universal and selective prevention and early intervention projects will be

implemented through building program capacity through hiring of staff, curriculum development, and training. Peer to peer mentoring would also require training and procedures for implementation.

g. Key milestones and anticipated timeline for each milestone.

- Month 1-- OAC approval
- Month 2 -- Prepare Request for Proposal (RFP)
- Month 3 -- Award Contract(s)
- Month 4 -- Build Training Capacity (Materials-Agendas-Locations-Time-Dates)
- Month 4 -- Action Plan Established & Submitted Regarding (Leadership team composition, Coordination, Funding, Visibility, Political Support, Training Capacity,
- Month 4 -- Hire Staff
- Month 5 -- October 2009, Day 1, Team Training
- Benchmark of Quality Measurement Tool Filled out by each participating school twice annually (January 2010, June 2010)

4. Programs

Program Title:	Proposed number of individuals or families to be served through June 2010 by type:		Number of months in operation through June 2010
	Prevention	Early Intervention	
Schools-based Prevention and Intervention Program for Kindergarten through Eighth Grade <ul style="list-style-type: none"> • 20 Rural schools • 3,750 pupils in Tier I and II 	<u>Tier I</u>	<u>Tier II</u>	9
	Individuals: 3,000	Individuals: 750	9
Total PEI project estimated <i>unduplicated</i> count of individuals to be served	Individuals: 3,000	Individuals: 750	9

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

Children and youth identified through the Secondary Tier as needing more extensive mental health services will be linked with DCFS services. Children and youth whose symptoms warrant a more comprehensive evaluation will be referred to an appropriate provider of choice, including primary physician, local community mental health clinic, county mental health clinic and/or insurance provider. Participating schools will be required to maintain an updated list of local providers and develop relationships with those with whom they make referrals.

Through the procurement process, agencies will be required to demonstrate that they have sufficient policies, management and organizational capacity in place to develop the program and achieve the desired outcomes. Proposals and bids will be reviewed with specific criteria and benchmarks associated with performance in delivering outcomes.

6. Collaboration and System Enhancements

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

In Fresno County, existing partnerships support the provision of school-based mental health and health care services through programs, such as CSS Children and Youth GSD School-based Program at a number of local school sites. A majority of schools and school districts have existing partnerships with community based service organizations developed through an extensive implementation of Early Periodic Screening, Diagnosis and Screening (EPSDT) and MediCal funded school-based services.

This project will leverage and expand upon these partnerships in an effort to link more students and families with appropriate levels of care. The Primary and Secondary Tier prevention and early intervention supports will identify and facilitate student (and possibly family) access to culturally appropriate mental health care services, substance abuse programs, and other county and school-sponsored resources. This will be a particular focus for children and youth (and possibly families) who have been inappropriately served or underserved. An overall effort will be made to link identified individuals with community networks reflective of their cultural background. Linkages with programs in underserved ethnic and language communities will be enhanced by collaboration with the Latino, Hmong and Southeast Asian, African American, Native American and other un-served and underserved communities.

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

Preventative and early intervention strategies within this project will promote early identification and referral. Early intervention will likely effectively interrupt the progression of problem behavior to more serious mental health issues. Early

identification and referral to appropriate community resources will assure that the local community-based mental health and primary care systems will have an opportunity for earlier intervention, which will enhance the effectiveness of those other systems. Training and consultation will engage families and other caregivers to better understand the relevance of concerns and risk factors of mental illness. Discussions and engagement of community-based services and the primary care system can also mitigate stigma commonly associated with seeking mental health services. Distressed children and adolescents place high demands on caregivers and institutions, straining economic, social and emotional resources. By providing preventative strategies at the Primary and Secondary Tiers, and early intervention at the Second Tier with follow-up treatment through linkages to primary care providers, health clinics and community mental health centers, as indicated, a gap in services can be closed to prevent significant harm to children and the community at large and significantly increase the chances for educational success.

c. Describe how resources will be leveraged.

The preventative and early intervention strategies in this project will require significant leveraged resources, in partnership with schools, and community based organizations in addition to other and state and local funds and resources to increase capacity for preventative and early intervention strategies within and across school districts. School districts and community organizations will provide significant in-kind support including space, equipment, staff and volunteer time, referrals, cross-training, mentoring, after-school programming, general funding and opportunities for Medi-Cal reimbursement, when Tertiary Interventions are indicated. In the procurement process, agencies will be asked to describe their plan for leveraging additional resources and/or funding.

d. Describe how the programs in this PEI project will be sustained

The programs in this PEI project will be sustained through continued MHSA funding. The initial or start-up costs include costs for materials that may be reused and redistributed throughout a school. Moreover, through leveraging existing resources, such as school and community based organization personnel, office space, and other in-kind support, the funding levels ultimately required for this project are a prudent community-wide investment to reduce service needs in the future that would otherwise be incurred if these children and youth were not provided preventative and early intervention strategies, such as those delivered through this project.

7. Intended Outcomes

The General PEI Planning Panel reviewed the priority needs of children and youth that were identified through the Community Input Process. The Planning Panel worked collaboratively to analyze the most essential individual and system level outcomes connected with the identified needs and to develop local strategies that would lead to these desired

outcomes. Specific measurement tools and current annual data will be collected in order to measure and evaluate the fidelity of implementation for the program. The primary tool for school teams to complete (two times per year) will be measurement of quality indicators. Tools should establish the baseline measure and progress at the end of the year. Ongoing data such as Office Discipline Referrals (ODRs) will also be used as an indicator with the use of the programs. Additional data will be: Suspension rates, truancy, referrals to special education and mental health, and drop out rates.

As noted above, the tools as Benchmark of Quality (BOQ) will assist with measuring the implementation of school-wide interventions. In addition to the BOQ, the School-wide Evaluation Tool (SET) can be conducted once a year with schools, or, when there is a discrepancy between interviews and/or focus groups and quantitative data. Specific surveys and tools will need to be established to measure the implementation of possible RJ conferences and the peer to peer mentoring program (if this is proposed). Consumers, family and the community will see a higher rate of engagement by schools.

Individual Outcomes	System/ Program/ Community Outcomes	Proposed Methods/ Measures of Success
<ul style="list-style-type: none"> • Increased number of school staff that are trained in recognition of early indicators of mental illness and how to refer students for screening and intervention • Increased knowledge of risk and protective factors • Enhanced resilience and protective factors, mental health status, early-age attachment, social support, attendance, and academic achievement 	<ul style="list-style-type: none"> • Prevent development of new cases of problem behavior by focusing on all students and staff • Efficient and rapid responses to problem behavior • provide social, emotional, and behavioral supports for children • Improve PEI supports for Children and youth • Increase access to mental health services for underserved children 	<ul style="list-style-type: none"> • Tracking logs to measure numbers exposed to educational messages • Surveys or focus groups to measure change in knowledge/attitudes about mental illness and when/ how to refer • records of student progress on individualized treatment goals • Consumer satisfaction surveys that assess client/family satisfaction and improvement in presenting problems • Quantitative analysis of identified referrals, frequency of contact, and associated reduction in suspension/expulsion

8. Coordination with Other MHSa Components

Through this project, individuals identified for more extensive services through the Secondary Tier will be provided tertiary interventions through MHSA CSS/DCFS programs, as indicated. MHSA CSS updates include programs for individuals, specifically children and youth, identified for need of more extensive mental health services through the interactions with child development specialists, professionals and paraprofessionals, will be linked to appropriate services within the CSS component. At this time no Capital Facilities and Technology funds have been identified for this project. MHSA CSS FY08/09 updates include outreach and engagement activities that are required to reach out to schools and other natural community settings in both rural and metropolitan areas.

The MHSA's Workforce, Education and Training (WET) Planning Panel has developed a series of Career Pathways strategies to diversify the mental health workforce to more closely reflect the community in which we serve. PEI and WET programs will partner in areas of staff recruitment and training. Additionally, Fresno County's WET plan includes Action Item no. 7, which educates consumers and family members on mental health illness, medications and their side effects, among other important mental health information. The specialists who work with parent and their children can provide linkages to the WET activities, as appropriate. At this time, no Capital Facilities and Technology funds have been identified for this project.

9. Additional Comments

N/A

County: Fresno **PEI Project Name:** 5. Horticultural Therapeutic Community Centers as Neighborhood Resource Center and Community Site for Peer Support
 Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

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

3. Children and Youth in Stressed Families	<input type="checkbox"/>	<input type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input type="checkbox"/>	<input type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input type="checkbox"/>	<input type="checkbox"/>		
6. Underserved Cultural Populations	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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

Survey and focus group data have highlighted un-served and underserved cultural, ethnic, racial, and linguistic populations as the single highest priority population. Lack of cultural sensitivity, linguistic barriers, stigma, and distrust, lack of health insurance, poverty and transportation are significant reasons for the disparities in access that communities constantly face as barriers to mental health systems. Fresno County’s demographics are unique. We have one of the largest Hmong populations in North America. Our un-served and underserved Southeast Asian populations also include Vietnamese, Khmer and Lao. Many in these populations suffer from PTSD as a result of political strife they experienced in their homelands and which provided the impetus for their emigration to the United States. They also experience the trauma associated with their status as immigrants, to include intergenerational conflict, loss of cultural ways, language barriers, and daily challenges associated with living in a foreign land.

Fresno County also has one of the largest agricultural economies in the United States. The labor force to support that economy includes significant numbers of undocumented migrant farm workers from Mexico and Central America, including First Americans from Oaxaca and other areas in southern Mexico. In addition to undocumented individuals from Mexico and Central America who only speak Spanish, we also have undocumented Mixtecos and Zapotecos who do not speak Spanish or English. Fresno County also has diverse Native American communities who experience multigenerational PTSD, poverty, and loss of cultural ways. Representatives from each of these groups helped inform the PEI projects, including Project 7, here, that were developed in the working groups of the planning panel.

This program was designed in response to PEI Community Needs, Priority Populations and principles identified by the State and supported by Fresno County’s Community Input Process, working groups, and Planning Panel. The following Table 7.1 illustrates the advantages of Horticultural Therapeutic Community Centers that direct address needs expressed by various individuals through the Community Input Phase:

Table 5.1 Advantages of Horticultural Therapeutic Community Centers

Community Organizing	increase a sense of community ownership and stewardship
	foster the development of a community identity and spirit
	bring people together from a wide variety of backgrounds (age, race, culture, social class)
	build community leaders
	offer a focal point for community organizing, and can lead to community-based efforts to deal with other social concerns
Crime Prevention	provide opportunities to meet neighbors
	build block clubs (neighborhood associations)
	increase eyes on the street
	is recognized by the many police departments as an effective community crime prevention strategy

Cultural Opportunities	Horticultural Therapeutic Community Centers offer unique opportunities for new immigrants (who tend to be concentrated in low-income urban communities) to: <ul style="list-style-type: none"> • Produce traditional crops otherwise unavailable locally • Take advantage of the experience of elders to produce a significant amount of food for the household • Provide inter-generational exposure to cultural traditions • Offer a cultural exchange with other gardeners • Learn about block clubs, neighborhood groups, and other community information
	Horticultural Therapeutic Community Centers offer neighborhoods an access point to non-English speaking communities
Youth	Horticultural Therapeutic Community Centers offer unique opportunities to teach youth about: <ul style="list-style-type: none"> • Where food comes from • Practical math skills • Basic business principles • The importance of community and stewardship • Issues of environmental sustainability • Job and life skills
	Community gardening is a healthy, inexpensive activity for youth that can bring them closer to nature, and allow them to interact with each other in a socially meaningful and physically productive way
Food Production	Many individuals, especially those from immigrant communities, take advantage of food production in Horticultural Therapeutic Community Centers to provide a significant source of food and/or income
	allow families and individuals without land of their own the opportunity to produce food
	provide access to nutritionally rich foods that may otherwise be unavailable to low-income families and individuals
	Urban agriculture is 3-5 times more productive per acre than traditional large-scale farming!
	Horticultural Therapeutic Community Centers donate thousands of pounds of fresh produce to food pantries and involve people in processes that provide food security and alleviate hunger
Health	Studies have shown that community gardeners and their children eat healthier diets than do non-gardening families
	Eating locally produced food reduces asthma rates, because children are able to consume manageable amounts of local pollen and develop immunities
	Exposure to green space reduces stress and increases a sense of wellness and belonging
	Increasing the consumption of fresh local produce is one of the best ways to address childhood lead poisoning
	The benefits of Horticulture Therapy can be and are used to great advantage in Horticultural Therapeutic Community Centers

3. PEI Project Description: (attach additional pages, if necessary)***a. Description of proposed PEI Intervention.***

This project will provide/leverage existing support for culture-based Horticultural Therapeutic Community Centers. The purpose of these Horticultural Therapeutic Community Centers will be to provide a culturally appropriate community center that will also serve as a neighborhood resource center for delivering peer support services; for communication with CHWs and other trusted individuals from within the community; and as a site for outreach and engagement on mental health issues and other human service needs as determined by each community. Through short term peer support and other types of short term early interventions, the Horticultural Therapeutic Community Center will provide a platform to address various culture specific traumas, including loss of traditional ways, PTSD, intergenerational conflict, among other non-SMI mental health concerns. Furthermore, this project provides sense of purpose for adults and older adults from communities suffering from high unemployment and low job skills. Horticultural Therapeutic Community Centers should be located at multiple sites that are accessible.

According to the American Horticulture Therapy Association, horticulture has been used as a therapeutic treatment modality for centuries. In 1798, Dr. Benjamin Rush, a signer of the Declaration of Independence, documented that gardening improved the conditions of mentally ill patients. Spanish hospitals in 1806 used horticultural activities for mentally impaired patients. Gardening as a means of physical and psychological rehabilitation was used in Veterans Administration hospitals for returning world war veterans in the U.S.A. In 1971, Kansas State University began the first horticultural therapy degree program. In 1973, the American Horticultural Therapy Association (AHTA) formed and is now the largest horticultural therapy organization in the United States. AHTA oversees the voluntary registration of professional horticultural therapists. Moreover, during the Community Input Phase stakeholders from the Hmong, Southeast Asian, African American, Native American, and Latino communities stated that Horticultural Therapeutic Community Centers would significantly contribute to their mental and social wellbeing. Physical, mental, social, and creative abilities are enhanced through horticultural therapy. The cycles of life are in immediate view in gardens. The ever-present processes of renewal provide encouragement to the suffering. Some of the proven benefits of horticultural therapy include:

- reducing physical pain;
- providing sensory stimulation;
- improving memory and concentration;
- easing emotional pain from bereavement or abuse;
- cultivating nurturing feelings;
- encouraging social interaction;

- teaching responsibility;
- reducing stress and anger;
- enhancing productivity and problem solving.

Through mental health education, outreach, and peer support treatment for non-SMI, the Horticultural Therapeutic Community Centers will serve to reduce cultural, linguistic, and trust barriers to mental health services.

Provider: To be identified through one or more RFPs or County Agencies. Collaborative proposals, if applicable, are strongly encouraged. Bid applicant(s), if applicable, must demonstrate bona fide cultural and linguistic competency for the communities identified in this project narrative.

Use of Funds:

To help fund creation of Horticultural Therapeutic Community Centers in multiple locations, including land leasing, building shelters at these sites that can be used as sites for delivering mental health information to the community, conducting focus groups, education, and short term mental health interventions and other preventative activities. Water costs, irrigation and equipment, garden tools, Bulletin boards, and other equipment that will serve the purposes of this project should also be included in funding. Funding will be used to develop Horticultural Therapeutic Community Centering consistent with the community input that requests Horticultural Therapeutic Community Centers as a culturally sensitive place to receive information about mental health systems, how to access these systems, to work with CHWs (see Project 2, above), and receive linkages or short term peer support interventions to address community mental health needs, such as that which addresses PTSD, anxiety, immigration-related depression, and other mental health concerns.

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

The Horticultural Therapeutic Community Centers as Neighborhood Resource Center and Community Site for Peer Support Project will deliver significant return on investment in terms of addressing several needs simultaneously. Data collected during the Community Input Phase show that un-served and underserved Hmong and Southeast Asians, Native Americans, African Americans, and undocumented, migrant Latinos lack full employment, experience loss of cultural traditions, experience disproportionate amounts of poverty, exhibit significant distrust of government and other officials, and often experience cultural insensitivity on the part of providers. In conjunction with other projects in this three-year plan, The Horticultural Therapeutic Community Centers as Neighborhood Resource Center and Community Site for Peer Support Project will provide a consistently available de-stigmatizing and welcoming site where culturally sensitive and linguistically appropriate peer support services, general education about mental health, primary care, human services, and

other types of outreach and engagement can take place. Since these sites will be located within the communities, concerns including transportation, health insurance, distrust of outsiders, and culture and language barriers are mitigated.

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

The Horticultural Therapeutic Community Centers as Neighborhood Resource Centers Project will reduce barriers to services because it will function at multiple sites in the community, involve trusted community leaders, and provide cultural sensitivity in addressing psycho-social health needs of the underserved communities. This project will establish a new natural, culturally sensitive and linguistically appropriate neighborhood site for delivery of non-SMI services, including peer support to address PTSD, intergenerational conflict, and generalized trauma associated with being an immigrant, i.e. loss of cultural traditions, changes in traditional family roles, ability to grow food, and trying to cope with different laws and customs of the host culture. Partners will include Faith-based organizations, advocacy groups, community leaders, and DBH.

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

- Native Americans in the eastern foothills and metropolitan areas of Fresno
- Hmong and Southeast Asians in the central and southwest Fresno metropolitan area
- African American communities in the west Fresno metropolitan area
- Underserved Latino communities in west Fresno County
- Other underserved communities

e. Highlights of new or expanded programs.

- Addresses loss of culture-specific traditions such as growing ones own food and for useful, culture-specific artifacts, such as baskets, among other things
- Addresses loss of traditional sense of purpose (i.e. through intergenerational conflict, loss of livelihood)
- For Native American community, such a Horticultural Therapeutic Community Center can help resume traditional practices of tending and harvesting indigenous agricultural plants
- Train-the-trainer approach
- Non-threatening and culturally sensitive

- Culturally competent outreach platform for addressing MH needs in specific cultural populations
- Helps build skills to reduce risk factors associated with multi-generational PTSD (Native Americans) and Trauma associated with new immigrant status and difficulties in assimilation to host culture
- Add sweat lodges and Native American gatherings for this underserved population
- Address other Southeast Asian cultural needs specifically

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

This project requires identification and leveraging of existing Horticultural Therapeutic Community Centers projects within the County. Additional Horticultural Therapeutic Community Centers will need to be created to serve various geographic areas and underserved populations. This project will require identifying specific plots of land, developing plans and getting approval for conversion to Horticultural Therapeutic Community Centers, including grading and leveling, irrigation requirements, and fencing. Additional materials will need to be identified for funding, including garden tools and equipment, soil, plants and seeds, and fertilizers/composting materials. Collaboration with community partners is required to identify culturally appropriate planning and organizational structure, including who membership/participation requirements, how the produce will be distributed, and how to incorporate/coordinate mental health and other supports at each of the Horticultural Therapeutic Community Center sites. This project will require collaboration with cultural advocacy organizations and other agencies that seek to address mental health needs in the community.

g. Key milestones and anticipated timeline for each milestone.

- Month 1 -- Receive California DMH approval for Plan
- Month 3 -- RFP developed, competitive procurement process completed
- Month 5 -- Contract awarded
- Month 7 -- Develop plots
- Month 6 -- Begin development of Horticultural Therapeutic Community Center policies and procedures
- Month 8 -- Coordinate mental health outreach and identify key mental health needs at each site
- Month 10 -- Conduct peer support groups to address the non-SMI key mental health needs at each site
- Month 10 -- Establish outreach and engagement with other groups
- Month 7 -- Program monitoring
- Month 10-12 -- Program evaluation

4. Programs

Program Title:	Proposed number of individuals or families to be served through June 2009 by type:		Number of months in operation through June 2010
	Prevention	Early Intervention	
The Horticultural Therapeutic Community Centers as Neighborhood Resource Center and Community Site for Peer Support Project	Individuals or Families: 1000	Individuals: 500	9
Total PEI project estimated unduplicated count of individuals to be served	Individuals or Families: 1000	Individuals: 500	9

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

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

Trusted CHWs and advocates who will be partners in the Horticultural Therapeutic Community Centers as Neighborhood Resource Center and Community Site for Peer Support Project will engage the communities through individuals participating in the Horticultural Therapeutic Community Centers and their families, friends, and neighbors. Through this education and outreach, linkages and contacts will be created, including linkages to other needed services, including substance abuse treatment, prevention and early intervention for domestic violence, sexual abuse, and linkages to human services. Through mental health education, outreach and peer support group therapy, individuals may be identified at the Horticultural Therapeutic Community Centers or through individuals who participate in the Horticultural Therapeutic Community Centers, who need more extensive mental health services. These individuals will be linked through a warm hand-off to appropriate mental health or primary care assessment and services.

