

County Name: Kern

Date: 09/2009

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

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

<b>County Mental Health Director</b>	<b>Project Lead</b>
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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   
Mental Health Director

9/2/09  
\_\_\_\_\_  
Date

Executed at Bakersfield, California



Kern County Mental Health MHS  
Prevention and Early Intervention Plan

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Signature

  
Mental Health Director

9/2/09

Date

Executed at Bakersfield, California

## **PEI Community Program Planning Process (Form # 2)**

**County: Kern**

**Date: Sept. 1, 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**

Jennifer Sinnette, LMFT, assumed the role of MHSA Coordinator just prior to the development of the Kern County Prevention and Early Intervention component and coordinated the community program planning process. Additionally, an MHSA PEI Support team, consisting of the MHSA Finance accountant (Quang Nguyen), MHSA Analysts (Amy Grundvig and Roman Juarez), Administrative Assistant (Ruth Tisdale), and the Mental Health Director (Dr. James A. Waterman), provided assistance and input throughout the process.

**b. Coordination and management of the Community Program Planning Process**

In addition to the MHSA Coordinator and Support Team, a team of PEI Workgroup Co-Chairs/Facilitators from mental health and social services throughout Kern County, and representing the various community members and diverse populations of individuals across the county, provided planning leadership and guidance throughout the stakeholder planning process. These Co-Chairs included the Mental Health Children's Services Administrator (Deanna Cloud), Regional Director for College Community Services (Bill Brooks), Clinical Director for Henrietta Weil Child Guidance Clinic (Linda Hoyle), Mental Health Unit Supervisor for Transition-age Youth (Cathy Monsibais), Mental Health Unit Supervisor for the Recovery and Wellness Center (Laurie Slate), Mental Health Crisis Services Administrator (Bill Walker), Mental Health Unit Supervisor for Older Adults (Peg Walker), the Aging and Adult Services Program Director (Paul Rozell), and the Behavioral Health Director for Clinica Sierra Vista (Christopher Reilly).

A PEI Taskforce consisted of all stakeholders in the PEI planning process. The Taskforce included 146 unique individuals representing mental health and substance abuse treatment providers, consumers, family members, military veterans, social services, educational personnel, law enforcement, public health, and other non-profit organizations and affiliations representing individuals from diverse ethnicities, cultures, and age groups.

The PEI Taskforce held the responsibility for reviewing all PEI Workgroups' input on key community needs, priority populations, and potential strategies to meet the key needs, and made recommendations for the Kern PEI Plan.

All stakeholders from the PEI Taskforce participated in smaller workgroups to ensure that the needs of unserved and underserved individuals across all age groups were appropriately addressed. Each Workgroup, Childrens, Transition-Age Youth (TAY),

Adults, and Older Adults identified key needs and priority populations, including those groups most underserved, and reviewed and analyzed potential prevention and early intervention strategies and projects to meet desired outcomes, and provided input to the PEI Taskforce.

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

The MHSA Support team and Workgroup Chairs ensured that stakeholders had the opportunity to participate in the PEI Community Program Planning Process through an extensive outreach process. This included reaching out directly to stakeholders in a variety of team, committee, and community meetings, announcement in the largest county newspaper, electronic and telephone contact, and presentation at collaborative and other meeting venues, such as open, community support group meetings. Examples of these include:

- Change Agents (group of mental health department, contracted mental health and substance abuse treatment, and community provider staff, consumers, and family members from metro Bakersfield as well as outlying Kern County areas)
- Behavioral Health Board
- Behavioral Health Board Subcommittees (Adult and Children’s Treatment and Recovery Services, Housing Services, Prevention Services, System Quality Improvement)
- County Mental Health Cultural Competency Committee
- County Expanded Management Meeting (includes all County Mental Health Supervisors and Administrators)
- Contract Providers CEO Committee (community-based mental health and substance abuse treatment providers)
- Dual Diagnosis Steering Committee
- Mobile Brief Services Steering Committee (MHSA CSS team serving predominantly Latino individuals and families in outlying county geographical areas)
- NAMI (General monthly meeting, Board meeting, support groups, and Outspoken Young Minds conference)

All interested stakeholders were added to a comprehensive MHSA PEI contact list (telephone, physical and email address contacts) for consistent notification of meetings, workgroups, and any other pertinent correspondence related to the PEI planning process.