6. Collaboration and System Enhancements

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

Key community partners in this project will include advocacy organizations, community-based, and faith-based organizations who work with the un-served and underserved cultural, ethnic, racial, and linguistic communities in Fresno County. It is anticipated that through the RFP process, several of these organizations will organize together to develop a close collaboration to achieve desired outcomes. The mental health education and outreach component of this project will reduce stigma and will encourage individuals to seek mental health services earlier. Many of these un-served and underserved individuals will be able to seek treatment at FQHCs or other community clinics.

b. Leveraging and Sustainability

There are several organizations that are in the developmental phase of Horticultural Therapeutic Community Centers. It is anticipated that many of these organizations will participate in the RFP process. One of the requirements of this project will be to contribute additional funding through other federal, state, and local sources. In this way, the Horticultural Therapeutic Community Centers project will develop a sustainable funding stream. Additionally, the nature of the project is intensive community participation. Studies show that the more intense a community's involvement in a project, the more likely it is that that community will fight to protect that resource.

7. Intended Outcomes

Individual	Program/System	Long Term Community
<ul style="list-style-type: none"> • Decrease in suicide ideation • Improved well being and hopefulness • Increased community connectedness • Increased social supports and reduced isolation • Improved access to care and knowledge of care options • Increased skills in problem solving and help-seeking 	<ul style="list-style-type: none"> • Increase in number of prevention programs and EI activities that are directed at culture-specific communities that are un-served and underserved • Increase in number of individuals/families who receive prevention programs and EI services and who are from un-served and underserved cultural, ethnic, racial, and linguistic communities, including rural areas of Fresno County 	<ul style="list-style-type: none"> • Increase in cultural competency and in the understanding that there is no one-size-fits-all model for delivery of prevention and early intervention strategies for mental health illness • Reduction in stigmatizing attitudes towards mental health illness and suicide • Earlier access to MH treatment and services for un-served and underserved cultural, ethnic, racial, and linguistic communities

8. Coordination with Other MHSA Components

The MHSA CSS FY08/09 updates include culture specific services that can work collaboratively with the CHWs in the PEI plan, as well as the Horticultural Therapeutic Community Centers project. Also, the Culture-based Access and Navigation Specialist Project will coordinate and partner with the Workforce Education and Training Component of MHSA to provide resource development and access to education, training and workforce development programs and activities. This will allow us to develop and maintain a culturally competent workforce and to include consumers and family members who can provide client and family-driven services in order to promote wellness, recovery and resiliency, which will in measurable outcomes. In particular, Fresno County’s WET plan includes Action Item no. 4, which provides cultural awareness training for staff, consumers, and families with the objective of improving cultural awareness and sensitivity in the delivery of mental health services, including short-term prevention and early intervention activities.

The Horticultural Therapeutic Community Centers project will provide a natural community setting for educational presentations that could include information on training and counseling programs designed to prepare and recruit individuals for entry into a career in the public mental health system through the Workforce Education and Training Component of MHSA. The Culture-based Access and Navigation Specialist project can assist the Workforce Education and Training Component in addressing the lack of equal opportunities and access to the public mental health workforce to underrepresented racial/ethnic, cultural and/or linguistic groups and help to prepare community members, consumers and family members. Through collaboration with WET, these individuals can be linked to careers in public mental health. CHW staff will meet monthly with Department of Behavioral Health/Department of Children and Family Services staff members who are currently involved in the implementation of other MHSA components such as PEI and CSS coordinators. This meeting will be used for updates about each component's progress during implementation. It will also be an opportunity to educate, inform and support families and individuals who might qualify for on-going services such as Community Services and Support.

a. Describe coordination with CSS, if applicable.

This project will provide expanded opportunities to refer clients to CSS programs as appropriate through engagement at the Horticultural Therapeutic Community Centers.

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

The MHSA's Workforce, Education and Training (WET) Planning Panel has developed a series of Career Pathways strategies to diversify the mental health workforce to more closely reflect the community in which we serve. PEI and WET programs will partner in areas of staff recruitment and training.

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

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

9. Additional Comments

N/A

County: Fresno **PEI Project Name:** 6. First-Onset Consumer and Family Support

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

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Psycho-Social Impact of Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At-Risk Children, Youth and Young Adult Populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Stigma and Discrimination	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input 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
Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Children and Youth in Stressed Families	<input type="checkbox"/>	<input type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input type="checkbox"/>	<input type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input type="checkbox"/>	<input type="checkbox"/>		
6. Underserved Cultural Populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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

Consumers and their families were vital in the Community Input Phase and represent approximately 30% of the Planning Panel and working group participants. Three focus groups were specifically made up of consumers. Approximately 37% of survey responses were from consumers, while another 9.6% were family members, and 6.3% declined to self identify. Consumers and family members actively participated in drafting all strategy recommendations and were instrumental in the creation the First Onset Consumer and Family Support Project described below.

3. PEI Project Description: (attach additional pages, if necessary)

a. Description of proposed PEI Intervention.

The First Onset Consumer and Family Support Project has three components. Project 6a. will provide intensive advocacy and case management for underserved individuals experiencing a first break mental illness to enhance recovery, while Project 6b. includes an in-home family-centered outreach and early intervention support that will facilitate appropriate consumer-family interaction and skill building. This project will also facilitate a back-up plan of action in the event of decompensation during recovery in order to get the consumer appropriately to psychiatric triage. Project 6c. will provide a one-day workshop on the prodromal phase of early psychosis for educating primary care, mental health and other stakeholders in warning signs and options to facilitate the early identification of serious mental illness.

Project 6a

The First Onset Consumer and Family Support Project, in partnership with other systems, including primary care, clinicians, school officials, and others, will develop strategies to reduce delays in treatment onset. The individuals addressed through this project will be those who experience a first break serious mental illness/serious emotional disturbance or who have very recently entered the system with a first break serious mental illness or serious emotional disturbance. These individuals may have a first point of contact anywhere in the community, through crisis intervention, through community clinics, or at any health care site or natural community setting. It is also noteworthy that the CHWs (see project 2, above) may assist families in seeking treatment from within communities, in collaboration with this project, and to ensure cultural and linguistic competency. Through the community education offered by the cultural brokers of project 2, individuals/family members who may otherwise feel stigmatized by the mental health system or by their or their culture's attitudes towards mental illness will have increased access to these first-onset services for a first break serious mental illness. Developing an understanding for a serious mental illness is a major hurdle for consumers and their families and they need to be given time and special help, such as education, advocacy, training and goal setting in order to develop a recovery plan. This project will foster good therapeutic and personal relationships with the consumer and family

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which are crucial for success and increased quality of life during the recovery process. Optimizing and intensifying wrap-around services immediately after a crisis is very important in recovery and is currently used as a model in Australia, Canada, and in the United Kingdom.

Optimal and intensive intervention in first episode psychosis will require enhancing the quality of treatment. The idea of a '*critical period*' for addressing the first onset consumer more intensively at a stage in which the illness responds well to intervention is supported by recent studies.¹ According to McGorry², there is a strong and extensive literature that supports a moderate correlational link between duration of untreated psychosis and both short and long term outcomes. In addition to the evidence-based argument, patients and families who participated in the focus groups, working groups, and Planning Panel described the destructive effects of delay and the range of negative psychosocial outcomes which are compounded during the period of untreated psychosis. These include loss of employment failure, DSH, law enforcement difficulties, family distress and dysfunction, aggression, substance abuse, and homelessness, among many other problems.

Intensive post-crisis support can be crucial for the consumer and family during this highly stressful period. This project will devote significant resources to ensure that a range of strategies will contribute significantly in helping consumer and family during the recovery process. Some of these individualized strategies will increase the remission rate for positive symptoms and improve negative symptoms to enhance the quality of life. An integrated wrap-around model with the First Onset Consumer and Family Support staff and individuals from other systems is likely to mitigate future crises and facilitate a more complete recovery.

The First Onset Consumer and Family Support Project is designed to help individuals experiencing *first onset of serious mental illness* through wrap-around intensive services from the crisis access point or other point of entry (e.g. primary care, county mental health facilities, referral through school psychologist, CHW/Faith-based center, or inquiries/assistance to the consumer from cultural brokers or other advocate) in order to facilitate the recovery process and mitigate future episodes and reduce the incidence of decompensation. The services that are proposed in this project include clinical treatment; case management; advocacy; and other 'whatever-it-takes' services to provide stability and reintegration for the consumer in all settings that are natural for the individual who has experienced a first break serious mental illness. 'Whatever-it-takes' services include education and advocacy for family members, life-skills training for the consumer, collaborative support bridges across systems (e.g. between teachers and parent-partner of consumer) and support tailored and targeted for whatever natural settings and systems a consumer operates in, including school, locating

¹ Harrison, G., Hopper, K. Craig, T, et al. Recovery from psychotic illness: a 15- and 25-year international follow-up study. *Br J Psychiatry*. 2001;178:506–517. Birchwood, M. Todd, P. Jackson, C. Early intervention in psychosis: the critical period hypothesis. *Br J Psychiatry*. 1998;172(Suppl. 33):53–59. McGorry, PD. Jackson, HJ. *The recognition and management of early psychosis: a preventive approach*. New York: Cambridge University Press; 1999.

² The recognition and optimal management of early psychosis: an evidence-based reform." McGorry, Patrick, in *World Psychiatry*. 2002 June; 1(2): 76–83 found at <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1489880#id565399>

housing, grocery shopping, primary care, workplace/employment, realistic goal-setting, culturally/linguistically appropriate linkages, among others, in order to provide the type of support that will reduce the impact of the first break serious mental illness on the consumer to facilitate recovery and reintegration.

Crisis access points include homes, sites within the community, and emergency rooms. The project will provide treatment, advocacy, education, and linkages as described above for consumers and their families or support persons. A significant component of this project will include helping family members understand and develop skills to both cope with their own feelings and concerns and to help their loved one in recovery. The nature of the illness and the individually tailored services require significant flexibility and creativity on the part of the First Onset Consumer and Family Support staff. Significant amounts of time may need to be devoted to working with consumers and personnel in any one of a variety of systems. This project will require close collaboration with various systems, including schools, primary care, courts, DBH, DCFS among others. This project will also help consumer and family members manage stress and take greater control by helping consumer and family through life-skills training, realistic goal settings, job coaching, among other types of advocacy and engagement designed to improve the quality of life for consumer and family.

The primary goal of this project is to provide immediate intensive services ranging from clinical treatment through whatever it takes to assist the consumer in the recovery process. According to Vancouver/Richmond Early Psychosis Intervention, several studies have shown that delays between onset of psychotic symptoms and commencement of appropriate treatment can cause significant disruption at a critical developmental stage and cause significant secondary problems. The longer the period of untreated illness, the greater the risk for psychological and social disruption and secondary morbidity, such as major depression, for the person and their family. Because a psychotic episode often isolates the person from others and causes difficulties in familial and social relationships, difficulties in school and work performance occur and compound the problem with unemployment, substance abuse, depression, self harm or suicide. Problems with law enforcement can also develop. Some evidence shows that long delays in treatment may cause the illness to become less responsive to treatment. It has been found that delays in receiving treatment are associated with slower and less complete recovery and that long duration of psychotic symptoms before treatment appears to contribute to poorer prognosis and a greater chance of early relapse. It is hypothesized that untreated psychosis causes greater biological entrenchment of schizophrenia.³

The intensity of services offered through this project to individuals experiencing a first onset of a serious mental illness will ensure appropriate systems and services linkages. All settings and systems that the consumer is naturally a part of, including schools, community college, primary care, employment, housing, community centers, among others, will potentially serve as sites for services, as deemed appropriate. The primary goal of this project is to enhance recovery so that the consumer is given the best possible chances to avoid further negative consequences, including substance abuse, unemployment, homelessness, and unlawful behavior. In the event that decompensation appears to deescalate into these negative outcomes, immediate intervention will necessarily be available through Project 6b below.

³ http://www.hopevancouver.com/Early_Intervention-Why_is_it_Needed.html

In order to meet the needs outlined in this project description, this project will include 1.0 FTE Psychiatrist, minimum of 4.5 FTE Licensed Mental Health Clinicians, Peer Support Specialists, Case Management, and other support and office staff. Additionally, this project also includes 0.3 FTE Clinician and 0.3 FTE CMHS from the Asian Pacific Islander (API) Team to address first onset of SMI of individuals from the API community and 0.5 FTE Clinician and 1.0 FTE CMHS from the Latino Team to address first onset of SMI of individuals from the Latino Community. The purpose of these positions within the API and Latino Teams is to provide the same what-ever-it-takes approach of this First Onset Consumer and Family Support Project but specifically adapted to the API and Latino communities in order to reduce the cultural and linguistic barriers to access specifically experienced in these communities. This project also envisions close collaboration with consumer advocacy groups and MOUs will be drafted, as appropriate.

In addition to the clinical care for first onset consumers with a serious mental illness with psychotic features provided by the mental health specialists, specific education, advocacy, and linkages will include the following:

- Educates the consumer and/or family about diagnosis and treatment in plain language
- Provides specific strategies to cope with mental illness symptoms and medication side effects
- Advocacy for consumers and family members, including information about an individual's or family's rights
- Bridges across systems (DBH/DCFS/School/Law Enforcement/Courts/Primary care) for consumers in recovery to help them function in their natural daily lives within the systems that they otherwise function, such as schools, places of employment, or other setting. These bridges will be voluntary and can be refused by the consumer.
- Stigma education/Self esteem building for consumer (i.e. what to feel/say to people when asked about ones mental illness)
- Culturally/linguistically competent
- Communication links
- Life-Skills training, to include skills in
 - Housing
 - transportation
 - Linkages to human services
 - Realistic post-crisis goal-setting
 - Job coaching
 - Socialization programs

Features of the Life-Skills training during the recovery period include:

- Adopt an individualized approach to measure progress
- The goals must reflect meaningful issues for the client so that the consumer is more likely to be committed to the recovery process
- By being actively involved in personally meaningful goals, the consumer gains a sense of control over his or her own life
- Clearly specified goals can facilitate a more coherent pursuit of relevant, feasible outcomes

Funding Project 6a:

Provider: To be identified through one or more RFPs or County Agencies. Collaborative proposals, if applicable, are strongly encouraged. Bid applicant(s), if applicable, must demonstrate bona fide cultural and linguistic competency for the communities identified in this project narrative.

Use of Funds:

Funding includes costs to assess the rates of recovery/decompensation of consumers who participate in this project. Primary purpose of funding is to provide intensive wrap-around services, including clinical treatment, advocacy, and 'whatever-it-takes' services, including life-skills training, linkages to human services, and case management to assist and support the consumer in the recovery process in the settings and with all the systems with which this individual naturally interacts. Staffs associated with this project include:

- 1.0 FTE Psychiatrist
- Building a First Onset Team to meet the anticipated number of first onset consumers, currently estimated at 263 individual consumers (minimum of 4.5 FTE Clinicians, plus support and office staff)
- Peer Support Specialist
- Case management
- Assembling an API Team to address first onset consumers from the API community (0.3 FTE Clinician, 0.3 FTE CMHS)
- Assembling a Latino Team to address first onset consumers from the Latino community (0.5 FTE Clinician, 0.5 FTE CMHS)

Project 6b:

In-home Family Centered Outreach Support will complement Project 6a., above by providing Consumer-Family Advocates to work in the home to develop prevention and early intervention strategies with families of consumers experiencing a first break mental illness or experiencing early onset of a crisis that might trigger unnecessary involvement with law enforcement or involuntary services or admission to emergency departments or the criminal justice system. The Consumer-Family Advocates will provide education to the family about mental illness and recovery; help the family and consumer develop positive interaction skills and communication techniques; and help build resiliency in the family in an effort to prevent future mental health crises that require involuntary psychiatric triage. This project will also help families develop de-escalation techniques so that if a consumer begins to decompensate, the family will be prepared to intervene

in the most appropriate manner, thereby preventing the need for more extensive services and providing crucial early intervention strategies to most appropriately meet the needs of the consumer.

The Consumer-Family Advocates will work collaboratively with other components of the PEI plan, including the CHW, integration of primary care and PEI, and CIT, as appropriate entrees to mental health services for individuals experiencing a first break serious mental illness/serious emotional disturbances and their families. Consumer-Family Advocates will be available to families in rural and un-served and underserved regions of the county and provide culturally and linguistically appropriate outreach and engagement. They will also work collaboratively with the CHW for those communities that need more culturally specialized consumer support. The prevention and early intervention services provided by the Consumer-Family Advocates will ultimately assist families to develop an appropriate home environment that facilitates the consumer's recovery from a first onset of a serious mental illness. The Consumer-Family Advocate will also assist the consumer and family to develop a back-up plan of action in the event that a consumer who has experienced a first onset decompensates within the first year. This back-up plan will include the above noted de-escalation techniques, an appropriate method of transportation to a mental health triage facility, and a list of community partners/resources, including peer support, who can be called upon to assist in the crisis.

In cases of relapse or decompensation, the Consumer-Family Advocate will work collaboratively with individuals/components of project 6a. above, in order to facilitate enhanced linkages to County Mental Health, primary care, or other providers, as appropriate. The target population for this project is individuals experiencing a first onset of a serious mental illness or experiencing an early onset of a crisis. These services will ensure that the best treatment decisions are made in consultation with consumer, family, and other key players in the consumer's life.

Funding Project 6b.

Provider: To be identified through one or more RFPs or County Agencies. Collaborative proposals, if applicable, are strongly encouraged. Bid applicant(s), if applicable, must demonstrate bona fide cultural and linguistic competency for the communities identified in this project narrative.

Use of Funds:

Ongoing funding will 2.0 FTE Consumer-Family Advocates, plus in operational costs that may include office space, cell phones, computer and other office supplies, among other reasonable operational expenses, plus in travel costs associated with travel to homes and other natural community settings for the purpose of providing the outreach and early interventions within the scope of this project.

Project 6c

Educational and Clinical Training Workshop on Prevention and Recovery of Psychosis is a project that will host a UCSF educational seminar for primary care practitioners, mental health practitioners, school psychologists, and other stakeholders and professionals who will benefit from knowledge about scientific advances in the understanding of psychosis, and early onset signs in the prodromal phase of psychosis. The workshop has a one-time cost of approximately \$7,800.00. This project is designed to enhance early identification of early phases of psychosis. It is *Indicated* prevention in that it is concerned with sub-threshold symptoms which confer enhanced risk for a more severe disorder. The early intervention component can be defined as indicated prevention, early case detection and optimal management of the first episode of illness and the subsequent 'critical period'. Through clinical training workshop, it is anticipated that increased awareness of signs and symptoms will aid in the early intervention.

- Community outreach to assist in the identification of precursors to psychosis, including changes in:
 - Behaviors
 - Speech
 - Thinking
 - Social Interaction
 - Emotional coping

- Early help can:
 - Reduce suffering of individuals
 - Prevention or delay
 - Shorten duration of treatment
 - Avoiding crisis episodes
 - Addresses co-morbidity

Funding Project 6c:

Provider: UCSF Educational and Clinical Training Workshop on Prevention and Recovery of Psychosis

Funding:
\$7,800.00, one-time

Use of Funds:

Funding includes a one-time cost of \$7,800.00 for one-day workshop. This cost includes travel and lecture rates for the UCSF personnel to teach this workshop. It is anticipated that the venue for this workshop will be leveraged from the community, local university or college, high school, or some other public/community venue.

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

As noted, over 30% of the participants in the Community Input Phase of planning included consumers and family members, who were instrumental in the development of this project, through discussion about their experiences, needs, wants, and from explanations of what did and/or did not work for them as individual consumers, family member and other loved ones.

Consumers described detailed experiences of mistreatment, largely from ignorance of mental illness on the part of first responders, primary care, family members and other systems personnel, such as school personnel and others, which presented significant obstacles in their recovery. One individual in recovery described how his teacher routinely reported him to disciplinary officials at school because his medications made him very disoriented. Another described how he was inappropriately placed in special education. One advocate reported that an individual in recovery from psychosis made an unlawful u-turn. When the police officer pulled him over, the young man in recovery became stressed and called his father to come to the scene. The father tried to explain to the police officer that his son was in recovery, but the officer ignored the father's pleas to de-escalate the situation. Ultimately the individual in recovery was charged with resisting arrest and assault on a police officer—unnecessarily harsh charges that resulted from ignorance of mental illness at best, and insensitivity or discrimination at worst. Others described experiences that helped them—of case managers who spent appropriate time and energy; of advocates who stepped in at the right moments; of teachers and other officials who cared.

This project will provide clinical treatment, advocacy, education, and intensive case management to create important bridges across systems to address the types of experiences expressed by consumers and family members throughout the Community Input and Strategy Development Phases of PEI planning. As a result of the intensive clinical treatment, advocacy for both consumer and family, and 'whatever-it-takes' services designed to facilitate reintegration and normalcy for the consumer, this project addresses the consumer-identified need for post-crisis advocacy and wrap-around services needed for improving the consumer's chances to more fully recover and improve the quality of their lives.

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

This project will deliver clinical treatment, case management, advocacy, and 'whatever-it-takes' services in a variety of natural settings, beginning at the mental health crisis access point, including home, various community settings, mental health facilities, and emergency rooms. Post crisis settings will include homes, school, work sites, courts, or in whatever natural setting that is appropriate for advocacy, education, and assistance to meet the needs of the consumer and their family. In short, the settings and organizations in which various advocacy, training, and education services will be delivered must be determined according to the most appropriate individualized intervention strategy in which the consumer (and family, if appropriate) and support staff work together as partners in the recovery process.