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

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

In this PEI planning process, we first compiled information regarding the unserved and/or underserved populations identified in our Community Services and Supports (CSS) planning process. The robust CSS community program planning process included input by members of diverse populations throughout Kern County. In summary, MHSA staff in locations throughout Kern County conducted a total of 45 focus groups. Participants included mental health and substance abuse providers and volunteers, advocates for specific groups of interested community members such as seniors, children, consumers, rural regions of the county, the Spanish speaking community, faith community, and transition-aged youth. Two of the groups convened in outlying areas were held in Spanish. MHSA staff conducted 1,673 short surveys, in both Spanish and English, with community members interested in commenting on how to improve local mental health services. Consumer surveys included those from 710 adults, 141 youth, and 37 older adults. With permission of consumers, 75 surveys were sent to family members and support persons. An MHSA CSS Workgroup comprised of 46 members representing stakeholder consumers and family members from Bakersfield and rural areas of the county, community partner agencies (schools, law enforcement, social service agencies, behavioral health board senior collaborative, health clinics) reviewed stakeholder input from the surveys and focus groups, and reviewed current services and prevalence rates for all ages, geographic regions, ethnic and racial populations in Kern County. The unserved and underserved populations that were identified by this CSS planning process included:

- Individuals who are geographically isolated
- Isolated persons with severe mental illness
- Transition-Age Youth (TAY; 16-25 years old) suffering from co-occurring disorders
- Individuals (0-15 years old) at-risk of hospitalization or out-of-home placement
- Youth (0-15 years old) involved in the juvenile justice system
- Individuals (0-15 years old) in foster care
- TAY aging out of youth supportive services
- Individuals (TAY) at-risk of hospitalization, incarceration, and homelessness
- Individuals (26-59 years old) who are severely mentally ill, who are also dually diagnosed, homeless, or involved with the criminal justice system
- Individuals (60+ years old) geographically isolated, homebound, or isolated mentally ill

Additional updated information about unserved and underserved populations to be included in the PEI planning process came from data including updated prevalence rates of those we serve and recommendations given from stakeholders. These additional data shared similar populations as our CSS planning process with a focus on the need to serve the following populations most: Latino/Hispanic, LGBTQ, Co-Occurring, and TAY.

We also reviewed information and input provided by the local Behavioral Health Board's Prevention Services Subcommittee from their review and recommendation made in 2007 identifying five priority areas to research as potential prevention services to be included in the MHSA PEI component planning. These included:

- Adolescent suicide

- Services for persons exposed to trauma
- Services to the homeless with mild to moderate conditions
- Services to persons suffering from first-break psychotic episode

The strategies we used to include members from unserved and underserved populations in our planning process included input provided by diverse stakeholders in the CSS planning process, holding stakeholder meetings in settings outside of traditional mental health clinics and facilities, and in areas chosen by stakeholder participants. Additionally, we sought key members of underserved populations to address individuals from diverse ethnic and cultural populations in their familiar settings, such as faith groups and churches, lesbian/gay/bisexual/transgender/questioning (LGBTQ) organizations and affiliations, consumers and family members, family resource center in predominantly Latino community, collaborative meetings for military veterans, youth, and seniors, and education with school educators, students, and parents. We included information and announcements of stakeholder meetings in newspaper and ethnic radio broadcasts.

**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.**

The same overall stakeholder participation strategy was implemented to obtain input from individuals reflecting the diversity of the demographics of Kern County, including but not limited to: geographic location, age, gender, race/ethnicity, and language. Because of the vast size of our county, we believed it was critical to ensure that key representatives and members of diverse and underserved populations participated in the PEI Taskforce and Workgroups, as well as to assist with direct outreach in their communities. The Kern County lines stretch from the Coastal Range to the West through the Mojave Desert and to the Sierra Nevada Range to the East. The land area of the county stretches over 8,140 square miles with a population of 800,458 (U.S. Census 2008 estimate), which makes Kern the third largest county by area in the contiguous United States. Kern County has 11 incorporated cities and an additional four areas with large populations. However, half of all county residents live in Bakersfield. In order to reach the populations across the entire county, the MHSA Support Team included the assistance from community members and partner agencies to ensure outreach to all areas and diverse populations of the county. These efforts yielded participation from either community members or key representative from each of the 11 incorporated cities as well as the additional four populated areas mentioned. The western half of the county is largely Latino, including migrant workers (served by Clinica Sierra Vista, College Community Services, KCMH, and Child Guidance Clinic); the areas in the eastern half tend to be mostly Caucasian and retired individuals (served by College Community Services, Clinica Sierra Vista, and KCMH). Key members and stakeholders of underserved populations participated in the entire PEI community planning process to ensure that the needs of the unserved and underserved individuals and groups they represent would be accurately presented and strategies would be developed to meet those needs.

Examples of these key members of underserved populations included transition-aged youth, LGBTQ individuals, faith-based members, representatives working with youth deemed at-risk for mental health concerns and school failure, older adults, and the African-American and Latino ethnic communities, including those whose primary language is Spanish. Key members representing the Latino community for example, were critical to providing advocacy and input regarding the needs of this population. Some of the challenges we faced in obtaining greater numbers of Latino community members in workgroups included challenges in obtaining available interpreters for meetings held in Spanish and cultural differences, in that often individuals from the Latino community feels safer in working with members of their own community, and have difficulty participating in meetings outside of home and family.

Several key members of the Latino population and Spanish speaking communities participated in the PEI Taskforce and several different PEI Workgroups to address the needs of Latinos across all age groups. Examples of these key members included the Director of Behavioral Health at Clinica Sierra Vista, the largest health care agency in Kern County providing physical and behavioral health care primarily to migrant communities in Arvin, North, Central, and East Bakersfield, Delano, Frazier Mountain, Lake Isabella, Lamont, McFarland, and Kern River Valley; the Latina Supervisor of the MHSa CSS Mobile Brief Services Team which serves primarily Spanish-speaking Latino individuals and families in the western rural communities of the county, many of whom are uninsured and have had difficulty in accessing mental and behavioral health services. Another key Latino community member included a staff member for Radio Bilingue, a national, non-profit radio network with full Latino control and leadership, and the only national distributor of Spanish language programming in public radio. Radio programs are distributed twenty-four hours per day, seven days per week, and airs throughout all of Kern County; and outreach to individuals and community health managers in our desert and mountain areas including: Lake Isabella, Ridgecrest, Tehachapi, Wasco, and Mojave. This allowed the opportunity for PEI information and announcements to be shared broadly and in a culturally and linguistically competent manner.

Additional strategies to provide opportunities to participate for individuals reflecting the diversity of the county's demographics included holding stakeholder meetings in non-mental health, community settings at various times of the day to accommodate needs of students, families, and others who may be unavailable during traditional workday hours of 8:00a.m. through 5:00p.m. The majority of meetings were held in the larger metro areas of Bakersfield, as chosen by stakeholder participants to best meet the needs of the majority of persons involved.

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

Multiple outreach attempts and successes came from speaking with our county Consumer/Family Learning Centers (CFLC) and Kern NAMI chapter. The CFLCs and

NAMI chapter groups are located in Bakersfield, as well as the mountain and desert county areas of Tehachapi and Ridgecrest. These groups provided involvement from consumers and family members representing individuals with serious mental illnesses and emotional disturbances across age groups. In addition, contact was made with other community organizations, including prevention and social services, local veterans association, and medical clinics and providers to encourage participation from their population of individuals and families who have a serious mental illness or emotional disturbance.

- 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**

The same overall stakeholder participation strategies were implemented to obtain input from each of these required stakeholders and more. Sign-in sheets at meetings and Workgroups allowed us to ensure that stakeholders from these required populations were included. Stakeholders willing to self-disclose their direct affiliation included:

- 26 Education, including teachers, professors, Superintendent of School, and administration
- 13 Consumer/Family member
- 64 Mental health provider
- 23 Physical health provider
- 26 Social service provider/agency/organization (across all age groups)
- 4 Law enforcement, including police, probation, and district attorney's office
- 21 General community
- 4 Vocational
- 2 Media
- 5 Military veterans
- 4 LGBTQ
- 4 Aging

Other individuals representing the interests of individuals with serious mental illness or serious emotional disturbance and their family members, and those from underserved populations also participated in the PEI program planning process. Details are provided in Table 1.