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

This project will address underserved TAY who experiences a first onset of a serious mental illness. Ideally, this project will focus on underserved communities in the rural areas of Fresno County, including Latino communities in west Fresno County, African Americans in the west Fresno metropolitan area, Native Americans in the foothills, and Hmong and Southeast Asians in the central Fresno metropolitan areas. Through the 'whatever-it-takes' services, culturally and linguistically appropriate services and sites, including appropriate culturally important spiritual healers, and culturally-sensitive treatment provisions, including horticulture therapy, among others will be provided to individuals from traditionally un-served and underserved communities in Fresno County, as appropriate.

e. Highlights of new or expanded programs.

Specific education, advocacy, and linkages include the following:

- Educates the consumer and/or family about diagnosis and treatment in plain language
- Provides specific strategies to cope with mental illness symptoms and medication side effects
- Advocacy for consumers and family members, including information about an individual's or family's rights
- Short-term bridges across systems (DBH/DCFS/School/Law Enforcement/Courts/Primary care)
- Stigma education/Self esteem building for consumer (i.e. what to feel/say to people when asked about ones mental illness)
- Culturally/linguistically competent
- Communication links
- Life-Skills training, to include skills in
 - Housing
 - transportation

- Linkages to human services
- Realistic post-crisis goal-setting
- Job coaching
- Socialization programs

Features of the Life-Skills training:

- Adopt an individualized approach to measure progress
- The goals must reflect meaningful issues for the client so that the consumer is more likely to be committed to the recovery process
- By being actively involved in personally meaningful goals, the consumer gains a sense of control over his or her own life
- Clearly specified goals can facilitate a more coherent pursuit of relevant, feasible outcomes

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

Case management staff and training must be contracted, including protocols for access to the consumer at the earliest possible sign of crisis, ideally at the crisis access point. Education and advocacy resources must be identified. Timelines must be established and individualized team decision making protocols must be inclusive of the individual consumer, case manager, family and appropriate systems personnel, such as school officials, court officials, social workers, and others, based on the needs of each individual case.

g. Key milestones and anticipated timeline for each milestone.

- Month 1 – OAC approval
- Month 2 – RFP, if applicable, developed
- Month 4 -- Contract awarded, if applicable
- Month 5 -- Establish protocols for first contact with first onset consumer and family members
- Month 5 -- Development of policies and procedures
- Month 6 -- Coordinate mental health outreach and identify key personnel at likely sites
- Month 7 -- Collaborate with existing County mental health services
- Month 9 -- Begin deployment of First Onset Consumer and Family Support
- Month 5-6 – Program monitoring
- Month 6-12 – Program evaluation

4. Programs

Program Title:	Proposed number of individuals or families to be served through June 2010 by type:		Number of months in operation through June 2010
	Prevention	Early Intervention	
First-Onset Consumer and Family Support	Individuals: n/a Families: n/a	Individuals: 100 Families: 100	9
In-home Family-Centered Outreach Support	Individuals: n/a Families: n/a	Individuals: 200 Families: 200	9
Educational and Clinical Training Workshop on Prevention and Recovery of Psychosis	Individuals: 200 Families: 300	Individuals: n/a Families: n/a	9
Total PEI project estimated unduplicated count of individuals to be served	Individuals: 200 Families: 200	Individuals: 300 Families: 300	9

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

The linkages to County mental health services that will be provided by this project are fundamental to its purposes. Since this project seeks to address first onset of serious mental illness through wrap-around consumer and family support, this project will be relying on key County mental health facilities, including psychiatric triage, as well as community partners and advocates in whatever natural settings individual consumers avail themselves.

6. Collaboration and System Enhancements

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

The primary function of this project is to provide advocacy for consumers during recovery from a first onset of a serious mental illness in as many of the settings in which a consumer naturally functions, including schools, colleges or universities, faith-based organizations, community groups, or any other system, as deemed appropriate and with the full participation of the consumer and family members. It is expected that the best chances for recovery and enhanced quality of life will require participation from key players in those natural life settings that are part of a consumer’s daily routine.

Sustainability

MHSA will fund this project through PEI on an ongoing basis. As an outcomes assessment of this project shows reductions in relapse and decompensation, a reduction in future crises, increase in resiliency and full recovery, and lower service pressures, this project will likely not only be sustained but significantly expanded to increase the positive outcomes of these services to an increased population.

7. Intended Outcomes

Individual	Family	System
<ul style="list-style-type: none"> • Decrease positive and negative symptoms • Maintain or increase cognitive abilities • Minimize side-effects • Reduce secondary morbidity • Preservation of psychosocial skills • Decreased need for hospitalization • More rapid recovery • Reduced vocational/developmental disruption • Less disability and lower risk of relapse • Reduced risk of suicide 	<ul style="list-style-type: none"> • Increased coping skills about what their child is going through • Increased knowledge about what their child is experiencing • Reduction in fear and stigma • Reduction in distress and isolation • Increase in positive contribution to child’s recovery • Reduction in financial burdens that result from mental health care costs • Increased chances for fulfilling relationship with child 	<ul style="list-style-type: none"> • Lower health care costs • Less hospitalization • Lower law enforcement costs • Enhanced awareness of serious mental illness across systems • Reduction in stigma and discrimination against those with serious mental illness • Reduction in recurring need for crisis intervention

8. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.

The CSS process is committed to rural and metropolitan services through FSP partners, such as Turning Point, among others. The individual experiencing first onset of a serious mental illness and their family will be linked up with approved MHSA CSS plan FSPs or other levels of care, as appropriate, after the time limits of this project have been reached or as more extensive needs are identified in the recovery process.

The MHSA's Workforce, Education and Training (WET) Planning Panel has developed a series of Career Pathways strategies to diversify the mental health workforce to more closely reflect the community in which we serve. PEI and WET programs will partner in areas of staff recruitment and training. In particular, Fresno County's WET plan includes Action Item no. 7, which includes education for consumers and families on mental illness, medications, side effects, among other mental health issues. It is anticipated that PEI and WET will collaborate both projects closely.

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

At this time, no Capital Facilities funds have been identified for this project. IT computer labs may possibly be used for families to gather medical information and help with providers. IT computer labs will be located in un-served and underserved areas of Fresno County.

9. Additional Comments

N/A

County: Fresno **PEI Project Name:** 7. Crisis and Acute Care Prevention and Early Intervention

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

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

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

The PEI Community Planning Process for Fresno County found that crisis intervention services (CIS) involves an estimated 250 unique individuals per year in Fresno County. While significant numbers of these individuals are from un-served and underserved communities, a first onset mental health crisis can affect all communities and families.

Community input highlights significant mental health challenges for families and individuals as a result of the continued financial distress of the economic downturn. Unemployment is ranked as the highest priority stressor leading to mental health concerns in our community through our Community Input Survey. Also, the highest priority underserved population selected in our Community Input Survey is *the poor*. Many individuals from un-served and underserved communities, especially individuals from impoverished rural areas of Fresno County are likely to experience increased anxiety, depression, and adjustment disorders, among other mental health concerns, as a result of their difficult economic circumstances. Many of these individuals will need short term prevention and early intervention to help them through this period of mental health concern and to prevent escalation of their mental health problems into more serious disorders, including substance abuse, gambling, domestic violence, and co-occurring disorders.

3. PEI Project Description: (attach additional pages, if necessary)***a. Description of proposed PEI Intervention.***

As a result of the severe economic downturn and the mental health stressors that result, it is anticipated that there will be a significant increase in calls into the urgent mental health care center developed through Fresno County's CIS re-design as a result of adjustment disorders, depression, anxiety and other non-SMI. These mental health concerns will need to be addressed through prevention and early intervention strategies to be delivered in a targeted and short-term manner through the urgent mental health care facility by having the ability to discuss new and growing mental health concerns with a clinician, who can then link the individual to other components and projects of the PEI plan by utilizing CHWs, peer support, prevention and early intervention activities in the community clinics, through Consumer-Family Advocates, and with other projects, natural settings, and community partners, as appropriate. In the event that an individual presents with more extensive mental health needs, the individual will be linked to appropriate mental health treatment through CSS or other appropriate County or private mental health treatment services.

Project 7 funding:**Provider:**

To be identified through RFP or developed in close collaboration with MHSA and DBH

Use of Funds:

- 1.0 FTE Clinician: The clinician will provide very short term prevention and early intervention services for individuals who call the urgent mental health care facility or arrive in person. Clinician will ensure that appropriate linkages are provided for individuals who present with more extensive mental health problems. Funding includes operational costs for computer, phone line, and other office expenses. It is anticipated that this position will be contracted with Fresno County mental health services.
- 1.0 FTE Licensed Mental Health Clinician to assist first responders during psychiatric crisis. Funds will be used to pay for annual costs for CIT training and to fund 1.0 FTE Licensed Clinician to liaison with first responders to psychiatric crises in order to provide effective clinical guidance to ensure consumer well-being and safe transportation to triage.
- 1.0 FTE Peer Support Specialist: Peer support specialist will be devoted to providing short term peer support interventions for consumers early in the manifestation of mental illness through the Urgent Care facility.
- 1.0 FTE Clerical Staff will support clinician and expansion of call-in operations at the urgent mental health care facility. Funding includes operational costs for computer, phone line, and other office expenses. It is anticipated that this position will be contracted with Fresno County mental health services.

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

The urgent mental health care prevention and early intervention call center expansion project will address the community input regarding the increase in mental health concerns that result from the deteriorating economic conditions, including depression, anxiety, adjustment disorders, and other mental health concerns. By providing quick-access, short-term prevention and early intervention services for individuals seeking help for their economically-driven mental health concerns, and through linkages to appropriate prevention and early intervention activities in the community, it is anticipated that these mental health concerns will be caught and addressed early on, thereby preventing more serious mental health problems or illnesses from developing. Use of Licensed Clinician plus Peer Support Specialist is a cost effective and sustainable approach to addressing these mental health concerns.

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

The urgent mental health care prevention and early intervention call center expansion will be provided through County mental health, because it is anticipated that this will be the entry for many new cases of mental health concerns. In anticipation of this increase in volume for less severe, although acute cases of mental health concerns, every effort will be made to facilitate immediately linkages to other PEI activities in the community, including CHWs, peer support, community clinics with prevention and early intervention components, among others. When an individual presents with more extensive mental health needs, appropriate linkages will be made to CSS, county and/or private mental health services. The role of the clinician will be to assess, deliver quick-access, short-term assistance, and hand these individuals off to more appropriate prevention and early intervention activities.

e. Highlights of new or expanded programs.

- 1.0 FTE Licensed Mental Health Clinician contracted to assess and provide quick-access, short-term prevention and early intervention services
- 1.0 FTE Peer Support Specialist
- Urgent mental health care Call-center expansion to field increase in calls for acute cases of depression, anxiety, adjustment disorders as a result of the growing difficult economic conditions of Fresno County
- Linkages to appropriate PEI activities and/or community resources, as appropriate
- Linkages to more extensive CSS or other County or private mental health services, as appropriate
- Peer Support Specialist to provide short-term peer support to consumers early in the manifestation of mental illness through the County urgent care center.

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

Contract licensed clinician and provide clerical assistance for expansion at urgent mental health care call center. Develop resource guide and protocols for quick-access, short-term help and linking individuals with acute mental health concerns to appropriate prevention and early intervention programs that are culturally and linguistically competent. Develop process to identify and provide appropriate linkages for those who need more extensive mental health services. Hire/contract 1.0 FTE Peer Support Specialist for short term peer support for consumers early in the manifestation of mental illness.

g. Key milestones and anticipated timeline for each milestone.

- Month 1 – OAC approval
- Month 2 -- Identify key community partners and law enforcement officials who will participate in the initial phases of CIT

- Month 2 -- Contract clinician and clerical assistant to set up urgent mental health care call center expansion, including protocols for assessment capabilities, quick-access prevention and early intervention services and appropriate linkages to outside services.
- Month 3 -- First CIT curriculum developed through collaborative efforts of key community partners
- Month 3 -- Community partners and urgent mental health care center will establish collaborative relationship; CIT training will be trained on its function; conduits to prevention and early intervention projects should begin to be established
- Month 3-5 -- Urgent mental health care call/wellness center will be operational and capable of addressing increase in need for quick-access, short-term prevention and early intervention services for non-SMI.
- Month 3 -- First CIT cohort should be trained
- Month 6 -- Second CIT cohort should be trained
- Month 6 -- First CIT debriefing/focus group to assess all mental health crisis calls: discussion of what worked/what did not work
- Month 2-6 – Program monitoring
- Month 6-12 – Program evaluation

4. Programs

Program Title:	Proposed number of individuals or families to be served through June 2009 by type:		Number of months in operation through June 2010
	Prevention	Early Intervention	
9b. Urgent mental health care Prevention and Early Intervention Call Center Expansion	Individuals: 2400	Individuals: 14500	9
Total PEI project estimated unduplicated count of individuals to be served	Individuals: 2400	Individuals: 30650	

6. Collaboration and System Enhancements

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

Expansion of the urgent mental health care call center for short-term prevention and early intervention and linkages by the clinician will require collaborative relationships with law enforcement and other first responders; community organizations and other PEI partners and programs; and CSS or other County/private mental health services.

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

It is anticipated that the source of entry for individuals in mental health crisis and other acute cases of depression, anxiety, or other non-SMI will be through emergency rooms and/or the urgent mental health care facility. In cases of mental health crisis, County mental health will work closely with emergency room personnel through the Mobile Crisis Unit that will be deployed for mental health crises throughout Fresno County. Through the urgent mental health care facility and collaborative crisis intervention training, this project will strengthen its partnerships between County mental health,

emergency room care, law enforcement, and consumer advocacy organizations. Other partners include local mental health professionals, universities, consumers and family members.

d. Describe how the programs in this PEI project will be sustained

It is anticipated that acute cases of non-SMI mental health concerns, including depression, anxiety, and adjustment disorders, among others, that frequently result from severely adverse financial circumstances will decrease as the current economic downturn improves. In the event that economic conditions remain poor for Fresno County for the longer term, the collaborative network of short-term prevention and early intervention services developed through the PEI plan and with the help of community partners to address the acute non-SMI problems that result will have positive outcomes on the entire system, allowing resources to be used in a more cost-effective manner. As mental health concerns are treated early through prevention and early intervention efforts, it is expected that more extensive mental health problems will be avoided.

7. Intended Outcomes

Individual	Family	Systems/Organization
<ul style="list-style-type: none"> • De-escalation of crisis • More sensitive treatment • More efficient access to crisis treatment • Less discrimination • Less deleterious post-crisis recovery • Improved safety • Increased access and short-term treatment for acute cases of non-SMI 	<ul style="list-style-type: none"> • Less family distress • Fewer financial burdens on family as a result of legal consequences of crisis • Improved safety of loved one • Less trauma as a result of crisis or acute cases of non-SMI 	<ul style="list-style-type: none"> • Greater collaboration between organizations • Increased public safety • Decrease in escalation of acute non-SMI mental health concerns into more extensive mental health problems

8. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.

CIT and urgent mental health care prevention and early intervention service expansion will collaborate very closely with the CSS update and crisis intervention services re-design for Fresno County. Fresno County expects to implement a Crisis Psychiatric Response Service that will include mobile crisis services, collaboration with emergency rooms, and the urgent mental health care facility

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

The MHSA's Workforce, Education and Training (WET) Planning Panel has developed a series of Career Pathways strategies to diversify the mental health workforce to more closely reflect the community in which we serve. PEI and WET programs will partner in areas of staff recruitment and training. In particular, Action Item no.5 of Fresno County WET plan includes funding to help train law enforcement, probation, and other first responders in cultural competency and fundamental concepts of MHSA, including PEI and CSS.

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

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

9. Additional Comments

N/A

County: Fresno PEI Project Name: 12a. Blue Sky Wellness Center

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

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

B. The following projects are existing approved MHSA projects funded through the CSS plan, but are prevention and early intervention projects by definition and should therefore be more appropriately placed within the three-year PEI plan.

3. PEI Project Description: (attach additional pages, if necessary)

a. Description of proposed PEI Intervention.

Blue Sky Wellness Center

Blue Sky is a stigma-busting, confidence building resource in our community for consumers and family members who may or may not receive mental health services offsite through Fresno County's Department of Behavioral Health (DBH), and their contracted providers. Although currently funded through CSS, Blue Sky is engaged in what can only be described as prevention and early intervention activities. These activities are described below. There is no treatment offered at Blue Sky. Instead, linkages for services are provided to the appropriate agencies through Blue Sky's unique position in the community as a hub of mental health awareness, outreach and engagement. As a result, it is proposed that Blue Sky be funded through PEI, which will free up funding within CSS to provide increased services. In support of this and in addition to the prevention and early intervention activities currently in place, Blue Sky will provide site resources and will work collaboratively with the following proposed PEI projects:

- Cultural-based Access and Navigation Specialists (CHW) and Community-based Peer Support
- First Onset Consumer and Family Support Project
- Suicide Risk and Para-Suicide Behavior Project
- Mental Health Education Council to Reduce Culture-based Stigma and Discrimination

In addition, it is important to note that the location of Blue Sky on Blackstone Avenue, centrally located within easy walking distance from a major public bus terminal at Manchester Center, provides a convenient location for prevention and early intervention activities within the metropolitan area of Fresno. While the PEI projects in this plan significantly focus on the rural un-served and underserved communities throughout the County, this PEI project will specifically serve many of the un-served and underserved individuals within the main metropolitan area of the County.

Specifically, prevention and early intervention activities will be expanded at Blue Sky through the development of a toll-free warm line staffed by consumers and family members. The warm line will have the ability to provide prevention and early intervention support through phone calls in each of the County's threshold languages. This warm line will also be the same warm line described in the Suicide Risk and Para-Suicide Behavior project.

Blue Sky will also be a collaborative site for the First Onset Consumer and Family Support project through its support components, including peer support and activities. First onset consumers can be immediately linked to Blue Sky to get critical information about living with mental illness, to socialize, and to participate in recovery activities that will help them recover in the best possible way. Families will receive important information and build important relationships with other family members through activities and knowledgeable individuals at Blue Sky. Blue Sky holds a unique position within the community in its openness and commitment to mental health awareness and recovery, as a welcoming environment for consumers and family, and in its connectedness to key personnel in the mental health community.

Blue Sky will also collaborate closely with the CHW project as a site where important outreach and engagement can be made in a non-stigmatizing and non-discriminating environment. The Horticultural Therapeutic Community Centers project has a peer support component that can leverage Blue Sky for education and outreach to the community leaders and consumers from the various ethnic communities. While the Horticultural Therapeutic Community Centers are designed to be a natural community site for culturally appropriate peer support, consumers from the cultural and ethnic communities can avail themselves of the prevention and early intervention supports provided through Blue Sky. The CHW project will be able to reach an increased number of people from the un-served and underserved communities within the major metropolitan area of the County as a result of the connectedness of Blue Sky to the mental health community; to the proximity of consumer experts and family member experts; and to general knowledge of where to go for what need. The Mental Health Education Council will be able to develop projects voluntarily through resources at Blue Sky, including consumers and family members who want to tell their story; provide insight into their experiences about what worked and what didn't work; and help in other ways with stigma reduction and awareness of mental illness. Additionally, the Mental Health Education Council may be able to leverage meeting space at Blue Sky, provided space is available.

Currently, Blue Sky provides prevention and early intervention support through the "Village" peer and family member center model. The "Village" center model will be leveraging the experiences and expert knowledge of consumers and family members and interested members of the community for the purpose of developing a "Village" team. The "Village" team will target the mental health needs of un-served and underserved cultural, ethnic, linguistic and racial communities including the Latino, Southeast Asian, Native American and African-American communities and will be trained in basic behavioral health and physical health education. This team should also be available to provide outreach and engagement at other natural community settings, including the Horticultural Therapeutic Community Centers, schools, senior centers, and at other sites. Bilingual and bicultural team members will also offer in-home services and other 'out of the office' services to local families, distributing educational materials and offering information about locally available services. The prevention and early intervention services are voluntary and will be made available at times/locations that are convenient for the family members.

Core Prevention and Early Intervention Services at Blue Sky

Peer Advisory Council:

Blue Sky will have a Peer Advisory Council to steer the process planning and implementation or prevention and early intervention activities from the consumer and family perspective. This Peer Advisory Council will have representation from the TAY Advisory Council and ensure active participation from adult and older adults and family member populations. TAY will have an active role in guiding and having ownership of their TAY prevention and early intervention services at Blue Sky.

Volunteers and Consumer-Paid Staff:

Blue Sky will hire consumers and family members and seek consumer/family member volunteers to provide supportive services. Examples include but are not limited to:

- Group and individual supportive services in addition to teaching Wellness Recovery, Action Plan services and Crisis Plan services
- Provide a toll-free warm line for non-crisis supportive services
- Group Transportation
- Teach life skills courses, e.g., money management, independent living skills, cooking, cleaning, etc.
- Provide social, recreational opportunities and leisure education
- Job readiness services
- Social benefits counseling
- Literacy and other educational services
- Other needed support services as identified through consumers/family members

Blue Sky will hire bilingual and bicultural staff to provide culturally and linguistically appropriate strength-based mental health supportive services that are consumer and family driven. All staff will meet the language proficiency requirements set by County policy for bilingual pay and will be interviewed in the specific language identified for this target population. Should a potential consumer require language assistance for a language outside the proficiency of the staff, a certified interpreter will be acquired.

Every effort will be made to recruit and hire staff who are proficient in any of the threshold languages beside English and who has the knowledge and skills to work with the diverse cultures. Staff from the targeted communities and surrounding communities in the TAY, adult and other adult populations must be included in the hiring process.