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

The MHSA Coordinator provided training for staff and stakeholders at PEI stakeholder meetings, including the initial introductory stakeholder meeting, training meeting for Workgroup chairpersons, and subsequent Taskforce and Workgroup meetings. Training included an introduction to the MHSA and PEI guidelines and resource materials. An initial stakeholder MHSA PEI introduction and orientation meeting was held on May 6, 2008. Twenty stakeholders and representatives of diverse county populations participated in this initial meeting, including county and contract mental health and substance abuse providers, department of human/social services, public health, public schools (elementary through high school), aging and adult services, UCLA Psychiatry program, local Behavioral Health Board, and Board of Supervisors. The Kern County Mental Health Director spoke on the importance of MHSA and of Prevention and Early Intervention in our community. He emphasized our commitment to total inclusion of the community and the efforts that would be made to ensure all voices were heard and included, including our county outlying areas. We encouraged these stakeholders to reach out to their respective communities and assist in encouraging stakeholders to participate in the PEI community program planning process.

Due to the small size of our MHSA Support Team, we believed we would need further help from the community and partner agencies to ensure broad county exposure to PEI and total inclusion of consumers as well as stakeholders from diverse and underserved populations. Thus, we sought out persons we believed had the greatest connections with individuals from a variety of community groups, including but not limited to: underserved cultural populations (Latino, LGBTQ, Veterans, Transition Aged Youth (TAY), African American, and local community programs), Children and youth (especially those who are trauma exposed, at risk for school failure and juvenile justice involvement, in stressed families, and experiencing “first break”), and those most at risk of suicide.

The MHSA Coordinator and Support Team created an *MHSA Prevention and Early Intervention Workgroup Co-Chair Information Packet* (Attachment 1) to thoroughly educate the group of nine PEI Workgroup chairpersons on MHSA and PEI guidelines, and assist them in facilitating the workgroups throughout the program planning process. Forms were developed and included to provide structure to the process in order that each group could move at a fairly similar pace, thereby creating final recommendations together to the PEI Taskforce.

The MHSA Coordinator and Support Team held two informational training sessions with the Co-Chairs. We discussed, in detail, the purpose of the MHSA as well as the PEI component, including but not limited to: key community needs, priority populations, the community planning process, and timelines. Each chair was asked to outreach directly to individuals and groups in their respective communities to encourage participation of stakeholders. In addition, we provided the chairs with a table/list, based off the requirements set forth in the PEI guidelines, of all who should participate in the planning process, and to invite and keep track of who was asked, confirmed, or declined participation.

The MHSA Support Team and Workgroup Co-Chairs provided information and training for all PEI stakeholders interested in participating in workgroups. This full PEI stakeholder group, called the PEI Taskforce, met together to further review the PEI guidelines and discussed the workgroups' process. All stakeholders received a hard copy of the training materials and notes for reference. The documents were made available to anyone interested from the public, whether or not they were able to participate in the workgroups. In addition the MHSA Coordinator and members of the MHSA Support Team were present at each workgroup meeting to assist in answering questions as they arose from participants.

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

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

The county found all processes in the CSS planning process to be helpful. However, through our own analysis as well as direct feedback from stakeholders, it was determined that stakeholder meetings were the preferred method for gathering data in the county. This was applied to the PEI process in our efforts to broaden our stakeholder base and include members of diverse groups throughout the entire planning process, from identification of key community needs and priority populations, intended outcomes from PEI strategies, and the development and recommendation of specific strategies and projects to successfully meet the needs and provide the outcomes intended.

In our PEI planning we built on this process from the CSS planning and sought stakeholder members from diverse groups and communities to review and analyze information provided from the CSS planning, and from current stakeholder input.

The county also experienced challenges with the CSS planning. Although the planning process was robust, including surveys and focus groups with individuals throughout the county, mental health contract providers expressed concern that they were left out of much of the decision process. With the PEI planning we strengthened our collaboration and inclusiveness with contract providers by including representatives from our mental health contract agencies to participate as chairpersons for the PEI Workgroups, to be directly involved and represented throughout the planning process. Feedback from our contract providers indicated that these extra efforts were very appreciated. These efforts have increased the collaboration and coordination between the county and a number of contract agencies. The MHSA Support Team hopes to continue in this path by using these methods in the future.

Challenges arose in the CSS stakeholder voting process for recommending strategies and projects. Many stakeholders were involved in the workgroup process, but at the meeting when voting took place for projects to recommend for the CSS, some stakeholders expressed concern that some organizations brought large numbers of people to "sway" the voting to their desired recommendation. When beginning the PEI planning process, the MHSA Support Team was encouraged to provide a "fair" voting process to include all

stakeholders who participated in the planning process (via workgroups and/or input provided by other means), as they were knowledgeable of the reviews and discussions regarding needs, outcomes, and potential PEI strategies to meet those needs.

**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.**

A total of 387 stakeholders (146 unique individuals) participated in the PEI workgroups, and who represented the PEI priority populations in all parts of the planning including, but not limited to: underserved ethnic and cultural populations (Latino, African-American, LGBT, Aging, and others), individuals working with people experiencing the onset of serious psychiatric illness and those who have experienced what is known as “first break”, transition-age youth from a variety of settings (stressed families, foster care, trauma), persons from education systems working with children and youth at risk for failure, and representatives from the juvenile justice system.

The following Table 3 includes details of groups contacted and those who participated in this PEI planning process. Specific letters are given to indicate in which PEI workgroup the organization/individuals participated. All workgroup participants were members of the PEI Taskforce that evaluated PEI strategies and projects provided by each workgroup as recommendations for Kern’s PEI Plan.

Children’s Workgroup = C  
TAY Workgroup = T  
Adult Workgroup = A  
Older Adult Workgroup = O

Table 1

Group	Who we contacted	Result
Adult Educational Services	Regional Occupational Center	Unable to attend – Time/Commitment
	Vocational Services	Participated in workgroups (T, A)
Adult Protective Services	Aging & Adult Services (APS)	Co-chaired workgroup (O)
African-American Community	African-American Chamber of Commerce	Unable to attend - unknown
	Local African-American Networks (churches, networks)	Participated through email correspondence, some participation in workgroups (C, T, A)
CalWorks	Department and Contractor CalWorks Teams	Participation from staff in workgroups (C, A)
Churches/Spiritual	FaithNet Organization	Representative participated in workgroups (C, T, A), group participated in voting process
	Local Community churches	Some participation by individuals in workgroups (C, T, A, O)
Colleges/Universities	Cal State Univ., Bakersfield	Participated in workgroups (A, O)
	Bakersfield College	Participated in workgroups (A, O)
Community Based Orgs	Greenacres Community Center	Held workgroup meeting (A)
	Boys and Girls Club	Unable to attend - unknown
	Network for Children	Participated in workgroups (C, T)
	Alliance Against Family Violence	Participated in workgroups (A)
	Kern Senior Collaborative	Participated in workgroups (O)

	Senior Serve/Elder Connection	Participated in workgroups (O)
	Smother's & Assoc. Psychological and Education	Participated in workgroups (A)
	California Action Partnership – Kern	Participated in workgroups (C, A)
	Insights Living Health Center	Participated in workgroups (C, T, A)
	New Life	Participated in workgroups (T)
	Helping Hands	Participated in workgroups (T)
	Adaptive Aquatics	Participated in workgroups (O)
	United Way of Kern	Participated in workgroups (T)
	Community Connection for Child Care	Declined - Time/Commitment
	Clinica Sierra Vista <input type="checkbox"/> Arvin <input type="checkbox"/> Central Bakersfield <input type="checkbox"/> Death Valley <input type="checkbox"/> Delano <input type="checkbox"/> East Bakersfield <input type="checkbox"/> Frazier Mountain	Co-chaired workgroups, participated in workgroups (C, T, A)
	Glenn & Giordano Physical Therapy	Participated in workgroups (O)
	Kern Lifeline	Declined – Unknown
	Mercy Hospitals of Bakersfield	Participated in workgroups (A, O)
	Keith Chiropractic	Participated in workgroups (O)
	Consumer/Family Learning Center	Participated in workgroups (C, T, A)
	Current clients through teams	Participated in workgroups (C, T, A, O)
	NAMI – Outspoken Young Minds	Participated in workgroups (C, T)
Courts	CASA	Participated in workgroups (T)
Disability Services	Kern Regional Center	Participated in workgroups (C)
Emergency Services	KCMH Crisis Services	Participated in workgroups (A, O)
	Differential Response	Declined - Unknown
Employee unions	Local Union stewards	Declined participation - Time/Commitment
Employment Centers	Employer's Training Resource Center	Participated in workgroups (A)
Ethnic Media	Radio Bilingue	Participated in workgroups (C, A)
Family Members/Consumers	NAMI	Participated in workgroups (C, T, A, O)
Family Resource Centers	East Kern Family Resource Center	Declined - Unknown
First 5	First 5 of Kern	Participated in workgroups (C)
Home and Community Care	Mercy – Memorial Home Health	Participated in workgroups (O)
Homeless Shelters	Bakersfield Homeless Shelter	Participated in workgroups (C, T)
	Homeless respite program	Declined – Time/Commitment
	Hearthstone	Participated in workgroups (T)
Human Services	Department of Human Services	Participated in workgroups (C, T)
Latino Community	Outlying clinics serving Latinos	Participated in workgroups (C, T, A, O)
	Department teams working with majority of Latino populations	Participated in workgroups (C, T, A, O)
	Hispanic Chamber of Commerce	Unable to attend - unknown
LGBTQ Community	Bakersfield LGBTQ Group	Declined – Not comfortable
	Individual contacts with LGBTQ Community	Participated in workgroups (C, T, A, O)
	GLSSN	Declined – Not comfortable
	PFLAG	Declined – Not comfortable
Maternal Child and Adolescent Services	WIC	Declined - Unknown
	Maternal Child Outreach Program	Declined - Unknown
	Black infant health program	Declined - Unknown
	Medically Vulnerable Infants Program	Declined - Unknown
	Adolescent/Family Life Program	Declined - Unknown
Newspaper	Bakersfield Californian	Unable to attend - unknown