Educational Services:

Educational services about behavioral health issues and anti-stigma information will be made available to all included age groups. Blue Sky staff will educate DBH staff, primary care physicians and the community about behavioral health issues, wellness and recovery. Staff will provide training to DBH staff, primary care physicians, consumers and family members on Wellness Recovery Action Plans and Crisis Plans at least once annually. Training for DBH staff will also include family support perspectives. Family education should involve a partnership among consumers, families and supporters, and practitioners. Through relationship building, education, collaboration, problem solving, and an atmosphere of hope and cooperation, family education helps consumers and their families and supporters to:

- Learn about mental illness
- Develop strategies to manage their mental illness
- Reduce tension and stress within the family
- Provide social support and encouragement to others
- Focus on the future
- Find creative ways for families and supporters to help consumers in their recovery

Classes will be provided regarding what youth need to know for successful living in the community. There will be training and curriculum for individual support, including:

1. Problem solving
2. Skills development
3. Education about the consumer's illness and their role in the therapeutic process
4. Modeling and supervision, in the home and in community settings, to teach the consumer on fundamental life skills, including:
 - a. Personal hygiene
 - b. Household chores (housekeeping/cooking/laundry shopping)
 - c. Money management skills
 - d. Community transportation
 - e. Housing-- locating, financing and maintaining safe, clean and affordable housing

Family Support and Education:

Family services are an integral component to wellness and recovery for the consumer populations being served through MHSA. Family support services must acknowledge the age populations being served. Center staff will be representative of consumer and family members, in which a partnership will be created among consumers, families, supporters and practitioners. Through relationship building, education collaboration, and problem solving an atmosphere of hope and

cooperation will be created. Educational/Family Support will provide consumers/family members the following opportunities to:

- Learn about mental illness
- Master new ways of managing their mental illness
- Reduce tension and stress within the family
- Provide social support and encouragement to each other
- Focus on the future
- Find ways for families and supporters to help consumers in their recovery

Warm Line:

Blue Sky will be responsible for the 24/7 implementation of a warm line, more specifically the line will be staffed by consumers, family members, and/or volunteers from each unique age group. The warm line will be staffed 24 hours per day, seven (7) days per week for telephone calls from consumers who may need prevention and early intervention supports in any of the County's threshold languages. The warm line staff/volunteer on duty will be required to provide support, advocacy services, and make referrals to emergency services or to community based programs, as appropriate.

Funding: \$1,005,436.00, ongoing

At a minimum the suggested staffing plans for Blue Sky will consist of three positions equivalent to Fresno County's Community Mental Health Specialist; six Peer Support Specialists/Parent Partners and two Office Assistants. Staffing patterns will allow for staff specialization in services to the three different age groups; vendor shall submit a staffing plan that identifies staff fully devoted to family services, and capable of meeting the families' identified needs. "The Center" will also secure consultation services of a Licensed Mental Health Clinician to provide oversight to the program design and implementation. Specific Program Services will include:

1. Self-help and consumer-run programs such as a drop-in center, club houses, anti-stigma campaigns, job training classes, advocacy programs, and peer education
2. Classes and other instruction for consumers regarding what consumers need to know for successful living in the community
3. Family support, education, and consultation services, parenting support and consultation services, self-help groups and mentoring
4. Consumer advocacy on criminal justice and/or child welfare issues
5. Transportation services

6. Education for primary care providers and other health care providers to increase coordination and integration of mental health and primary care, and other health services

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

Over 30% of the participants in the Community Input Phase of planning included consumers and family members, who were instrumental in the development of this project, through discussion about their experiences, needs, wants, and from explanations of what did and/or did not work for them as individual consumers, family members and other loved ones.

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

This project was approved through the CSS community planning process and approved by the OAC in Fresno County's CSS plan. This project will provide a non-stigmatizing safe place for socialization and mental health advocacy for culturally and ethnically diverse TAY, Adult, and Older Adult consumers and their families in the major metropolitan area of Fresno County that is conveniently located.

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

This project will address underserved TAY, Adults and Older Adults who experience serious or other mental illness from diverse communities in the metropolitan areas of Fresno County, including Latinos, African Americans from the west Fresno metropolitan area, Native Americans, and Hmong and Southeast Asians in the central Fresno metropolitan areas. Because it is a walk-in prevention and early intervention facility and because of its central metropolitan location and within easy walking distance from a main bus terminal at Manchester Center, underserved individuals from various locations within the major metropolitan center of Fresno will have easy access.

e. Highlights of new or expanded programs.

Specific education, advocacy, and linkages include the following:

- Educates the consumer and/or family about diagnosis and treatment in plain language
- Provides specific strategies to cope with mental illness symptoms and medication side effects

- Advocacy for consumers and family members, including information about an individual's or family's rights
- Stigma education/Self esteem building for consumer (i.e. what to feel/say to people when asked about ones mental illness)
- Culturally/linguistically competent
- Communication links
- Life-Skills training, to include skills in
 - Housing
 - transportation
 - Linkages to human services
 - Realistic post-crisis goal-setting
 - Job coaching
 - Socialization programs

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

Education and advocacy resources are already in place. Timelines must be established and individualized team decision making protocols must be inclusive of the individual consumer, case manager, family and appropriate systems personnel, such as school officials, court officials, social workers, and others, based on the needs of each individual case.

g. Key milestones and anticipated timeline for each milestone.

Blue Sky Wellness Center is operational. The only milestone required is OAC approval for funding through PEI.

4. Program

Program Title:	Proposed number of individuals or families to be served through June 2009 by type:		Number of months in operation through June 2010
	Prevention	Early Intervention	
Blue Sky Wellness Center	Individuals: 200 Families: 200	Individuals: 100 Families: 100	12
Total PEI project estimated unduplicated count of individuals to be served	Individuals: 200 Families: 200	Individuals: 100 Families: 100	12

Program Title:	Proposed number of individuals or families to be served through June 2009 by type:		Number of months in operation through June 2010
	Prevention	Early Intervention	
Warm-line at Blue Sky	Individuals: 1200 Families: 1200	Individuals: 1200 Families: 1200	12
Total PEI project estimated unduplicated count of individuals to be served	Individuals: 1200 Families: 1200	Individuals: 1200 Families: 1200	12

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

Blue Sky Wellness Center will provide linkages to individuals for appropriate CSS or other County/private mental health services as appropriate. The warm line, in particular, will have the responsibility to provide linkages to those who call in and indicate a need for treatment or other more extensive services, such as crisis services. The warm line will also be able to provide linkages to other prevention and early intervention projects or activities in the community or to primary care

clinics, including the short term prevention and early intervention services provided at those community clinics with integrated mental health prevention and early intervention activities, including assessment and linkages to more appropriate services.

6. Collaboration and System Enhancements

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

Blue Sky will be a safe place for the consumer and a place for outreach, possibly into other systems, in order to provide advocacy, mental health education, and life skills for consumers and family members during recovery from a first onset of a serious mental illness. Blue Sky will work with many of the settings in which a consumer naturally functions, including colleges or universities, faith-based organizations, community groups, or any other system, as deemed appropriate and with the full participation of the consumer and family members. For example, stigma-busting activities that result from the Mental Health Education Council work will collaborate with Blue Sky to engage the community and consumers in many natural community settings. It is expected that the best chances for recovery and enhanced quality of life will require participation from key players in those natural life settings that are part of a consumer's daily routine, thus Blue Sky, consumers, and family members will work collaboratively with others in the community, including personnel from faith-based organizations and neighborhood resource centers, among many others.

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

Blue Sky will provide referrals and linkages to primary care clinics that provide prevention and early intervention support and mental health clinics that are County-based or private, as appropriate.

c. Leveraging and Sustainability

MHSA will work in collaboration with the faith-based community, and other organizations that support Blue Sky. Moreover, Blue Sky is operated through an existing not-for-profit charitable Mennonite organization called Kings View Corporation. Kings View has extensive collaborative relationships throughout the County and will continue to work collaboratively to maximize the effectiveness and sustainability of the Blue Sky Wellness Center. Additionally, as outcomes assessments of Blue Sky indicates increased success of the prevention and early intervention activities, including improved recovery of individuals with first onset mental illness, an increase in resiliency and full recovery, and lower service pressures, this

project will likely not only be sustained but significantly expanded to increase the positive outcomes of these services to an increased number of individuals.

7. Intended Outcomes

Individual	Family	System
<ul style="list-style-type: none"> • Decrease positive and negative symptoms • Maintain or increase cognitive abilities • Minimize side-effects • Reduce secondary morbidity • Enhanced quality of life • Preservation of psychosocial skills • Preservation of family and social supports • Decreased need for hospitalization • More rapid recovery • Less stressful assessment and treatment • Reduced vocational/developmental disruption • Better prognosis • Less disability and lower risk of relapse • Reduced risk of suicide • Fewer legal complications 	<ul style="list-style-type: none"> • Increased coping skills about what their loved one is going through • Increased knowledge about what their loved one is experiencing • Reduction in fear and stigma • Reduction in distress and isolation • Increase in positive contribution to loved one's recovery • Reduction in financial burdens that result from mental health care costs • Increased chances for fulfilling relationship with loved one 	<ul style="list-style-type: none"> • Lower health care costs • Less hospitalization • Lower law enforcement costs • Enhanced awareness of serious mental illness across systems • Reduction in stigma and discrimination against those with serious mental illness • Reduction in recurring need for crisis intervention

8. Coordination with Other MHSA Components

The CSS process is committed to both rural and metropolitan services through FSP partners, such as Turning Point, among others. Individual experiencing first onset of a serious mental illness and their family will be linked up with approved MHSA CSS plan FSPs or other levels of care, as appropriate. Individuals suffering from serious or other mental

illness can receive services through CSS, as appropriate, while also participating in the psycho-social benefits of the prevention and early intervention activities at Blue Sky.

The MHSA's Workforce, Education and Training (WET) Planning Panel has developed a series of Career Pathways strategies to diversify the mental health workforce to more closely reflect the community in which we serve. PEI and WET programs will partner in areas of staff recruitment and training. In particular, Fresno County's WET plan includes Action Item no. 7, which includes education for consumers and families on mental illness, medications, side effects, among other mental health issues. It is anticipated that PEI and WET will collaborate both projects closely.

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

At this time, no Capital Facilities funds have been identified for this project. IT computer labs may possibly be used for families to gather medical information and help with providers. IT computer labs will be located in un-served and underserved areas of Fresno County.

County: Fresno **PEI Project Name:** 12b. Team Decision Making

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

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

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

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

The Community Input Phase for Fresno County identified the Team Decision Making program as providing prevention and early intervention services. The program provides for preservation/stabilization of children who are at risk of out-of-home placement. Mental health staff provides pre-screening, assessments, family support, initial crisis intervention and linkage to other resources and services for ongoing treatment if required. Focus groups throughout the planning process identified the need to have a mental health component to the Team Decision Making program, which allows staff to identify children and families who are at risk of developing a mental illness due to the family situation.

2B.1 Data Review and Analysis.

To help identify the selection of Key Community Mental Health Needs and Priority Populations, we conducted a thorough review of the available data sources. The County used MHSA staff to review our CSS needs Assessment for information pertinent to Prevention and Early Intervention planning and to identify additional data sources helpful for PEI planning.

The information that was reviewed and analyzed included data from the following sources; CSS materials, MHSA Survey A, MHSA Survey B, PEI Community Focus Groups, PEI Community Stakeholder Input, Kings View Corporation, Outreach & Engagement Report.

The County compiled this data along with the involvement of the community stakeholders. Community stakeholders also participated in the methodology utilized to analyze the data to create a final report. The community stakeholders also helped identify additional data sources to help select key mental health needs and priority populations. In the PEI selection process the community stakeholders later helped the County determine which programs were best fit the County's needs.

2B.2 Stakeholder Input

Community stakeholder input was obtained throughout the planning process and used to help identify and select the Key Community Mental Health Needs and Priority Populations that these projects address. In addition, the County reviewed stakeholder input gathered from the CSS planning process to identify input relevant to prevention and early intervention planning and concluded that the following projects met the criteria for PEI: Blue Sky Wellness Center, Team Decision Making, Outreach and Engagement and Functional Family Therapy.

Community stakeholder input was gathered during our PEI Community Program Planning as discussed in FORM No. 2. Data, community input and additional resource information was gathered from community stakeholder meetings, focus

groups, surveys, County departmental meetings and community forums. The County's PEI planning panel consisted of a diverse panel and key PEI stakeholder as discussed in FORM No. 2.

The input from this planning process was analyzed, synthesized, and used to identify and select the Key Community Health Needs and Priority Populations that ***Project 8b – Team Decision Making*** addresses.

2B.3 Project identification

As a result of input and analysis, the County along with the community stakeholders selected to transfer the **Team Decision Making** program from the CSS plan to PEI. The Team Decision Making program addresses the key community mental health needs, priority population and age groups required by PEI.

The Team Decision Making program addresses the key community mental health needs which identify *Psycho-Social Impact of Trauma and At-Risk Children, Youth and Young Adult Populations*.

The priority population addressed by the Team Decision Making program are; *Trauma Exposed individuals, Individuals Experiencing Onset of Serious Psychiatric illness, Children and Youth in Stressed Families, Children and Youth at Risk of or Experiencing Juvenile Justice Involvement, and Underserved Cultural Populations*.

3. PEI Project Description: *Team Decision Making*

a. Description of proposed PEI Intervention.

The Team Decision Making (TDM) program is a multi-disciplined/multi-dimensional process, comprised of parents, family, care givers, probation officers, social workers, teachers, community representatives, and mental health staff. This collaborative group comes together in an effort to address stability and permanence in the child's best interest and least restrictive environment. The team works together to preserve/stabilize placements, determine the safety and welfare of children and their family. Through the CSS component of the MHSA plan, the County was allowed funding to provide a mental health component to the TDM.

The County's Department of Children and Family Services, Child Protective Services (CPS) receives all referrals and leads the TDM meetings. Reasons for TDM's include Emergency Removal, Imminent Risk of Removal, and Placement Change. The County's mental health staff role or component of the TDM is to act as a consultant, prevent inappropriate placement and provide initial crisis intervention if needed. Additional services outside of participating in the TDM process include but not limited; mental health assessments to both children and families, critical incident debriefing, initial therapy, parent partner services, consultation with child welfare (CPS), initial crisis intervention, medication and

medication supports, and linkage to other community services to assist the child and family to maintain and preserve a stable environment.

The target population includes children and their families, un-served and/or underserved Latino, Southeast, Asian, and African-American, children/families with serious emotional disturbances (SED) who are at-risk of out of home placement, or at risk of institutional care, hospitalization, incarceration, or at risk of changes to their current placement, and who are involved in the child welfare system. MHSA funds will be used to services up to 140 children, youth and families that have no, or limited, means of payment for services per year.

The objective/goals of the TDM is make appropriate plans for preventing foster care placements, to reduce out-of-home care and placement changes due to emotional or behavioral problems. In addition, purpose of the TDM is to maintain the child in their home setting or community and in their current school and reduce the long-term adverse community impacts of untreated mental illness. The program promotes the goals of the MHSA which include Community collaboration, Wellness, Resiliency, Recovery, Consumer/Family driven, integrated services, Cultural Competency, Underserved Communities, and is Outcome Based.

Collaboration between child welfare services, probation, schools, family caregivers, community and faith based organizations, and children's mental health, is achieved through mental health staff support in the form of Community Mental Health Specialist and Parent Partners in the TDM process. This collaboration will lead to shared information and resources to meet the needs of the child/family.

The County's mental health staff will develop and expand partnerships with Latino community, South East Asian, African American, Community and Faith Based organizations, and Native American Tribal organizations. The current TDM collaborative is comprised of parents/family members, care givers, probation officers, social workers, teachers, community and faith based organizations, and County mental health staff in operating a wellness philosophy that includes the concept of both recovery and resiliency for children with serious emotional disorders.

The County's mental health component is comprised of five (5) staff which include; one (1) Supervisor, one (1) Licensed mental health clinician, two (2) community mental health Specialist, and one (1) parent partner. Current staff is reflective of the target population and receives cultural competency training provided by the County annually. More than 50% of staff are bilingual and require very minimal use of available translation/interpreting services.

The Clinical supervisor is partially funded through mental health realignment funds (50%) and MHSA dollars (50%). The supervisor will continue serving as a team leader for the TDM mental health staff. The team leader shall be responsible for various administrative functions, such as triage and assignment of staff to TDM's; collaboration with child welfare agencies, probation schools, etc., monitoring of staff training needs, monitoring of program outcomes to assess the quality of the program services. In addition, the supervisor may attend TDM's, and assist staff and collaborative members with complex cases as needed.

The licensed mental health clinician shall provide mental health assessment and linkage to appropriate agencies for further long-term treatment and other comprehensive services. In a time of need, the clinician is available to provide

immediate crisis intervention for both child and/or family. The clinician will also provide consultation and training to TDM participants, including collaborative partners and foster parents, to educate them on mental health issues relative to each particular client/family, such as information on the trauma associated with placement moves for children in foster care.

Community mental health (CMHS) specialist will act as liaisons and provide linkage for mental health needs (including the identification of crisis services) of the client/family. Each CMHS will participate in the initial/entry TDM when client/families' mental health needs are first discussed, and maintain involvement in future TDMs to address mental health needs of the identified client/family(s). CMHS's will provide case management and linkage referrals which may include services, as specific needs warrant, including, but not limited to psychiatric evaluation, medication support, and ongoing therapy by identifying and linking client/families to children mental health provider organizations.

Parent partners will be part of the TDM process providing peer support services to families. In addition, the parent partner would provide education and advocacy services to clients and their families, assist families in navigating through the mental health and child welfare delivery systems. The parent partner position will always remain a consumer/family.

Total program cost for the County's in house mental health component is \$471,297 for FY 2008-09. MHSA funding provides for support to families through food, clothes, hygiene, travel expenses and transportation, County personnel expenses and operating expenditures. For more detailed information please see FORM 4, budget narrative for *Children and Youth 3 Team Decision Making*

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

Although the TDM was operated under the MHSA General System Development, Community Services and Supports (CSS), this project was identified as a prevention and early intervention project meeting the key community mental health needs, priority population, and desired outcomes by PEI planning panel which included community stakeholder participation.

The County selected this project based on research information and model Annie E. Casey's Team Decision Making promising practice. The County's planning panel analyzed the existing demographics and service data received to date from existing program. Through the County's planning process the PEI planning panel was able to determine the community needs and priority populations identified by our stakeholders and key community partners. The County reviewed the existing TDM program to identify practices that would work with our community and that would achieve the desired outcomes for the PEI component. In summary, our selection was based on stakeholder input, data analysis, and program outcome information.

The TDM program mental health component addresses the Psycho-Social Impact of Trauma and At-Risk Children Youth and Young Adult Populations as a major mental health concern. The TDM prevents the inappropriate placement of a child and addresses any immediate mental health needs and services required for said target population. Without the

appropriate prevention and intervention from the TDM could lead to significant trauma in the family, with significant negative affects on children and youth in those families, which in turn causes poor coping skills, deliberate self harm, negative social outcomes, including school failure, unemployment, criminal behavior, incarceration, and substance abuse, among others. The primary focus of this program is to make appropriate plans for preventing foster care placements, to reduce out-of-home care and placement changes due to emotional or behavioral problems, address any mental health needs and prevent any negative impact on the family. By addressing the mental health component of the TDM, the goal of this program is to provide sustainability for the child in the most appropriate home setting or community, maintain child in their current school and reduce the long term adverse community impacts of untreated mental illness.

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

The existing TDM program settings will continue services at various sites but will be mostly held at County operated Child welfare sites. The Department of Children and Family Services, Child Protective Services (CPS) takes the lead in facilitating the TDM meetings and determines appropriate meeting location based on families need and location.

TDM meetings are held primarily at the Child welfare sites, the Selma Regional Center (Rural), and community based organizations such as the Foster Family Agency. Facilities utilized are dependent on family convenience and amount of space required to hold a TDM meeting.

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

This TDM program will focus on the unserved and underserved cultural, ethnic, and racial populations. The TDM will provide services to all Fresno County residents in both rural and metropolitan areas. TDM meetings will be held at facilities dependent on space and convenience of family. The target population includes children and their families, unserved and/or underserved Latino, Southeast, Asian, and African-American, children/families with serious emotional disturbances (SED) who are at-risk of out of home placement, or at risk of institutional care, hospitalization, incarceration, or at risk of changes to their current placement, and who are involved in the child welfare system.

e. Highlights of new or expanded programs.

Highlights of the existing program included the expansion of enhanced services through means of increased capacity, staffing and promotion of consumer/family oriented program. Enhancements include:

- Increasing services from 60 to 140 for each twelve month period, original program exceeded capacity estimates.
- Enhanced staffing will provide mental health staff at initial/entry level TDM to fully engage attendees at the first point of contact.
- The addition of the licensed clinician enhanced the clinical capacity of the TDM process.
- Expansion of funding to include a clinical supervisor time ensures team direction, clinical oversight and outcomes program monitoring.
- Prioritization of which TDM's may need mental health involvement will be achieved through this program expansion based on increase staff availability.
- Intervention for children exposed to traumas associated with out-of-home placement.