Older Adult Services	Older Adult MH Team	Participated in workgroups (O)	
Public Defenders	District Attorney's Office	Participated in workgroups (C, T)	
Public Health	Department of Public Health	Participated in workgroups (C)	
Regional Centers	Kern Regional Center	Participated in workgroups (C)	
School Districts	Local School Districts	Participated in workgroups (from 5 distinct districts) (C, T)	
Senior Centers	Local community senior centers	Participated in workgroups (O)	
Sheriff/Police	Bakersfield Police Department	Participated in workgroups (O)	
	KC Sheriff's Office	Unable to attend - unknown	
Special Ed. Groups	Richardson Special Needs	Participated in workgroups (C)	
	KC Consortium, SELPA	Participated in workgroups (C)	
Specialty MH Services	Kern County Mental Health	Participated in workgroups (C, T, A, O)	
	Clinica Sierra Vista Behavioral Health	Participated in workgroups (C, T, A, O)	
	Clinica Sierra Vista adult Co-occurring residential program	Declined - unknown	
	Child Guidance Clinic	Participated in workgroups (C, T)	
	College Community Services	Participated in workgroups (C, T, O)	
Sports	Local youth sports teams/coaches	Declined – Not comfortable/Time	
	YMCA	Unable to attend - unknown	
Substance Abuse Treatment Providers	STEPS	Participated in workgroups (A)	
	KCMH Substance Abuse	Participated in workgroups (A)	
	Taft Sober Living	Participated in workgroups (T)	
	Other Comm. SA Providers	Declined – Commitment / Unable to attend - unknown	
Superintendent of Schools	KC Superintendent of Schools	Participated in workgroups (C)	
TAY	KCMH TAY Team	Participated in workgroups (C, T)	
	Network for Children	Participated in workgroups (C, T)	
	Dream Center	Participated in workgroups (C, T)	
Veterans	Local Veteran's Association	Unable to attend - unknown	
	NAMI Front Line Veterans	Participated in workgroups (A)	
Other	County Administrative Office	Participated in workgroups (C, A)	
	Behavioral Health Board	Participated in workgroups (C)	
	Housing Authority of Kern	Participated in workgroups (T)	
	Unicorn Gardens (TAY group home)	Declined – Time/Transportation	
	Individuals/Consumers from each age group represented	Children – Participated in workgroups (C)	
		TAY – Participated in workgroups (T)	
	Adults – Participated in workgroups (A)		
	Older Adults – Participated in workgroups (O)		

The Workgroup Chairpersons also represented required stakeholders and unserved/underserved communities. We believed that these individuals would be most effective to outreach to diverse stakeholders and facilitate workgroups because of their experience with our community and the populations of stakeholders we were targeting, as well as in mental health, prevention, early intervention, and our community at large. These Co-Chairs have worked extensively in Kern County, mostly with our Mental Health populations, and have positive connections in the community. They assisted in ensuring that we had an all-inclusive planning process. The table below displays some of the networks we knew each had established to assist in this process.

Table 2

<b>Who</b>	<b>Networks/Connections</b>
KCMH Children’s System Administrator	Child/Youth Specialty Mental Health (consumers, family members, staff)
	School Districts
	Community resources for Youth
	Juvenile Justice
KCMH TAY Supervisor	TAY Specialty Mental Health (consumers, family members, staff)
	Foster care (consumers, family members, staff)
	Community resources for TAY
Child Guidance Clinics Administrator	Child/Youth Specialty Mental Health (consumers, family members, staff)
	School Districts
	Underserved cultural populations (Latino, African American)
	Community resources for youth
Clinica Sierra Vista Administrator	Specialty Mental Health, Adult/Child (consumers, family members, staff)
	Community Health Clinics (in outlying areas, Latino populations)
	Underserved populations (Latino, uninsured)
	Maternal/Family Health programs
	School Districts
	West and South Kern locations in outlying areas
	Community resources for all groups in West and South Kern
KCMH Crisis Services Administrator	Adult Specialty Mental Health (consumers, family members, staff)
	Emergency/Crisis response
	Local Hospitals and inpatient treatment settings
	Community resources for adults
College Community Services Administrator	Adult Specialty Mental Health (consumers, family members, staff)
	East Kern locations in outlying areas
	Community resources in East Kern
KCMH Recovery and Wellness Team Supervisor	Adult Specialty Mental Health (consumers, family members, staff)
	Recovery-oriented resources for adults
	LGBTQ community connections and resources
	Consumers in recovery
Aging & Adult Services, Adult Protective Services Director	Older Adult Community Health (consumers, family members, staff)
	Community resources for older adults throughout Kern County
	Non-typical community services in prevention and early intervention
KCMH WISE (older adult) Team Supervisor	Older Adult Specialty Mental Health (consumers, family members, staff)
	Community resources for Older Adults

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

**a. The date of the public hearing:**

The public hearing took place at the public Behavioral Health Board meeting on May 18, 2009, at 5121 Stockdale Highway, Bakersfield, CA, 93309.

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

The PEI Plan proposal was posted on the Kern County Mental Health public website from April 6, 2009 through May 18, 2009 for public review and comment. All stakeholder participants and others included in the contact database were notified via email that the Plan was posted for review and comment. All mental health and contract provider staff were encouraged to review the Plan via announcement on the Kern County Mental Health Net, an intranet site accessible to all employees. Additionally, announcements were made at all regularly held Behavioral Health Board subcommittee meetings, and at local NAMI general meetings, classes, and support group meetings. Contact information was provided in the posting and in person announcements for individuals interested in obtaining a hard copy of the Plan for review. Draft copies were placed in county mental health clinics and Consumer/Family Learning Centers. Stakeholder partners and participants distributed copies within their organizations and affiliation groups.

**d. A summary and analysis of any substantive recommendations for revisions.**

No substantive comments were made during the 30-day review period or at the public hearing to recommend adjustment to the PEI Plan proposal. However, comments were given via email regarding the stakeholder meetings. The majority of these were positive and indicated satisfaction with the process and thanked the Support team for the increased efforts to be inclusive. However, one comment suggested holding a larger number of stakeholder meetings in Spanish (given the percentage of Latinos in Kern County who speak Spanish in the home), and considering State-approved evidenced-based models that can be used in Spanish and have been tested for effectiveness with Latinos. Although key informants, including many who work directly with the Latino population participated in the planning meetings and workgroups, the MHSA Support team is working with community partners in our Latino communities to better address the need for additional stakeholder meetings facilitated in Spanish.

**e. The estimated number of participants:**

Over 330 individuals participated in the planning and creation of the Kern MHSA PEI Plan.

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

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 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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. PEI Priority Population(s) Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input checked="" type="checkbox"/>	<input 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"/>		

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

### **Data Review and Analysis**

To help inform the identification and selection of Key Community Mental Health Needs and Priority Populations, the PEI Children's Workgroup conducted an in-depth review of available data sources. The MHSA Coordinator and Workgroup Chairs shared the information provided by the CSS planning process on key needs and priority populations helpful to prevention and early intervention planning. Other important data reviewed and analyzed included data provided from the California Department of Education, California Department of Alcohol and Drug Programs, Local Education Agency Plan, Healthy Kids Annual Report, Kern County Network for Children, Bakersfield City School District, Office of Juvenile Justice and Delinquency Prevention (OJJDP) Juvenile Offenders and Victims: 2006 Report, Kern High School District, and the University of Colorado and the Robert Wood Johnson Foundation. This data was reviewed and analyzed in conjunction with presentations and discussion regarding specific strategies to address the key needs and priority populations of children and families throughout Kern County.