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

The existing TDM program requires the following actions for maintenance of services:

- Continued partnership collaboration with child welfare, probation, schools, family and care givers, and community and faith based organizations.
- Continuous staff training and development to recruit and maintain staff.
- Identify consumer and/or family mental illness and provide services in a cultural sensitive manner.
- Assure program fidelity.

g. Key milestones and anticipated timeline for each milestone.

The existing TDM program will only require approval from State DMH, services will be continued without a gap in services to children and their families. Once approved by the State, the County will transfer the funding stream from CSS to PEI component and acknowledges the program can not be transferred back.

4. Programs

Program Title:	Proposed number of individuals or families to be served through June 2010 by type:		Number of months in operation through June 2010
	Prevention	Early Intervention	
Team Decision Making	Individuals:89 Families: 45	Individuals:90 Families: 44	12
Total PEI project estimated <i>unduplicated</i> count of individuals to be served	Individuals:89 Families:45	Individuals:90 Families:44	12

The County has identified the Team Decision Making program as a prevention and early intervention program and desires to transfer this program from the current CSS component to the new PEI component. There will be no gap in continued services to consumers and their families. Funding costs in the amount of \$471,297 will be financed through MHSA PEI component making available the same dollar amounts in the existing CSS component for expansion of existing programs and/or creation of new programs.

The County’s approved CSS plan included activities that meet the criteria for PEI funding. The County requests the approval from the State to move the Team Decision Making (TDM) program activities to the PEI component. The TDM program activities previously funded by CSS meets PEI criteria in the following ways:

1. It targets individuals and families whose risk factors of developing mental illness is significantly higher than average. 90% of children in TDM meetings are at risk of out-of-home placement.
2. The goal of the TDM is to reduce risk factors or stressors for children and their families and building protective factors and skills and increasing community support to provide stabilization.
3. Provides support in encouraging and promoting wellness, resiliency, and recovery
4. Provides for pre-screening and assessments to identify children and families with mental illness and/or serious emotional disturbances in its early manifestation.
5. Provides low intensity case management (less than six months).
6. The TDM program is designed and implemented in collaboration with other system and organizations for the well being of children and their families.

7. Services for ongoing mental health treatment will be referred to County and/or community resources.
8. Provides engagement of the family and support to the family in its role in the individual's wellness.
9. Services delivered in a non-traditional setting dependent on the collaborative and family convenience.

The TDM program is serving individuals prior to the development of a serious emotional disturbance. The County will ensure that this service will only be provided to individuals prior to the development of a serious emotional disturbance and do so will include screening and assessment and then refer individuals who need mental health treatment to County mental health programs and/or community/faith based organization for further treatment.

We have completed and are submitting a Plan Amendment for the removal of this specific CSS activity from our CSS Program and Expenditure Plan. The transfer of the funding source from CSS to PEI will be effective at the start of the fiscal year following approval of this PEI project.

Since this activity is focused on individuals prior to the development of a mental illness or very early after its manifestation, it should be funded by PEI rather than CSS. The program will continue to focus on the Priority Population(s) and Key Community Mental Health Need(s) identified in our PEI planning process, and will serve individuals with Prevention and Early Intervention services. This service is different from our approved CSS program, especially as to treatment services provided to individuals and their families. One hundred percent (100%) of the TDM program will be transferred over to the PEI component and provide for only selective prevention and early intervention.

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

This PEI Project was designed in an inclusive planning process that included county and private providers of health, primary care, and mental health services. We believe that these community partner agencies, including health and primary care providers, are key partners in the strengthened network of care. As a result, the TDM program consisting of collaborative members requires specific and formal referral linkages to assessment and treatment resources when participants believe that more extensive treatment is needed. These referral mechanisms will include linkage to the County mental health Department of Children and Family Services as a primary provider and private or non-profit mental health service providers, or MHSAs programs established under the CSS program.

This PEI Project will include specific and formal referral linkages to mental health and non-mental health agencies. All these agencies have been involved in the PEI community planning process as key community stakeholders, and currently participate in the strengthening network of care. The TDM program has sufficient activities to achieve the program/system outcomes we have listed in question 7. Our collaborative activities (outlined in question 6 below) identify the partner and leveraged resources that will assure program fidelity and that the program will achieve our objectives. These leveraged and collaborative resources include the following:

- Medi-Cal revenue funds
- Assigned staff

- Added services to program participants
- Specific contributions, such as transportation, food, clothes
- Facilitated referrals and linkage

Being that the mental health component of the TDM is provided in-house by the County assure that the program is accessible to children and their families, with service provided by the County and community organization that have strong credibility in our service area. Furthermore, should ongoing treatment services be required appropriate linkage and referrals will be provided utilizing the County resources as the primary and community and faith based organizations as a secondary.

6. Collaboration and System Enhancements

This project will supplement and enhances the Fresno County's Annie E. Casey Team Decision Making program, which incorporates the addition of a mental health component that provides for; case management, pre-screening, mental health assessment, linkage/referral to appropriate treatment for ongoing support services, advocacy, education and training, and consultation services. In addition, TDM participants receive training on mental health issues relative to children/family, such as trauma associated with placement moves for children in the child welfare system.

The existing program is operated by the County's Department of Children and Family Services, Child Protective Services in conjunction with the County's mental health, probation, schools, family, caregivers, and community and faith based organizations. Our project includes specific and formal collaboration with community-based mental health clinics and services, to assure that services are available to high priority populations, and that referrals for follow-up mental health treatment and services are timely and appropriate

Monitoring of outcomes will be done in a community process that includes the MHSA Steering Committee. This process will allow us to consider future extension of this project or other programs to achieve desirable individual, system and community outcomes.

We anticipate that this program will be an ongoing PEI project, depending on community review at periodic intervals, and assessment of the extent to which this project meets the identified individual, system and community outcomes. The County will continue to create new revenue sources and leverage funds through collaborative partnerships.

7. Intended Outcomes

Individual	Family	System/Organization
<p>Children</p> <ul style="list-style-type: none"> • Age-appropriate development • School Success • Decrease in contact with Juvenile Justice • Develop appropriate coping skills • Mental health issues are addressed and linked to appropriate community resources 	<ul style="list-style-type: none"> • A higher level of understanding and performance in what is perceived as functional behavior in a family • Decrease in abuse, neglect and domestic violence • Consistent, reliable behavior by parents • The consumer’s realization that the family can be supportive • Child placed in safe home setting 	<ul style="list-style-type: none"> • Children grow up resilient and productive • Children avoid long term impacts of mental health

8. Coordination with Other MHSA Components

The MHSA CSS update to the State included many services available to children, where more extensive services are needed. The CSS updates also included a Full Service Partnership team that can collaborate with certain aspects of this project, including referrals for children involved in the juvenile justice system. At this time, no Capital Facilities and Technology funds have been identified for this project. Workforce Education and Training funds will be utilized for staff and community training for skills and techniques necessary to support the TDM program.

9. Additional Comments: N/A

County: Fresno **PEI Project Name:** 12c. Outreach and Engagement

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

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

2. PEI Priority Population(s) Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Children and Youth in Stressed Families	<input 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 type="checkbox"/>	<input type="checkbox"/>		
6. Underserved Cultural Populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The County's approved Community Services and Supports (CSS) plan included activities that meet the criteria for Prevention and Early Intervention (PEI) funding. The County has decided to move these CSS activities to the PEI component. These activities previously funded by the CSS meets the PEI criteria as stated in section 4 of this worksheet.

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

The Community Input Phase for Fresno County identified the Outreach and Engagement program as providing prevention and early intervention services. The program provides for improving accessibility and promoting mental health awareness to the unserved and underserved population. Contracted vendor staff provide community outreach including but not limited to education on mental health through community presentations and engaging individuals in a cultural sensitive manner to provide appropriate linkage for additional services. Focus groups throughout the planning process identified the need to reducing disparities in access to mental health services and reducing stigma and discrimination.

2B.1 Data Review and Analysis.

To help inform the identification and selection of Key Community Mental Health Needs and Priority Populations, we conducted a thorough review of the available data sources. The County used MHSA staff to review our CSS needs assessment for information pertinent to Prevention and Early Intervention planning and to identify additional data sources helpful for PEI planning.

The data that was reviewed and analyzed included data from the following sources; CSS materials, MHSA Survey A, MHSA Survey B, PEI Community Focus Groups, PEI Community Stakeholder Input, Kings View, Outreach & Engagement Report.

The County compiled this data along with the involvement of the community stakeholders. Community stakeholders also participated in the methodology utilized to analyze the data to create a final report. The community stakeholders also helped identify additional data sources to help select key mental health needs and priority populations. In the selection process the community stakeholders later helped the County determine which programs would best fit the County's needs.

2B.2 Stakeholder Input

Community stakeholder input was obtained throughout the planning process and used to help identify and select the Key Community Mental Health Needs and Priority Populations that these projects address. In addition, the County reviewed stakeholder input gathered from the CSS planning process to identify input relevant to prevention and early intervention

planning and concluded that the following projects met the criteria for PEI: Blue Sky Wellness Center, Team Decision Making, Outreach and Engagement and Functional Family Therapy.

Community stakeholder input was gathered during our PEI Community Program Planning as discussed in FORM No. 2. Data, community input and additional resource information was gathered from community stakeholder meetings, focus groups, surveys, County departmental meetings and community forums. The County's PEI planning panel consisted of a diverse panel and key PEI stakeholder as discussed in FORM No. 2.

The input from this planning process was analyzed and synthesized and used to identify and select the Key Community Mental Health Needs and Priority Populations that ***Project 14 – Outreach and Engagement*** addresses.

2B.3 Project identification

As a result of input and analysis, the County along with the community stakeholders selected to transfer the **Outreach and Engagement** program from the CSS plan to PEI. The Outreach and Engagement program addresses the key community mental health needs, priority population and age groups required by PEI.

The Outreach and Engagement program addresses the key community mental health needs which identify *Disparities in Access to Mental Health Services* and *Stigma and Discrimination*.

The priority population addressed by the Outreach and Engagement are; *Trauma Exposed individuals, Children and Youth in Stressed Families, Children and Youth at Risk of school failure, and Underserved Cultural Populations*.

3. PEI Project Description: Team Decision Making

a. Description of proposed PEI Intervention.

The Outreach and Engagement (O&E) program promotes awareness of youth mental illness and increases access to behavioral health services for unserved and underserved children and youth and their families throughout the County of Fresno. Outreach and engagement is accomplished in a variety of ways via media, public presentations, community involvement and personal contact. In addition, the program strives to decrease the stigma and discrimination of mental illness through the use of effective marketing and personal contacts to all major ethnic cultures in the County. Program success is measured on how effective the program is linking children and youth and their families to existing services and engaging families of all cultures and ethnic diversity for referrals to ongoing treatment services. Outreach and engagement does not provide treatment services but rather links those consumers requiring additional mental health

services to the appropriate organization(s) that best meet the need of the individual. In addition, O&E provides for education and public awareness to educate the public on early signs of mental illness and the negative long-term effects it can have if it goes untreated.

The O&E program shall be a partnership between contracted service provider and the County's Department of Children and Family Services (DCFS). The goals of the O&E program are to reach/engage unserved targeted populations to reduce ethnic disparities. As a result of the O&E services, as well as linkage services, participants should experience reductions in homelessness, hospitalizations, incarcerations, out of home placements, emergency room visits, and stigma associated with mental health. Community collaboration and cultural competency shall also be promoted throughout the O&E program. The service provides and promotes accessibility to mental health services, appropriate linkage, and timely services.

An outreach and engagement service is the new front door to accessing and exploring alternatives to mental health. Without a healthy and vibrant outreach effort, the intended mission of MHSA falls short of engaging the unserved/underserved populations that MHSA was created to reach.

The target population is children/youth 0 to 18 years of age and their families who are at risk of or facing mental illness. Priority populations have been identified through outreach and engagement services provided in both metropolitan and rural settings. O&E staff will present and engage consumers in such places as homeless encampments in downtown Fresno and other public venues in rural areas. The goal of the program is to reduce ethnic disparities, stigma and linking consumers to County and/or private service providers.

O&E staff will provide education to families, County mental health and non-mental health agencies, and community and faith based organizations. Outreach and engagement services are defined as those activities aimed at increasing access to services for unserved/underserved populations through the following approaches:

1. Outreach to families, employers, primary care providers and others on how to recognize the early signs of potentially severe and disabling mental illness.
2. Linking potential clients to medically necessary care provided by COUNTY mental health and private providers to access services for children and youth.
3. Work towards reducing stigma associated with either being diagnosed with mental illness or seeking mental health services.
4. Reduce discrimination against people with mental illness.

The Outreach portion of the above definition refers to the initial connection with a potential consumer. Whether through a one to one contact, through a presentation or a flyer, the consumer is made aware of the availability of mental health services for the youth and their family. Unfortunately this initial exposure to the local range of services is not always enough for the family to actually pursue services.

Engagement is about establishing a trusting relationship between the worker and the potential consumer as the primary vehicle for assisting clients towards actually beginning services. Engagement is the more intensive of the two, as it requires significant patience and skills on the part of the worker to do “whatever it takes” to move the client towards eventual treatment, should that be something the consumer wants. That process of linking can take many forms and a lot more time than one “thinks it should”. It requires workers to drop all expectations of when potential consumers will actually seek treatment and focuses more on how and what it will take for it to occur, based on the timing and needs of the individual. For this reason engagement is always about the quality of the relationship between the parent partners and the potential consumer for it to be the most useful for the youth and their family.

To meet the needs of the unserved/underserved, the MHSA also suggests emphasizing strategies that help reduce the effects of untreated mental illness, namely suicide, incarcerations, school failure and drop out, unemployment, prolonged suffering, homelessness, and removal of children from their homes.

The O&E program approach will be designed and operated to fulfill all 5 of the fundamental concepts inherent in MHSA. All O&E services will encourage **community collaboration** with individuals, families, local organizations, agencies, businesses and stakeholders and will be aimed at creating a shared plan for exercising the most effective method to reach the underserved. O&E services will be delivered in a **culturally sensitive and culturally competent manner**, respecting language and the diversity of each major ethnic group in the community, as well as the differences associated with gender among youth and their families. O&E services will be **client/family focused and driven**. Youth and their families are the best predictors of what O&E services will reach others. Their experience is valuable to gauge what has been successful and which activities and processes have frustrated them the most in their attempts to access services.

The underlying philosophy for O&E activities will be based upon the **principles of wellness, recovery and resiliency**. This focus encourages hope, accepts the individual where they are in their recovery process without criticism or judgment, and manages symptoms and illness within the abilities of the client. Youth, in particular, thrive under the resiliency model where they are taught problem solving skills, are mentored with positive role models, and optimism and hope are provided by caring individuals in their lives.

Lastly, O&E activities contribute to primarily to an **integrated service function** where the mental health system becomes seamless to the individual and their families in accessing and receiving services. O&E activities through this integration approach will help inform youth and their families to the full range of integrated services in the COUNTY and the most efficacious way to access them. Significant here is the ability of the outreach worker to engage the participant in that safe and trusting relationship so that the participant can move easily and seamlessly through the system towards the services most appropriate to meet their needs.

Contracted provider will staff one program administrator/manager, two family involvement coordinators, and six parent partners for a total of nine staff for services. The provider will continue to strive for staffing pattern reflective of the target population it serves and will be culturally sensitive to its environment. Staff will receive training and technical support in cultural competency and subcontract for interpreting services when needed.

The O&E program administrator shall provide team leadership and oversight of the projects goals, administrative functions, and required and desired outcomes. The administrator will network and collaborate with community and faith based organizations, schools, primary care professionals, County mental health department, and consumers and their families.

Family involvement coordinators (one will be a consumer/family member), will oversee and supervise all outreach and engagement activities. One of the Coordinators will be assigned to supervise 3 of the urban Parent Partners while the other will supervise 3 of the rural Parent Partners. Both Coordinators will provide direction and input to the Parent Partners regarding O&E approaches, appropriate linkages and interface with the County. Each Family Involvement Coordinator will create and operate an active peer to peer outreach program at appropriate settings and centers in their assigned urban or rural areas.

The parent partner staff will conduct presentations, develop print, TV/radio material, and advocate for the County's MHSA programs and how to navigate through the County's mental health system and other available resources in their communities. Through the marketing presentations, the Parent Partners will ultimately generate referrals and linkages necessary for unserved/underserved youth and their families to eventually engage in treatment through available community resources. Parent partners will be the staff that works behind the scenes to "convince" families that this program is different and worth engaging in. They will be knowledgeable of all available County services and will develop peer support groups to aid prospective consumers in seeking needed treatment.

Parent Partners will develop that trusting relationship with the potential consumer based on their own experience with the mental health system. They know personally the value of that one to one relationship in moving a client towards actually seeking services.

All of the Parent Partners hired will be consumers and/or family members of consumers and reflect ethnic and cultural community to be served. The existing contract provider has selected parent partner advocates from families who have attained success through the County's mental health system or who have been successful in obtaining services for themselves and their children. Three (3) of the Parent Partners will be assigned to work in the urban settings of Fresno metropolitan area and three (3) will be responsible for canvassing the rural communities of Laton, Riverdale, Mendota, Orange Cove, Selma, Five Points, Huron etc.

Total funding requirements for the existing O&E program provides for the contracted provider services. Program expenditures include support for food, clothing, and hygiene, personnel expenditures, and operating expenditures such as translation and interpreting services, travel and transportation, other general expenses. See FORM 4 for further detail program and budget narrative.

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

Although the O&E was operated under the MHSA General System Development, Community Services and Supports (CSS), this project was identified as a prevention and early intervention project meeting the key community mental health needs, priority population, and desired outcomes by the PEI planning panel, which included community stakeholder participation.

The County selected this project based on the existing services provided by the O&E program. The County's planning panel analyzed the existing demographics and service data received to date from existing program. Through the County's planning process the PEI planning panel was able to determine the community needs and priority populations identified by our stakeholders and key community partners. The County reviewed the existing O&E program to identify practices that would work with our community and that would achieve the desired outcomes for the PEI component. In summary, our selection was based on stakeholder input, data analysis, and program outcome information.

O&E staff will provide education to families, County mental health and non-mental health agencies, and community and faith based organizations. Outreach and engagement services are defined as those activities aimed at increasing access to services for unserved/underserved populations through the following approaches:

1. Outreach to families, employers, primary care providers and others on how to recognize the early signs of potentially severe and disabling mental illness.
2. Linking potential clients to medically necessary care provided by County mental health and private providers to access services for children and youth.

3. Work towards reducing stigma associated with either being diagnosed with mental illness or seeking mental health services.
4. Reduce discrimination against people with mental illness.

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

The County currently contracts outreach and engagement services. Although the O&E is operated out of its main office located in the metropolitan area of Fresno, over 80% of its outreach and engagement takes place out in the field in non-traditional settings in both rural and urban areas throughout the County. Two teams will split into rural and urban areas of the county focusing on cultural and ethnic activities to provide the greatest outreach and engagement opportunities reaching out to youth and their families.

For example, the contracted provider will coordinate outreach and engagement activities around Cesar Chavez's holiday and local parades, International Labor Day, Cinco de Mayo, Mother's Day, and Mexican Independence Day in September. In addition, the O&E coordinators will also coordinate activities around immigration rights gatherings as they develop.

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

Outreach and engagement services will be provided in both urban and rural areas of Fresno County targeting the Latino, Southeast Asian, African American, Caucasian and Native American populations. Activities will be coordinated with the community being served in a culturally sensitive manner. For example, Native Americans activities may be scheduled during local Powwows, cultural craft and heritage days and special events catering to a particular tribal organization.

e. Highlights of new or expanded programs.

Highlights of the existing program included the expansion of enhanced services through means of increased capacity, staffing and promotion of consumer/family oriented program. Enhancements include:

- Increasing services, as of April 2009 the program has contacted 3,410 people in the community, of which 770 have been assisted in accessing mental health resources and other support services.
- Staffing has increased outreach presentations at schools to provide awareness and provide mental health discussions such as depression, self-mutilation, bipolar disorders, ADHD, eating disorders and suicide.

- Since January 2008 through April 2008 the program has provided 780 presentations to the community.
- The program has increased community collaboration, creating partnerships with 87 community and faith based organizations.
- MHSA funding has provided for transportation to further increase services to the unserved and underserved population in rural areas.

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

The existing O&E program requires the following actions for maintenance of services:

- Continuation in increasing community partnerships and maintaining existing collaboration such as schools and cultural ethnic communities.
- Continuous collaboration with the community to participate in outreach and engagement.
- Continuous staff training and development to recruit and maintain staff.
- Identify consumer and/or family mental illness and provide linkage to services in a cultural sensitive manner.

g. Key milestones and anticipated timeline for each milestone.

The existing O&E program will only require approval from State DMH, services will be continued without a gap in services to children and their families. Once approved by the State, the County will transfer the funding stream from CSS to PEI component and acknowledges the program can not be transferred back.

4. Programs

Program Title:	Proposed number of individuals or families to be served through June 2009 by type:		Number of months in operation through June 2010
	Prevention	Early Intervention	
Outreach and Engagement	Individuals: 468 Families: 232	Individuals: 0 Families: 0	12
Total PEI project estimated <i>unduplicated</i> count of individuals to be served	Individuals: 468 Families: 232	Individuals: 0 Families: 0	12

The County has identified the Outreach and Engagement program as prevention and early intervention program and desires to transfer this program from the current CSS component to the new PEI component. There will be no gap in continued services to consumers and their families. Funding will be financed through MHSA PEI component making available the same dollar amounts in the existing CSS component for expansion of existing programs and/or creation of new programs.

The County’s approved CSS plan included activities that meet the criteria for PEI funding. The County requests the approval from the State to move the Outreach and Engagement (O&E) program activities to the PEI component. The O&E program activities previously funded by CSS meets PEI criteria in the following ways:

1. It targets individuals and families whose risk factors of developing mental illness are significantly higher than average.
2. The goal of the O&E is to reduce risk factors or stressors for children and their families and building protective factors and skills and increasing community support to provide stabilization.
3. Provides Education and Mental Health awareness to unserved and underserved population.
4. Provides linkage to children and families with mental illness in its early manifestation.
5. The O&E program is designed and incorporates community collaboration with other system and organizations for the well-being of children and their families.
6. Services requiring ongoing mental health treatment will be referred to County and/or community resources.
7. Provides engagement of the family and support to the family in its role in the individual’s wellness.

8. Services delivered in a non-traditional settings to provide services to target populations

The O&E program is serving individuals prior to the development of a serious emotional disturbance. The County will provide oversight and ensure that this service will only be provided to individuals prior to the development of a serious emotional disturbance and refer individuals who need mental health treatment to County mental health programs and/or community/faith based organization for further treatment.

We have completed and are submitting a Plan Amendment for the removal of this specific CSS activity from our CSS Program and Expenditure Plan. The transfer of the funding source from CSS to PEI will be effective at the start of the fiscal year following approval of this PEI project.

Since this activity is focused on providing outreach and engaging individuals prior to the development of a mental illness or very early after its manifestation, it should be funded by PEI rather than CSS. The program will continue to focus on the Priority Population(s) and Key Community Mental Health Need(s) identified in our PEI planning process, and will serve individuals with Prevention and Early Intervention services. This service is different from our approved CSS program, in that it does not provide for treatment services but rather linkage to other services. One hundred percent (100%) of the O&E program will be transferred over to the PEI component and provide for only selective prevention and early intervention services.

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

This PEI Project was designed in an inclusive planning process that included county and private providers of health, primary care, and mental health services. We believe that these community partner agencies, including health and primary care providers, are key partners in the strengthened network of care. These referral mechanisms will include linkage to the County Mental Health, Department of Children and Family Services as a primary provider and private or non-profit mental health service providers, or MHSA programs established under the CSS program.

This PEI Project will include specific and formal referral linkages services, all of which include agencies that have been involved in the PEI community planning process as key community stakeholders, and currently participate in the strengthening of the network of care. The O&E program has sufficient activities to achieve the program/system outcomes we have listed in question 7. Our collaborative activities (outlined in question 6 below) identify the partner and leveraged resources that will assure program objectives.

6. Collaboration and System Enhancements

This project will supplement and enhance Fresno County’s outreach and engagement providing education, awareness and linkage to the unserved and underserved population. The community will be made aware of resources available and will receive educational information about mental health.

Monitoring of outcomes will be done by the contract provider with analysis followed up by the County, on a monthly basis. This process allows the County to consider program modifications and/or seek out new ways in engaging the target population. We anticipate that this program will be an ongoing PEI project, depending on community review at periodic intervals, and assessment of the extent to which this project meets the identified individual, system and community outcomes. The County will continue to create new revenue sources and leverage funds through collaborative partnerships.

7. Intended Outcomes

Individual	Family	System/Organization
<ul style="list-style-type: none"> • Awareness of services available in the community • Peer support services • Education about mental illness • Support services throughout mental health and related fields (public health, schools, etc...) 	<ul style="list-style-type: none"> • Awareness of mental health program and services available in the community • Linkage in the community setting • Reducing stigma and discrimination in obtaining mental health services 	<ul style="list-style-type: none"> • Children avoid long term impacts of mental health • Children grow up resilient and productive • Linkage to appropriate services in the community • Understanding/education of mental health • Reduce cost resulting from system • Accessing cultural appropriate services

8. Coordination with Other MHSA Components

The MHSA CSS update to the State included many services available to children, where more extensive services are needed. The CSS updates also included a Full Service Partnership team that can collaborate with certain aspects of this project, including referrals for children and families requiring mental health and comprehensive services. At this time, no

County: Fresno

Form No. 3

Date: 7/7/09

Capital Facilities and Technology funds have been identified for this project. Workforce Education and Training funds will be utilized for staff and community training for skills and techniques necessary to support the O&E program.

9. Additional Comments: N/A

County: Fresno **PEI Project Name:** 12d. Functional Family Therapy

Date: 4/14/09

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

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

2. PEI Priority Population(s) Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Children and Youth in Stressed Families	<input 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 type="checkbox"/>	<input type="checkbox"/>

The County's approved Community Services and Supports (CSS) plan included activities that meet the criteria for Prevention and Early Intervention (PEI) funding. The County has decided to move these CSS activities to the PEI component. These activities previously funded by the CSS meets the PEI criteria as stated in section 4 of this worksheet.

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

The Community Input Phase for Fresno County identified the Functional Family Therapy program as providing prevention and early intervention services. The program provides for intensive mental health intervention and community supports to the unserved and underserved population. Contracted provider staff provides intervention services for a minimum of 15 weeks employing the three phases of intervention; Engagement and motivation, Behavioral change, and Generalization (linkage for additional services appropriate to consumer and family). Focus groups throughout the planning process identified at risk children, youth and young population who are at risk of or involved in the juvenile justice system as a priority population.

2B.1 Data Review and Analysis.

To help form the identification and selection of Key Community Mental Health Needs and Priority Populations, the County, conducted a thorough review of the available data sources. The County used MHSA staff to review our CSS needs assessment for information pertinent to Prevention and Early Intervention planning and to identify additional data sources helpful for PEI planning.

The data that was reviewed and analyzed included data from the following sources; CSS materials, MHSA Survey A, MHSA Survey B, PEI Community Focus Groups, PEI Community Stakeholder Input, Kings View Corporation, Outreach & Engagement Report.

The County compiled this data along with the involvement of the community stakeholders. Community stakeholders also participated in the methodology utilized to analyze the data to create a final report. The community stakeholders also helped identify additional data sources to help identify additional key mental health needs and priority populations. In a selection process the community stakeholders later helped the County determine which programs would best fit the County's needs.

2B.2 Stakeholder Input

Community stakeholder input was obtained throughout the planning process and used to help identify and select the Key Community Mental Health Needs and Priority Populations that these projects address. In addition, the County reviewed MHSA/Prevention and Early Three-Year Plan Draft for Public Review and Comment

stakeholder input gathered from the CSS planning process to identify input relevant to prevention and early intervention planning and concluded that the following projects met the criteria for PEI: Blue Sky Wellness Center, Team Decision Making, Outreach and Engagement and Functional Family Therapy.

Community stakeholder input was gathered during our PEI Community Program Planning as discussed in FORM No. 2. Data, community input and additional resource information was gathered from community stakeholder meetings, focus groups, surveys, County departmental meetings and community forums. The County's PEI planning panel consisted of a diverse panel and key PEI stakeholder as discussed in FORM No. 2.

The input from this planning process was analyzed and synthesized and used to identify and select the Key Community Health Needs and Priority Populations that ***Project 8d – Functional Family Therapy*** addresses.

2B.3 Project identification

As a result of input and analysis, the County along with the community stakeholders selected to transfer the **Functional Family Therapy** (FFT) program from the CSS plan to PEI. The FFT program addresses the key community mental health needs, priority population and age groups required by PEI.

The FFT program addresses the key community mental health needs which identify *At Risk Children Youth and Young Adult Population*, while also addressing the priority population which include; *Children and Youth in Stressed Families, Children and Youth at Risk for School Failure, Children and Youth at Risk of or Experiencing Juvenile Justice involvement and Underserved Cultural Populations*.

3. PEI Project Description: *Team Decision Making*

a. Description of proposed PEI Intervention.

During the PEI planning process the County identified the FFT program (currently operating under the Community Services and Supports component of the MHSA plan), as an early intervention program for its services provided under contract. The County's planning panel recommended the transfer of the FFT program, during its PEI planning process. The PEI panel selected the FFT program based on program services and input received from community stakeholders who were educated about the program at focus groups and public meetings.

The FFT program is a service category within the Mental Health Services Act's (MHSA) Community Services and Supports component under which the COUNTY funds, through a contracted community service provider. The program

provides for functional family therapy and community support services to 120 unserved and underserved high-risk youth and their families with serious emotional disturbances who are involved with the juvenile justice system. Community supports are delivered in the form of clothing, food, hygiene, transportation, employment, and education supports to clients being served by the program.

The FFT program shall be a partnership between contracted service provider and the County's Department of Children and Family Services (DCFS). The goals of the FFT program include both short term and long term. Short-term goals include; clients gaining skills to reduce family conflict and the ability to identify familial strengths; clients will gain self confidence, increased ability to handle anger and manage difficult situations, and experience improved individual and family functioning. Long-term goals include parents and children identifying and building upon individual and family strengths and assets to help them develop new skills to enhance family resiliency. As a result of the FFT program services, as well as linkage services, participants should experience a reduction in long term affects due to mental illness.

The target population is children/youth 11 to 18 years of age and their families who are at risk of mental illness. Priority populations will be identified through outreach and engagement services provided in both metropolitan and rural settings. Up to 210 clients will be served during the year. The program will target unserved and underserved population such as Hispanic, African American, Southeast Asian children and youth that exhibit maladaptive, acting out behaviors, have a high risk of or present with delinquency, violence, and substance use/abuse. Service setting will primarily take place in the clients home but will also be provided at school sites and/or other community based organizations. FFT program will provide for reducing risk factors and building protective factors and skills and increasing support to the client and family.

The FFT program will increase its network resources through community collaboration and work with the County's Department of Children and Family Services. Referrals will be received from DCFS Juvenile mental health court, Juvenile justice campus, Fresno County Office of Education, Fresno County, Behavioral Health Department, and other community associated agencies.

Contracted provider will staff one (1) program manager, six (6) community mental health specialist, two (2) parent partners/care managers to operate the program (additional MHSA funding is provided for five (5) partial administrative support). Staffing will provide for a culturally sensitive environment and will receive appropriate training throughout the year for staff development in relation the program goals and objectives.

The program manager will be a licensed clinician and will be the team leader with strong skills working with children and families. In addition, the team leader will oversee the program administrative function and assist with networking and community collaboration.

The community mental health specialist role is to provide FFT intervention services through its 15-week process. Parent partners and care managers will assist in service coordination and ensuring that families receive peer support, education, advocacy services most appropriate for the families needs. Parent partners will work closely with professional staff and families to assist in planning and provision of treatment to youth and families. All parent partners' positions will be occupied by client/family members.

Total funding requirements for the existing FFT program for FY 2008-09 is \$544,581, which provides funding for the contracted provider services. Program expenditures include support for food, clothing, and hygiene, personnel expenditures, and operating expenditures such as translation and interpreting services, travel and transportation, other general expenses. See FORM 4 for further program budget narrative.

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

Although the FFT is operated under the MHSA General System Development, Community Services and Supports (CSS), this project was identified as a prevention and early intervention project meeting the key community mental health needs, priority population, and desired outcomes by the PEI planning panel, which included community stakeholder participation.

The County selected this project based on the existing services provided by the FFT program. The County's planning panel analyzed the existing demographics and service data received to date from existing program. Through the County's planning process the PEI planning panel was able to determine the community needs and priority populations identified by our stakeholders and key community partners. The County reviewed the existing FFT program to identify practices that would work with our community and that would achieve the desired outcomes for the PEI component. In summary, our selection was based on stakeholder input, data analysis, and program outcome information.

The FFT program staff will provide education to families, County mental health and non-mental health agencies, and community and faith based organizations about the programs role. FFT services are designed to increase access to services for unserved and underserved populations through the following approaches:

1. Engaging families, community organizations and schools as to how to recognize the early signs of potentially severe and disabling mental illness.
2. Linking potential clients to medically necessary care provided by COUNTY mental health and private providers to access services for children and youth.
3. Work towards reducing stigma associated with either being diagnosed with mental illness or requiring ongoing

mental health services.

4. Reduce discrimination against people with mental illness.

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

The County currently contracts FFT and its community support services. Although the FFT is operated out of its main office a majority of its services are provided in the home in non-traditional settings in both rural and urban areas throughout the County. The program operates outside of the unusual 8 to 5 Monday – Friday schedule and has operating hours convenient to meet the family needs. Clients are not incarcerated at the time of service delivery.

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

Functional Family Therapy and community supports services will be provided in both urban and rural areas of Fresno County targeting the Hispanic/Latino, Southeast Asian, and African American populations who are disproportionately of color, more likely to re-offend and less likely to succeed in family, school or community because of their emotional and behavior problems. Often these families tend to have limited resources, histories of failure, a range of diagnosis and exposure to multiple systems. In addition, the majority of participating youth have co-occurring serious emotional disturbances and substance abuse disorders.

e. Highlights of new or expanded programs.

Highlights of the existing program included:

- Served 320 adolescents and family members since inception of the program,
- Established and provides in home and community based services to families in Clovis, Coalinga, Del Rey, Firebaugh, Fowler, Fresno, Huron, Kerman, Orange Cove, Parlier, Reedley, Sanger and other surrounding communities.
- Approximately 50% of services are provided in the rural communities
- The FFT program provides for a culturally sensitive environment and strives for a staffing pattern to reflect target population.

- Provides for interpreting services when needed.

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

The existing FFT program requires the following actions for maintenance of services:

- Provide continuous information on child abuse prevention, parenting, and other family and child focused topics in educational presentations by care managers and parent partners.
- Provide intensive functional family therapy intervention.
- Provide individualized services for client and family such as education, school and other resources to support the client and their families throughout this process.
- Services provided at a convenience to the family.
- Continuous staff educational training regarding Capacity training, Evidence Based Training, Advocacy, and Cultural Competency.

g. Key milestones and anticipated timeline for each milestone.

The existing FFT program will only require approval from State DMH, services will be continued without a gap in services to children and their families. Once approved by the State, the County will transfer the funding stream from CSS to PEI component and acknowledges the program can not be transferred back.

4. Programs

Program Title:	Proposed number of individuals or families to be served through June 2009 by type:		Number of months in operation through June 2010
	Prevention	Early Intervention	
Functional Family Therapy	Individuals: 0 Families: 0	Individuals: 210 Families: 210	12
Total PEI project estimated <i>unduplicated</i> count of individuals to be served	Individuals: 0 Families: 0	Individuals: 210 Families: 210	12

The County has identified the FFT program as prevention and early intervention program and desires to transfer this program from the current CSS component to the new PEI component. There will be no gap in continued services to consumers and their families. Funding costs in the amount of \$544,581 will be financed through MHSA PEI component making available the same dollar amounts in the existing CSS component for expansion of existing programs and/or creation of new programs.

The County’s approved CSS plan included activities that meet the criteria for PEI funding. The County requests the approval from the State to move the FFT program activities to the PEI component. The FFT program activities previously funded by CSS meets PEI criteria in the following ways:

1. It targets individuals and families whose risk factors of developing mental illness is significantly higher than average.
2. The goal of the FFT is to reduce risk factors or stressors for children and their families and building protective factors and skills and increasing community support to provide stabilization.
3. Provides linkage to children and families with mental illness and/or serious emotional disturbances in its early manifestation.
4. The FFT program is designed and incorporates community collaboration with other system and organizations for the well-being of children and their families.
5. Services requiring ongoing mental health treatment will be referred to County and/or community resources.
6. Provides engagement of the family and support to the family in its role in the individual’s wellness.

7. Services delivered in a non-traditional settings to provide services to target populations

The FFT program is serving individuals prior to the development of a serious emotional disturbance. The County will provide oversight and ensure that this service will only be provided to individuals prior to the development of a serious emotional disturbance and refer individuals who need mental health treatment to County mental health programs and/or community/faith based organization for further treatment.

We have completed and are submitting a Plan Amendment for the removal of this specific CSS activity from our CSS Program and Expenditure Plan. The transfer of the funding source from CSS to PEI will be effective at the start of the fiscal year following approval of this PEI project.

Since this activity is focused on providing functional family therapy and community supports prior to the development of a severe mental illness or very early after its manifestation, it should be funded by PEI rather than CSS. The program will continue to focus on the Priority Population(s) and Key Community Mental Health Need(s) identified in our PEI planning process, and will serve individuals with Early Intervention services. This service is different from our approved CSS program, in that it does not provide for treatment services but rather intervention and linkage to other services. One hundred percent (100%) of the FFT program will be transferred over to the PEI component and provide for only early intervention services.

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

This PEI Project was designed in an inclusive planning process that included county and private providers of health, primary care, and mental health services. We believe that these community partner agencies, including health and primary care providers, are key partners in the strengthened network of care. These referral mechanisms will include linkage to the County Mental Health, Department of Children and Family Services as a primary provider and private or non-profit mental health service providers, or MHSA programs established under the CSS program.

This PEI Project will include specific and formal referral linkages services, all of which include agencies that have been involved in the PEI community planning process as key community stakeholders, and currently participate in the strengthening of the network of care. The FFT program has sufficient activities to achieve the program/system outcomes we have listed in question 7. Our collaborative activities (outlined in question 6 below) identify the partner and leveraged resources that will assure program objectives.

6. Collaboration and System Enhancements

This project will supplement and enhance the Fresno County’s mental health system providing education, awareness, intensive intervention and linkage to the unserved and underserved population. The community will be made aware of resources available to them and educating the public about mental health.

Monitoring of outcomes will be done by the contract provider with analysis followed up by the County, on a monthly basis. This process allows the County to consider program modifications and/or seek out new ways in engaging the target population. We anticipate that this program will be an ongoing PEI project, depending on community review at periodic intervals, and assessment of the extent to which this project meets the identified individual, system and community outcomes. The County will continue to create new revenue sources and leverage funds through collaborative partnerships.

7. Intended Outcomes

Individual	Family	System/Organization
<ul style="list-style-type: none"> • Early intervention services leading to less likelihood of severe mental health illness • Coping, anger management and social skills development • Learning to deal with stressful conditions • Increasing likelihood of doing better at school and attendance/grades • Awareness of services available in the community • Peer support services • Education about mental illness • Support services throughout mental health and related fields (public health, schools, etc...) 	<ul style="list-style-type: none"> • Strengthening family coping skills • Learning to function effectively through stressful family conditions • Reducing mental health problems in a family oriented setting • Awareness of mental health program and services available in the community • Linkage in the community setting • Reducing stigma and discrimination in obtaining mental health services 	<ul style="list-style-type: none"> • Reducing recidivism rates for juvenile justice system involvement • Higher performance at schools • Families staying together and reducing impacts of mental health on society • Children avoid long term impacts of mental health • Children grow up resilient and productive • Linkage to appropriate services in the community • Understanding/education of mental health • Reduce system wide cost resulting from reduction in juvenile system involvement

		<ul style="list-style-type: none">• Accessing cultural appropriate services
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8. Coordination with Other MHSAs Components

The MHSAs CSS update to the State included many services available to children, where more extensive services are needed. The CSS updates also included a Full Service Partnership team that can collaborate with certain aspects of this project, including referrals for children and families requiring mental health and comprehensive services. At this time, no Capital Facilities and Technology funds have been identified for this project. Workforce Education and Training funds will be utilized for staff and community training for skills and techniques necessary to support the FFT program.

9. Additional Comments: N/A

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

County Name: **Fresno**

Date: 4/27/09

PEI Project Name: **Integration of Mental Health PEI & Primary Care**

Provider Name (if known):

Intended Provider Category:

Proposed Total Number of Individuals to be served: FY 08-09 0 FY 09-10 1040

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

Total No. of Individuals to be served through PEI Expansion: FY 08-09 0 FY 09-10 1040

Months of Operation: FY 08-09 0 FY 09-10 9

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			
Licensed Clinician 10 x 0.5 FTE	\$0	\$259,688	\$259,688
Peer Support Specialist 10 x 1 FTE	\$0	\$183,690	\$183,690
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$443,378	\$443,378
b. Benefits and Taxes @ 27%	\$0	\$119,712	\$119,712
c. Total Personnel Expenditures	\$0	\$563,089	\$563,089
2. Operating Expenditures			
a. Facility Cost (rent, communications, equipment)	\$0	\$44,411	\$44,411
b. Other Operating Expenses	\$0	\$82,353	\$82,353
c. Total Operating Expenses	\$0	\$126,764	\$126,764
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$0
4. Total Proposed PEI Project Budget	\$0	\$689,853	\$689,853
B. Revenues (list/itemize by fund source)			
a. Medi-Cal (FFP only)		108,881	108,881
b. MAA		1,361	1,361
1. Total Revenue	\$0	\$110,242	\$110,242
5. Total Funding Requested for PEI Project	\$0	\$579,611	\$579,611
6. Total In-Kind Contributions	\$0	\$0	\$0

Project 1: Integration of Mental Health Prevention and Early Intervention and Primary Care at Federally Funded Clinics**A. Expenditures: \$689,854**

1. Personnel: Total personnel costs amount to **\$563,089**. This amount is the sum of salaries, benefits and taxes for 5.0 FTE Licensed Mental Health Clinicians, 10.0 FTE Peer Support Specialists, and benefits and taxes calculated at a rate of 27%, based on the likelihood that this project will be contracted to appropriate vendor(s).
2. Operating Costs: Total operating costs are estimated at **\$126,765**. This cost includes facility costs that include expenses for clinicians and peer support specialists at participating community clinics which include rent, utilities, security, janitorial services. In addition, facility costs include equipment such as Personal Computers which include lease and network connections at \$8,117 and laser printers at \$1,140 per month. Cost for network storage/IT support is \$7,977 and copy machine maintenance is \$296 per year. Phone costs for staff is \$43/month/desk phone and include cell phones has been budgeted at \$4,531 per year. Other operating costs include cost for training primary care clinical and administrative staff on issues of mental health to include signs and symptoms, stigmas, and HIPAA concerns. The Clinicians will be traveling between clinics and will incur costs associated with use of a County car. Program will also provide for vehicle maintenance, general office expenses and non-recurring expenses in the amount of \$27,539.

B. Revenues: \$110,242

1. Revenues for this program are estimated at \$110,242. Revenue funding consists of Medi-Cal FFP reimbursement (\$108,881), Medicare/Patient Fees/Patient Insurance (\$1361).

C. Total 9 month funding requested for Project 1: \$579,612

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

County Name: **Fresno**

Date: 4/27/09

PEI Project Name: Culture-based Access/Navigation Specialist & Peer Support

Provider Name (if known):

Intended Provider Category: Ethnic/Cultural Organization

Proposed Total Number of Individuals to be served: FY 08-09 0 FY 09-10 3600

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

Expansion: FY 08-09 0 FY 09-10 3600

Months of Operation: FY 08-09 0 FY 09-10 9

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			
Peer Support Specialist 9 x 1 FTE	\$0	\$165,321	\$165,321
Community Health Workers 4 x 1 FTE	\$0	\$73,476	\$73,476
	\$0	\$238,797	\$238,797
b. Benefits and Taxes @ 27%	\$0	\$64,475	\$64,475
c. Total Personnel Expenditures	\$0	\$303,272	\$303,272
2. Operating Expenditures			
a. Facility Cost (rent, communications, equipment)	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$35,453	\$35,453
c. Total Operating Expenses	\$0	\$35,453	\$35,453
3. Subcontracts/Professional Services (list/itemize all subcontract			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$0
4. Total Proposed PEI Project Budget	\$0	\$338,725	\$338,725
B. Revenues (list/itemize by fund source)			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$338,725	\$338,725
6. Total In-Kind Contributions	\$0	\$0	\$0

Project 2: Cultural-based Community Health Worker and Community-based Peer Support

A. Expenditures: **\$338,725**

3. Personnel: Total personnel costs amount to **\$303,272**. This amount is the sum of salaries, benefits and taxes for 9.0 FTE Peer Support Specialists, 4.0 FTE Community Health Workers (CHW) and benefits and taxes calculated at a rate of 27%, based on the likelihood that this project will be contracted to appropriate vendor(s).
4. Operating Costs: Total operating costs are estimated at **\$35,453**. Operating expenses include training the CHWs and Peer Support staff on County mental health resources, expenses associated with outreach and engagement of the CHW, costs for travel and transportation and other supplies. Program will also provide for vehicle maintenance, general office expenses and non-recurring expenses.

B. Revenues: **\$0**

C. Total 9 month funding requested for Project 2: **\$338,728**

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

County Name: **Fresno**

Date: 7/1/09

PEI Project Name: **Perinatal PEI Program for Pregnant/Parenting Women & Infants**

Provider Name (if known): **County of Fresno, Department of Public Health**

Intended Provider Category: **County Agency**

Proposed Total Number of Individuals to be served:	FY 08-09	<u>0</u>	FY 09-10	<u>360</u>
Total Number of Individuals currently being served:	FY 08-09	<u>0</u>	FY 09-10	<u>0</u>
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	<u>0</u>	FY 09-10	<u>360</u>
Months of Operation:	FY 08-09	<u>0</u>	FY 09-10	<u>9</u>

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			
Public Health Nurse - 2.0 FTE	\$0	\$135,912	\$135,912
Mental Health Clinician - 8.0 FTE	\$0	\$418,890	\$418,890
Community MH Specialist - 1.0 FTE	\$0	\$36,329	\$36,329
Clinical Supervisor - 1.0 FTE	\$0	\$64,445	\$64,445
Psychiatrist - .25 FTE	\$0	\$32,438	\$32,438
Subtotal Salaries, Wages	\$0	\$688,014	\$688,014
b. Benefits and Taxes @ 53%	\$0	\$364,970	\$364,970
c. Total Personnel Expenditures	\$0	\$1,052,984	\$1,052,984
2. Operating Expenditures			
a. Facility Cost (rent, communications, equipment)	\$0	\$30,743	\$30,743
b. Other Operating Expenses	\$0	\$88,688	\$88,688
c. Total Operating Expenses	\$0	\$119,431	\$119,431
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
a. Interpreter and Translation Services	\$0	\$7,500	\$7,500
a. Total Subcontracts	\$0	\$7,500	\$7,500
4. Total Proposed PEI Project Budget	\$0	\$1,179,915	\$1,179,915
B. Revenues (list/itemize by fund source)			
a. Medi-Cal (FFP only)	\$0	\$302,136	\$302,136
b. State General Funds (EPSDT)	\$0	\$247,202	\$247,202
c. MAA		\$3,629	\$3,629
1. Total Revenue	\$0	\$552,967	\$552,967
5. Total Funding Requested for PEI Project	\$0	\$626,948	\$626,948
6. Total In-Kind Contributions	\$0	\$0	\$0

Project 3: Perinatal Program for Pregnant/Parenting Women and their Infants**A. Expenditures: \$1,179,915**

5. Personnel: Total personnel costs amount to **\$1,052,984**. This amount is the sum of salaries, benefits and taxes for 2.0 FTE Nurses, 8.0 FTE Mental Health Clinicians, 1.0 FTE Community Mental Health Specialist, 1.0 FTE Clinical Supervisor, .25 FTE Psychiatrist plus benefits and taxes calculated at 53%.
6. Operating Costs: Total operating costs are estimated at **\$119,431**. Operating expenses include facility cost , including, utilities, security, janitorial (\$25,510), Facility cost will also include phone land lines and cell phones (\$3,000), Personal Computers (\$10,080), and Purchase of copy machine (\$2,400). Other operating expenses include cost for mileage reimbursement (\$25,410), education materials (\$5,000), training (\$22,275), supplies (\$10,995), medication costs (\$10,000) and overhead cost for Departments of Behavioral Health and Children & Family Services.
7. Subcontracts: Estimated cost for subcontracted services for translators and interpreters is **\$7,500**. This estimate is based on current contracted provider average cost of \$45/hour. The vendor will attempt to use in-house bilingual staff. If in-house bilingual staff are insufficient to meet service needs, contracted translators/interpreters will be used. In addition, culturally competent services/training of staff will take place.

B. Revenues: \$552,967

1. Revenues for this program are estimated at **\$552,967**. Revenue funding consists of Medi-Cal FFP reimbursement (\$302,135), State General Fund - EPSDT (\$247,202) and Medi-Cal Administrative Activities (\$3,628).

C. Total 9 month funding requested for Project 3: \$626,948

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

County Name: **Fresno**

Date: 7/1/09

PEI Project Name: **School Based PEI for K-8th Grade**

Provider Name (if known): **TBD**

Intended Provider Category: **Community Based Organization, Schools**

Proposed Total Number of Individuals to be served: FY 08-09 0 FY 09-10 3750

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

Total Number of Individuals to be served through PEI Expansion: FY 08-09 0 FY 09-10 3750

Months of Operation: FY 08-09 0 FY 09-10 9

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			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0

Subtotal Salaries, Wages	\$0	\$0	\$0
b. Benefits and Taxes @ 27%	\$0	\$0	\$0
c. Total Personnel Expenditures	\$0	\$0	\$0
2. Operating Expenditures			
a. Facility Cost (rent, communications, equipment)			
_____	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$0	\$0
c. Total Operating Expenses	\$0	\$0	\$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
a. Contracted Services			
_____	\$0	\$338,725	\$338,725
_____			\$0
_____			\$0
a. Total Subcontracts	\$0	\$338,725	\$338,725
4. Total Proposed PEI Project Budget	\$0	\$338,725	\$338,725
B. Revenues (list/itemize by fund source)			

1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$338,725	\$338,725
6. Total In-Kind Contributions	\$0	\$0	\$0

Project 4: School-based Prevention and Early Intervention for K-8th**A. Expenditures: \$338,725**

1. Personnel: There are no expenses in this category. All personnel will be provided under contract with a provider to be determined.
2. Operating Costs: There are no expenses in this category. All operations will be covered under contract with provider to be determined.
3. Subcontracts/Professional Services: The school based program will be contracted with a community based organization or School District(s) to be determined through the County's Request for Proposal process. Costs will vary depending upon selected bidder response to RFP.
 - a. Staffing costs are estimated at **\$157,500** and include salary/wages and benefits for various staff such as; administration, behavioral health staff, consultants, field experts to provide appropriate training to school staff and community (some of these costs may be in-kind).
 - b. Stipends for schools estimated to be **\$19,125**. Stipends may be provided to schools to relieve staff to attend program trainings and meetings related to the program. Stipends may be provided to approximately 20 schools.
 - c. Technical Assistance estimated to be **\$46,740**. Cost of technical assistance will provide for experienced field instructor presentation and trainings to staff. Cost will also include travel expenses for presenters residing in-state, but out of County.
 - d. Materials are estimated to cost **\$115,360**. Cost will be included for materials for approximately 20 schools related to the program. Each school will receive various materials and other training resources, Data Base Applications, Behavior Education Programs, Student incentives and Program Web site costs, etc.

B. Revenues: \$0**C. Total 9 month funding requested for Project 5: \$338,725**

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

County Name: **Fresno**

Date: 4/27/09

PEI Project Name: Horticultural Therapeutic Community Center

Provider Name (if known):

Intended Provider Category:

Proposed Total Number of Individuals to be served: FY 08-09 0 FY 09-10 1,500

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

Ttl No.of Individuals served through PEI Expansion: FY 08-09 0 FY 09-10 1500

Months of Operation: FY 08-09 0 FY 09-10 9

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			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
b. Benefits and Taxes @ 27%	\$0	\$0	\$0
c. Total Personnel Expenditures	\$0	\$0	\$0
2. Operating Expenditures			
a. Facility Cost (rent, communications, equipment)	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$0	\$0
c. Total Operating Expenses	\$0	\$0	\$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Subcontract to Vendor	\$0	\$135,490	\$135,490
_____	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$135,490	\$135,490
4. Total Proposed PEI Project Budget	\$0	\$135,490	\$135,490
B. Revenues (list/itemize by fund source)			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$135,490	\$135,490
6. Total In-Kind Contributions	\$0	\$0	\$0

Project 5: Horticultural Therapeutic Community Centers

A. Expenditures: \$135,490

4. Personnel: There are no expenses in this category. All personnel will be provided under contract with a provider to be determined.
5. Operating Costs: There are no expenses in this category. All operations will be covered under contract with provider to be determined.
6. Subcontracts/Professional Services: The use of funds will provide for contracted vendors to operate community gardens for the specific purpose of serving as neighborhood resource centers for mental health activities, including outreach and engagement, peer support, culturally appropriate mental health education, and to establish the garden site as a horticultural therapeutic community center that will serve underserved ethnic and cultural groups in a de-stigmatizing and culturally appropriate way. This project will serve as a bridge between County mental health and underserved communities for the purpose of reducing barriers in access to mental health services and will work in tandem with Project 2 CHws and Peer Support specialists.

B. Revenues: \$0

C. Total 9 month funding requested for Project 7: \$135,490

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

County Name: **Fresno**

Date: 4/27/09

PEI Project Name: First Onset Consumer and Family Support

Provider Name (if known):

Intended Provider Category:

Proposed Total Number of Individuals to be served: FY 08-09 0 FY 09-10 110

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

Expansion: FY 08-09 0 FY 09-10 110

Months of Operation: FY 08-09 0 FY 09-10 9

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			
Psychiatrist - 1 FTE	\$0	\$120,375	\$120,375
Lic MH Clinician - 5.5 FTE	\$0	\$291,798	\$291,798
CMHS - 3.5 FTE	\$0	\$102,596	\$102,596
Consumer Family Advocate - 2 FTE	\$0	\$90,000	\$90,000
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$604,769	\$604,769
b. Benefits and Taxes @ 55%	\$0	\$332,623	\$332,623
c. Total Personnel Expenditures	\$0	\$937,392	\$937,392
2. Operating Expenditures			
a. Facility Cost (rent, communications, equipment)	\$0	\$60,405	\$60,405
b. Other Operating Expenses	\$0	\$64,061	\$64,061
c. Total Operating Expenses	\$0	\$124,466	\$124,466
3. Subcontracts/Professional Services (list/itemize all subcontract			
	\$0	\$0	\$0
	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$0
4. Total Proposed PEI Project Budget	\$0	\$1,061,858	\$1,061,858
B. Revenues (list/itemize by fund source)			
a. Medi-Cal (FFP only)	\$0	\$93,739	\$93,739
b. MAA	\$0	\$0	\$0
1. Total Revenue	\$0	\$93,739	\$93,739
5. Total Funding Requested for PEI Project	\$0	\$968,119	\$968,119
6. Total In-Kind Contributions	\$0	\$0	\$0

Project 6: First Onset Consumer and Family Support

A. Expenditures: \$1,061,858

8. Personnel: Total personnel costs amount to **\$937,392**. This amount is the sum of salaries, benefits and taxes for 1.0 FTE Psychiatrist, 5.5 FTE Licensed Mental Health Clinician, 3.5 FTE Community Mental Health Specialist, 2.0 FTE Consumer Family Advocate, plus 1 FTE Office Assistant.
9. Operating Costs: Total operating costs are estimated at **\$124,466**. This cost includes facility costs that include expenses for clinicians and all other staff above, which also includes rent, utilities, security, janitorial services. In addition, facility costs include equipment such as Personal Computers which include lease and network connections at \$8,117 and laser printers at \$1,140 per month. Cost for network storage/IT support is \$7,977 and copy machine maintenance is \$296 per year. Phone costs for staff is \$43/month/desk phone and include cell phones has been budgeted at \$4,531 per year. Other operating costs include cost for training primary care clinical and administrative staff on issues of mental health to include signs and symptoms, stigmas, and HIPAA concerns.

B. Revenues: \$93,739

2. Revenues for this program are estimated at **\$93,739**. Revenue funding consists of Medi-Cal FFP reimbursement (\$93,739), Medicare/Patient Fees/Patient Insurance (\$0).

C. Total 9 month funding requested for Project 8: \$968,119

Project 7: Crisis and Acute Care Prevention and Early Intervention

A. Expenditures: **\$337,295**

10. Personnel: Total personnel costs amount to **\$225,764**. This amount is the sum of salaries, benefits and taxes for 2.0 FTE Licensed Mental Health Clinician, 1.0 FTE Peer Support Specialist, plus 1.0 FTE Office Assistant.
11. Operating Costs: Total operating costs are estimated at **\$17,781**. This cost includes facility costs that include expenses for clinicians and all other staff above, which also includes rent, utilities, security, janitorial services. In addition, facility costs include equipment such as Personal Computers which include lease and network connections at \$8,117 and laser printers at \$1,140 per month. Phone costs for staff is \$43/month/desk phone and include cell phones has been budgeted at \$4,531 per year. Other costs include County vehicle use and maintenance.

B. Revenues: **\$22,576**

3. Revenues for this program are estimated at **\$22,576**. Revenue funding consists of Medi-Cal FFP reimbursement (\$22,576), Medicare/Patient Fees/Patient Insurance (\$0).

C. Total 9 month funding requested for Project 7: **\$220,969**

Project 8a: Blue Sky Wellness Center

A. Expenditures: \$1,005,436

7. Personnel: There are no expenses in this category. All personnel will be provided under contract with a provider to be determined.
8. Operating Costs: There are no expenses in this category. All operations will be covered under contract with provider to be determined.
9. Subcontracts/Professional Services: This project exists as a prevention and early intervention project that is funded under CSS. We propose that this project be funded under PEI. Contracted vendor is Kings View Corporation. Existing services include facility costs, peer support services, staffing, equipment and furniture, materials to foster socialization, education, and outreach, are among some of the primary costs associated with Blue Sky Wellness Center.

B. Revenues: \$0

C. Total 12 month funding requested for Project 8a: \$1,005,436

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

County Name: **Fresno**

Date: 4/27/09

PEI Project Name: **Team Decision Making**

Services

Intended Provider Category: **County Agency**

Proposed Total Number of Individuals to be served:	FY 08-09	<u>0</u>	FY 09-10	<u>315</u>
Total Number of Individuals currently being served:	FY 08-09	<u>0</u>	FY 09-10	<u>315</u>
Expansion:	FY 08-09	<u>0</u>	FY 09-10	<u>0</u>
Months of Operation:	FY 08-09	<u>0</u>	FY 09-10	<u>12</u>

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			
Lic MH Clinician - 2.0 FTE	\$0	\$141,478	\$141,478
Community MH Specialist - 2.0 FTE	\$0	\$78,167	\$78,167
Parent Partner - 1.0 FTE	\$0	\$25,076	\$25,076
Bilingual Pay		\$3,900	\$3,900
Salary Savings @ 5%		-\$19,151	-\$19,151
Subtotal Salaries, Wages	\$0	\$229,470	\$229,470
b. Benefits and Taxes @ 55%	\$0	\$138,307	\$138,307
c. Total Personnel Expenditures	\$0	\$367,777	\$367,777
2. Operating Expenditures			
a. Facility Cost (rent, communications, equipment)	\$0	\$31,495	\$31,495
b. Other Operating Expenses	\$0	\$78,565	\$78,565
c. Total Operating Expenses	\$0	\$110,060	\$110,060
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
a. Clinical Supervision	\$0	\$57,715	\$57,715
b. Interpreter and Translation Services	\$0	\$8,739	\$8,739
a. Total Subcontracts	\$0	\$66,454	\$66,454
4. Total Proposed PEI Project Budget	\$0	\$544,291	\$544,291
B. Revenues (list/itemize by fund source)			
a. Medi-Cal (FFP only)	\$0	\$37,141	\$37,141
b. State General Funds (EPSDT)	\$0	\$29,713	\$29,713
c. Medicare/Patient Fees/Patient Insur	\$0	\$6,140	\$6,140
1. Total Revenue	\$0	\$72,994	\$72,994
5. Total Funding Requested for PEI Project	\$0	\$471,297	\$471,297
6. Total In-Kind Contributions	\$0	\$0	\$0

Project 8b: Team Decision Making**A. Expenditures: \$498,578**

10. Personnel: Total personnel expenditures are estimated at **\$367,777** and include wages/salaries, taxes and benefits for 2.0 FTE Licensed Mental Health Clinicians, 2.0 Community Mental Health Specialists, 1.0 FTE Parent Partner, plus bilingual pay.
11. Operating Costs: Total operating costs are estimated at **\$110,060** and include facility cost will include expenses for space for four (4) staff at 150 sq ft/person @ \$1.50/staff/sq ft/mo and includes rent, utilities, security, janitorial, etc in the amount of \$9,434. In addition, facility costs include equipment such as Personal Computers which include lease and network connections at \$8,117 and laser printers at \$1,140 per month. Cost for network storage/IT support is \$7,977 and copy machine maintenance is \$296 per year. Phone costs for staff is \$43/month/desk phone and include cell phones has been budgeted at \$4,531 per year. Other operating expenses include cost for services for client and families which include housing vouchers, travel and transportation and such items as clothes and hygiene products in the amount of \$15,000. This category also includes cost for medication and medication support and training in the amount of \$11,026. Program will also provide for vehicle maintenance, general office expenses and non-recurring expenses in the amount of \$7,539.
12. Subcontracts/Professional Services: Total Subcontracted services are estimated at **\$66,454** and include:
- a. 0.5 FTE Clinical Supervisor to provide oversight and accountability of this workplan/program. The residual expenses for the clinical supervisor will be paid through the County.
 - b. Interpreter/Translation Services in the estimated amount of 8,026. This estimate is based on current contracted provider average cost of \$45/hour. County will attempt to use in-house bilingual staff. If in-house bilingual staff are insufficient to meet service needs, contracted translators/interpreters will be used. In addition, culturally competent services/training of staff will take place.

B. Revenues: Revenues for this program are estimated at **\$72,994**. Revenue funding consists of Medi-Cal FFP reimbursement (\$37,141), Medicare/Patient Fees/Patient Insurance (\$6,140), and State General Fund - EPSDT (\$29,713).

C. Total 12 month funding requested for Project 8b: \$471,297

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

County Name: Fresno		Date: <u>4/27/09</u>			
PEI Project Name: Outreach and Engagement for Children/Youth					
Provider Name (if known): KingsView Corporation					
Intended Provider Category: Community Based Organization					
Proposed Total Number of Individuals to be served:	FY 08-09	0	FY 09-10	2400	
Total Number of Individuals currently being served:	FY 08-09	0	FY 09-10	2400	
Expansion:	FY 08-09	0	FY 09-10	0	
	Months of Operation:	FY 08-09	0	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					
	Program Administrator - 1.0 FTE	\$0	\$58,240	\$58,240	
	Family Involvement Coord - 2.0 FTE	\$0	\$72,135	\$72,135	
	Parent Partner - 4.0 FTE	\$0	\$87,361	\$87,361	
	Subtotal Salaries, Wages	\$0	\$217,736	\$217,736	
	b. Benefits and Taxes @ 28%	\$0	\$79,493	\$79,493	
	c. Total Personnel Expenditures	\$0	\$297,229	\$297,229	
2. Operating Expenditures					
	a. Facility Cost (rent, communications, equipment)	\$0	\$53,949	\$53,949	
	b. Other Operating Expenses	\$0	\$102,728	\$102,728	
	c. Total Operating Expenses	\$0	\$156,677	\$156,677	
3. Subcontracts/Professional Services (list/itemize all subcontracts)					
	a. Interpreter and Translation Services	\$0	\$3,000	\$3,000	
				\$0	
				\$0	
	a. Total Subcontracts	\$0	\$3,000	\$3,000	
	4. Total Proposed PEI Project Budget	\$0	\$456,906	\$456,906	
B. Revenues (list/itemize by fund source)					
	1. Total Revenue	\$0	\$0	\$0	
	5. Total Funding Requested for PEI Project	\$0	\$456,906	\$456,906	
	6. Total In-Kind Contributions	\$0	\$0	\$0	

Project 8c: Outreach and Engagement

A. Expenditures: **\$456,906**

13. Personnel: Total personnel expenditures are estimated at **\$297,229** and include wages/salaries, taxes and benefits for 1.0 FTE Program Administrator, 2.0 FTE Family Involvement Coordinator, 4.0 FTE Parent Partner.
14. Operating Costs: Total operating costs are estimated at **\$156,677** and include the following: Facility cost will include expenses for space and includes rent, utilities, security, janitorial, etc in the amount of \$53,949. Other operating expenses include cost for services which includes cost for travel and transportation in the amount of \$25,965. Program will also provide for vehicle maintenance, general office expenses, program operational costs and administrative overhead in the amount of \$76,763.
15. Subcontracts/Professional Services: Total Subcontracted services are estimated at **\$3,000** and include Interpreter/Translator Services in amounts based on current contracted provider average cost of \$45/hour. The vendor will attempt to use in-house bilingual staff. If in-house bilingual staff are insufficient to meet service needs, contracted translators/interpreters will be used. In addition, culturally competent services/training of staff will take place.

B. Revenues: **\$0**

C. Total 12 month funding requested for Project 8c: **\$456,906**

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

County Name: **Fresno** Date: 4/23/09

PEI Project Name: **Functional Family Therapy**

Provider Name (if known): **Comprehensive Youth Services**

Intended Provider Category: **Community Based Organization**

Proposed Total Number of Individuals to be served: FY 08-09 0 FY 09-10 210

Total Number of Individuals currently being served: FY 08-09 0 FY 09-10 210

Expansion: FY 08-09 0 FY 09-10 0

Months of Operation: FY 08-09 0 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			
Lic MH Clinician-Team Leader - 1.0 FTE	\$0	\$64,118	\$64,118
Community MH Specialist - 6.0 FTE	\$0	\$227,114	\$227,114
Parent Partner - 2.0 FTE	\$0	\$57,546	\$57,546
Clinical Director - .30 FTE	\$0	\$8,188	\$8,188
Peer Review - .10 FTE	\$0	\$5,561	\$5,561
Executive Director - .13 FTE	\$0	\$13,196	\$13,196
Financial Manager - .10 FTE	\$0	\$6,000	\$6,000
Bookkeeping/Receptionist - 1.10 FTE	\$0	\$40,352	\$40,352
Subtotal Salaries, Wages	\$0	\$422,075	\$422,075
b. Benefits and Taxes @ 27%	\$0	\$115,595	\$115,595
c. Total Personnel Expenditures	\$0	\$537,670	\$537,670
2. Operating Expenditures			
a. Facility Cost (rent, communications, equipment)	\$0	\$66,388	\$66,388
b. Other Operating Expenses	\$0	\$98,564	\$98,564
c. Total Operating Expenses	\$0	\$164,952	\$164,952
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
a. Consultant for FFT Model Fidelity	\$0	\$7,188	\$7,188
b. Interpreter and Translation Services	\$0	\$500	\$500
a. Total Subcontracts	\$0	\$7,688	\$7,688
4. Total Proposed PEI Project Budget	\$0	\$710,310	\$710,310
B. Revenues (list/itemize by fund source)			
a. Medi-Cal (FFP only)	\$0	\$91,151	\$91,151
b. State General Funds (EPSDT)	\$0	\$74,578	\$74,578
1. Total Revenue	\$0	\$165,729	\$165,729
5. Total Funding Requested for PEI Project	\$0	\$544,581	\$544,581
6. Total In-Kind Contributions	\$0	\$0	\$0

Project 8d: Functional Family Therapy**A. Expenditures: \$710,310**

16. Personnel: Total personnel expenditures are estimated at **\$537,670** and include wages/salaries, taxes and benefits for 1.0 FTE Licensed Mental Health Clinicians, 6.0 Community Mental Health Specialists, 2.0 FTE Parent Partner, plus Administrative Support. Administrative support will be provided in the form of a clinical director (.30 FTE), Peer Review (.10 FTE), Executive Director (.13 FTE), Financial Manager (.10 FTE), and Bookkeeping/Receptionist (1.10 FTE).
17. Operating Costs: Total operating costs are estimated at **\$164,952** and include the following: Facility cost will include expenses for space for staff at 150 sq ft/person @ \$1.50/staff/sq ft/mo and includes rent, utilities, security, janitorial, etc in the amount of \$52,888. In addition, facility costs include equipment, phone services and cell phones usage in the amount of \$13,500 per year. Other operating expenses include cost for services for client and families which include housing vouchers, travel and transportation and such items as clothes and hygiene products in the amount of \$11,500. This category also includes cost for medication and medication support, training expenses, and other miscellaneous program expenses in the amount of \$57,368. Program will also provide for vehicle maintenance, general office expenses and Administrative over head in the amount of \$29,696.
18. Subcontracts/Professional Services: Total Subcontracted services are estimated at **\$7,688** and include:
- a. Program Consultant to provide technical assistance on the FFT model to ensure fidelity to the program model (\$7,188)
 - b. Interpreter/Translation Services in the estimated amount of \$500. This estimate is based on current contracted provider average cost of \$45/hour. County will attempt to use in-house bilingual staff. If in-house bilingual staff are insufficient to meet service needs, contracted translators/interpreters will be used. In addition, culturally competent services/training of staff will take place.

B. Revenues: Revenues for this program are estimated at **\$165,729**. Revenues for this program are estimated at \$165,729. Revenue funding consists of Medi-Cal FFP reimbursement (\$91,151) and State General Fund - EPSDT (\$74,578).

C. Total 12 month funding requested for Project 8c: \$544,581

The Administrative Budget is based on the State's approval of Prevention & Early Intervention Plan by September 2009. All staffing costs are based on Fresno County's current salary and wage scale. Benefits and taxes are calculated at 53%. Costs for office supplies are calculated at a rate of \$516 per month per staff assignment. Facility costs include office rent and services, including janitorial services among other costs. Additional operating expenses include expenditures assigned to the PEI cost center from County Council and Risk Management. Other existing county personnel time devoted to PEI activities, including that of the Directors of Behavioral Health and Department of Children and Family Services, the MHSA Division Manager, Financial Analyst and Business Manager, will be billed to the PEI cost center, as appropriate.

1. Total personnel costs amount to **\$435,923**. This amount is the sum of salaries, benefits and taxes for the anticipated nine months of operation for FY09/10 for the following classifications: 1.0 FTE PEI Coordinator, 2.0 FTE Staff Analyst, 1.0 FTE Admitting Interviewer, 1.0 FTE Provider Relations Specialist, 1.0 Office Assistant, 1.0 Program Technician.
 - a. The PEI Coordinator will have overall administrative oversight of MHSA-funded prevention and early intervention programs and will largely be responsible for the development of an administrative structure that will support communication, collaboration, evaluation, referral and the leveraging of best practices and other resources across the different PEI Projects. This will include how programs will be connected across the four age-specific systems of care to develop an integrated prevention & early intervention continuum of care across the lifespan. The PEI Coordinator will also be responsible for ensuring cultural competency in the implementation and execution of all PEI projects in the three-year plan.
 - b. Staff Analysts will monitor program activities through systematic measures including service statistics, progress on reducing mental health disparities and progress on impacting other key individual and system-level evaluation outcomes. Data on these programs will be integrated with the existing MHSA performance tracking reports provided to management for program planning and decision-making. Staff Analysts will also manage individual contracts for ensuring contract compliance, including project fidelity, cultural competency requirements and appropriate use of funds.
 - c. Admitting Interviewer will be responsible for eliciting information by interviewing persons seeking mental health services (first onset and individuals receiving short term early intervention during the early manifestation of a mental illness) and determines financial responsibility for cost of medical care; and performs related work as required.
 - d. Provider Relations Specialist is utilized in Administration and is assigned to the Managed Care Program. The Provider Relations Specialist assists

private vendors with plan inquiries, problems, claim reimbursement, and provider/client satisfaction. Additionally, the Provider Relations Specialist recruits and trains contracted providers in Fresno County Mental Health Plan authorization and claim reimbursement procedures, and performs annual credential reviews including clinical site visits.

e. Program Technician Processes and maintains program area records including, but not limited to, computerized record keeping system and statistical record information. The Program Technician will also assist in the preparation of reports, correspondence, special studies, and research presentations. This position may also perform clerical and administrative support work and assign, review, and coordinate the work of lower-level clerical staff.

f. Office Assistant (OA) will provide clerical services. The OA will type; file; sort, and process materials; maintain records; process records; compose and edit reports and correspondence; transcribe dictation from a mechanical device; gather information; provide information to the public concerning departmental or County operations; obtain information from the public; receive and record payments; operate multi-line telephone system; operate word processors, mini-computers, duplicating machines, composing machines, computer terminals, microfilm equipment and microfiche readers; train employees; attend meetings and prepare minutes; and prepare or complete a variety of forms and documents.

2. Operating Expenditures: **\$414,527**

- a. Facility Costs amount to \$34,000
- b. Other operating costs amount to \$380,527.

3. Total Expenditures for Administration: **\$850,450**

County: County: Fresno Fresno					Date: 8-Jul-09	
		Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2008-09	Budgeted Expenditure FY 2009-10	Total
A. Expenditures						
1. Personnel Expenditures						
a. PEI Coordinator			1		\$64,530	\$64,530
b. PEI Support Staff						\$0
Staff Analyst			2		\$100,566	\$100,566
Admitting Interviewer			1		\$28,719	\$28,719
Provider Relation Specialist			1		\$29,925	\$29,925
Office Assistant			1		\$27,027	\$27,027
Program Technician			1		\$30,474	\$30,474
					\$281,241	\$281,241
d. Employee Benefits @ 55%					\$154,682	\$154,682
e. Total Personnel Expenditures				\$0	\$435,923	\$435,923
2. Operating Expenditures						
a. Facility Costs				\$0	\$34,000	\$34,000
b. Other Operating Expenditures				\$0	\$380,527	\$380,527
c. Total Operating Expenditures				\$0	\$414,527	\$414,527
3. County Allocated Administration						
a. Total County Administration Cost				\$0	\$850,450	\$850,450
4. Total PEI Funding Request for County Administration Buc				\$0	\$850,450	\$850,450
B. Revenue						
1 Total Revenue						\$0
C. Total C. Total Funding Requirements				\$0	\$850,450	\$850,450
D. Total In-Kind Contributions				\$0	\$0	\$0

#	List each PEI Project	Fiscal Year			Funds Requested by Age Group			
		FY 07/08	FY 09/10	Total	*Children, Youth, and their	*Transition Age Youth	Adult	Older Adult
1	Integration of Primary Care and Mental Health Prevention and Early Intervention at Federally Funded Clinics	\$0	\$ 579,612	\$ 579,612	\$ 231,845	\$ 115,922	\$ 115,922	\$ 115,922
2	Cultural-Based Access and Navigation Specialists and Community-Based Peer Support	\$0	\$ 338,725	\$ 338,725	\$ -	\$ -	\$ 169,362	\$ 169,362
3	Peri-Natal Prevention and Early Intervention Program for Pregnant/Parenting Women and their Infants	\$0	\$ 626,948	\$ 626,948	\$ 313,474	\$ 156,737	\$ 156,737	\$ -
4	Schools-based Prevention and Early Intervention Program for Kindergarten through Eighth Grade	\$0	\$ 338,725	\$ 338,725	\$ 338,725	\$ -	\$ -	\$ -
5	Horticultural Therapeutic Community Centers	\$0	\$ 135,490	\$ 135,490	\$ -	\$ 33,872	\$ 33,872	\$ 67,745
6	First-Onset Consumer and Family Support	\$0	\$ 968,119	\$ 968,119	\$ -	\$ 484,059	\$ 242,030	\$ 242,030
7	Crisis and Acute Care Prevention and Early Intervention Project	\$0	\$ 220,969	\$ 220,969	\$ -	\$ 110,485	\$ 55,242	\$ 55,242
8	Funding PEI Activities in CSS through PEI	\$0	\$ 2,478,220	\$ 2,478,220	\$ 1,486,932	\$ 247,822	\$ 371,733	\$ 371,733
	Administration	\$0	\$ 850,450	\$ 850,450	\$ 321,640	\$ 190,671	\$ 178,850	\$ 159,289
	Total PEI Funds Requested:	\$0	\$6,537,258	\$6,537,258	\$ 2,692,616	\$ 1,339,569	\$ 1,323,749	\$ 1,181,324

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

PEI Project Name:

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

The project selected for local evaluation is:

Project 7: Crisis and Acute Care Prevention and Early Intervention

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

Project 7, which addresses psychiatric crisis and acute care services in Fresno County, includes the following components:

- Clinician who is designed to work with first responders during psychiatric crises in the field;
- Clinician to work at the Urgent Care Center with individuals who present with acute mental health concerns early in their manifestation that are not SMI (SMI will be linked to appropriate services, including the PEI First Onset Project) ; and
- Peer Support Specialist to work with acute care consumers early in the manifestation of a mental illness over a short period of time.

PEI administrative staff selected Project 7 for local evaluation in order to highlight positive outcomes that result from addressing rapid response to mental illness through an provision of licensed field clinician to assist during psychiatric crisis response. We have selected this project for local evaluation in order to demonstrate positive outcomes to the community, including maximally appropriate crisis response services and urgent acute mental health care for consumers and family members.

The effectiveness of the proposed clinical field support during psychiatric crisis calls will provide support for leveraging existing resources within other County, Municipal and community agencies, such as the Sheriff’s Department, Jail Psychiatric Services, Municipal Police Agencies, and Consumer Advocacy Groups, among others.

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

Individual	Family	Systems/Organization
<ul style="list-style-type: none"> • De-escalation of crisis • Fewer legal concerns and legal costs • More sensitive treatment 	<ul style="list-style-type: none"> • Less family distress • Fewer financial burdens on family as a result of legal consequences of crisis 	<ul style="list-style-type: none"> • System resources are freed up • Jails can be used for criminals, individuals with non-SMI

<ul style="list-style-type: none"> • More efficient access to crisis treatment • Less discrimination • Less deleterious post-crisis recovery • Improved safety • Increased access and short-term treatment for acute cases of non-SMI 	<ul style="list-style-type: none"> • Improved safety of loved one • Less trauma as a result of crisis or acute cases of non-SMI. 	<ul style="list-style-type: none"> • Fewer officer injuries • Greater collaboration between organizations • Increased public safety • Reduction in amount of time officers need to respond at crisis scene • Decrease in escalation of acute non-SMI mental health concerns into more extensive mental health problems
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3. Describe the numbers and demographics of individuals participating in this intervention. Indicate the proposed number of individuals under each priority population to be served by race, ethnicity and age groups. Since some individuals may be counted in multiple categories, the numbers of persons on the chart may be a duplicated count. For “other”, provide numbers of individuals served for whom a category is not provided (i.e., underserved cultural populations; e.g., gay, lesbian, bisexual, transgender, questioning; hearing impaired, etc.). Please indicate at the bottom of the form an estimate of the total *unduplicated* count of individuals to be served. If the focus of the intervention is families, count each person in the family.

PERSONS TO RECEIVE INTERVENTION

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/DISCRIMINATION
<u>ETHNICITY/CULTURE</u>							
African American	10	10				10	20
Asian Pacific Islander	20	20				20	40
Latino	40	40				40	80
Native American	10	10				10	20
Caucasian	40	40				40	80
Other (Indicate if possible) LGBTQ Homeless	10 20	10 20				10 20	20 40
<u>AGE GROUPS</u>							
Children & Youth (0-17)	20	20				20	400
Transition Age Youth (16-25)	50	50				50	100
Adult (18-59)	50	50				50	100
Older Adult (>60)	30	30				30	60
TOTAL	150	150				150	300
Total PEI project estimated <i>unduplicated</i> count of individuals to be served _____ 650 _____							

4. & 5. How will achievement of the outcomes and objectives be measured? What outcome measurements will be used and when will they be measured? How will data be collected and analyzed?

i. The first component of evaluation will be to develop a short pre survey for first responders (law enforcement officers) who have responded to psychiatric crises in the past. A follow-up survey shall be provided to each first responder after having been

assisted by the licensed field clinician during a crisis call to document information from the crisis call, including amount of time spent at scene of crisis, outcome of the crisis (i.e. arrest, written 5150, de-escalation of crisis, among others), and whether having a mental health professional at the scene lead to changes in attitudes and knowledge about mental illness and psychiatric crisis response. For the first component, data can be measured and collected in advance prior to implementation of licensed clinician in field crisis response. Follow-up survey responses can be collected from first responders after a crisis response. While there is no way to compel responses to survey requests, a separately funded prevention and early intervention activity includes crisis intervention training (CIT) (funded through DMH Information Notice 08-37—see accompanying application, Enclosure 2). CIT and the CIT collaborative developed between County mental health and law enforcement agencies throughout Fresno County will assist the process of collecting this data. Furthermore, the PEI Coordinator will be responsible for soliciting, gathering and analyzing this data as well as any necessary follow-up activities to ensure collection of a representative set of data.

ii. The second evaluation component will require continuous data collection on psychiatric crisis response and three annual stages of evaluation of that data (i.e. at years one, two and three). We will be able to determine whether both person-level outcomes (some reduction in transportation to triage services, improvements in psychiatric crisis recovery, attitudes of family and loved ones, among others) and system level outcomes (including reduction in jail time and resources, officer attitudes towards mental illness, reduction in officer injuries, and other resource savings) as a result of implementing a licensed field clinician and through the Acute Care for non-SMI at the Urgent Care Center.

iii. A third component of evaluation for person-level outcomes will be to count the number of psychiatric crisis response calls that require transportation to triage services (i.e. the number of crises that are successfully de-escalated) for comparison to (1) psychiatric crisis calls that do not require transportation to triage services, and (2) crisis response data collected from a time period prior to project implementation for transportation to triage services. We anticipate that the activities of the licensed field clinician will result in some level of de-escalation of crises as well as some reduction in criminal charges. Also, the number of psychiatric crisis calls that result in the arrest of the consumer for violations of the law shall also be collected and analyzed. Data from the third evaluation component shall be continuously collected and analyzed at years one, two and three to determine whether there is a change in number of psychiatric crisis calls which result in transportation to triage services, the number of which result in an arrest for criminal activity, and the number of calls that are successfully de-escalated.

iv. A fourth evaluation component will be to measure the penetration rates of access and length of short-term treatment for acute cases of non-SMI. Data will be collected at the Urgent Care Center by the Clinician and Peer Support Specialist.

vi. Additionally, data can be collected from willing families, consumers, and advocates regarding crisis response under the range of variables noted above (responders

with/without filed clinician, triage needs, post crisis recovery, among others). County Jail Services and Jail Psychiatric Services will also provide data.

All other data will be continuously collected and analyzed annually for reporting purposes. All collected data will be de-identified and securely stored for evaluation purposes.

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

A significant component this project includes knowledge about cultural communities, customs, and ways to respond during a crisis that incorporate culturally sensitive and linguistically appropriate methods. Additionally, the acute care component of this project will include collaboration with the Community Health Workers and Peer Support Specialists of project 2.

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

Continuous collaboration through the CIT Collaborative, which includes County mental health, law enforcement, consumers, families, consumer advocacy groups, and cultural advocacy groups (representing Hmong, Southeast Asian, Latino, Rural, Native American and African American communities) provide critical, real-time data on crisis response and problems experienced during crisis response. The collaborative is a recent and growing organization that leverages resources from several agencies and organizations within the County. Volunteer and staff time, office space, computer and office supplies, and incentives are among the resources that are leveraged.

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

The report on the evaluation will be posted to the MHSA web site annually, and a detailed report will be provided to the Directors. Law Enforcement Agencies and Consumer Advocate organizations will also be provided the report. Again, Fresno County has established a CIT Collaborative that meets monthly. The CIT Collaborative includes consumer advocacy organization, law enforcement agencies, including rural and urban law enforcement agencies, cultural brokers, County mental health staff, and others. On-going evaluation will be organized through this collaborative. Additionally, the County Mental Health Board, the County Board of Supervisors, and/or the County Administrative Officer will be provided the report.

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