### **Stakeholder Input**

Stakeholder input was obtained throughout the planning process. Even as workgroups began to meet and plan, stakeholders were encouraged to send comments and suggestions via telephone, email, or in person with the MHSA Coordinator, Support Team, or Workgroup Chairs, whether or not individuals were able to participate in the PEI workgroups. All input from the stakeholder process was used to select the Key Community Mental Health Needs and Priority Populations that each project addresses.

The PEI Children's Workgroup was inclusive of key PEI stakeholders and our stakeholder input diverse. Children's workgroup members included individuals of five different Kern County school districts, Superintendent of Schools, consumers and family members, private and non-profit children and family mental health and substance abuse services and advocacy organizations, the local Behavioral Health Board, homeless shelter, law enforcement, including police and probation, medical providers and hospitals, human services, Spanish radio media, both public and private mental health and substance abuse treatment providers, and the faith community.

This stakeholder workgroup met together on 08/05/08, 08/19/08, 09/09/08, 09/30/08, and 10/08/08, 10/27/09. Building on the input provided in the CSS planning process, PEI workgroup participants discussed and analyzed diverse data as well as their own experiences with key needs and priorities for children and families in Kern from diverse populations. Seventy-five initial needs and topics were noted. These were further grouped into themes in order to help prioritize for this project. The key needs and priority populations identified in the CSS planning that appeared relevant to the PEI planning included identification and services for youth with mental and behavioral health problems, increase in self-help and support groups, increased mental health services to the Latino ethnic population, increased community information and education, and housing. Expanding on these, this PEI workgroup discussed community capacity, strengths, existing resources, gaps in services, and review of strategies and practices they thought would best address and provide positive outcomes for key prevention and early intervention needs for our county.

Through this extensive review and input process, the key needs and priority populations recommended included early identification of, and intervention for children and youth at risk for mental health and substance abuse problems, depression and suicide, and violence.

The populations presented as most at risk were children and youth in stressed families, including those experiencing poverty and domestic violence, children and youth at risk for school failure and increased risk of experiencing juvenile justice involvement.

The group discussed the importance of certain factors, including but not limited to addressing the most at-risk children and families in the school setting where children spend a majority of their time, recommending projects that have shown success in improving outcomes for the needs identified, the ability to provide culturally and linguistically appropriate services, accessible services to all, including free services, children and families working with individuals they know and trust, and that referrals to services be non-punitive, so that children identified as “at-risk” and encouraged to participate in services will not feel as if they have done something wrong.

Once key needs and priority populations were identified, stakeholders presented potential strategies and projects that they believed would work with our community and that would achieve the desired outcomes. These strategies included identifying children and youth at-risk, reduce risk factors, prevent the exacerbation of a possible mental, behavioral, or substance abuse problem, or intervene early to increase the support and pro-social skills and interactions with children and families. The strategies presented and discussed included First Break Early Intervention, Student Assistance Programs, Expansion of the Kern County 2-1-1 Phone Referral System, NAMI Outspoken Young Minds program, Nurse-Family Partnership, and Probation’s Early Intervention Program. The stakeholders recommended each of these six models to be presented to the PEI Taskforce for vote on the highest strategies to include in the Kern PEI Plan. The Student Assistance Program model held the highest majority of votes from stakeholders at 33 percent for this age group and population.

As a result of this input and analysis, the projects provided within the Student Assistance Programs appeared to best meet each of the key needs and intended outcomes desired by stakeholders.

#### Key Community Mental Health Needs

- Psycho-Social Impact of Trauma
- At-Risk Children, Youth and Young Adult Populations
- Suicide Risk

#### Priority Populations

- Trauma Exposed Individuals
- 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

### 3. PEI Project Description:

#### STUDENT ASSISTANCE PROGRAMS

We selected the Student Assistance Programs (SAP) project based on stakeholder recommendation and research information that indicated evidence of success in improving outcomes for each of the needs and intended outcomes provided from the PEI stakeholders. Rather than focus on one or two key needs, the SAP project intends to address and significantly prevent and reduce the negative impact associated with escalating mental and behavioral health issues, including but not limited to substance abuse, violence, depression and suicide, school failure, and subsequent potential criminal involvement and incarceration.

The development of Student Assistance Programs is often hampered by a lack of available funding, staff expertise, and school buy-in. Most school districts place an understandable priority on standardized test score improvement, which leaves SAPs, counseling, and learning support efforts inadequately supported to address the needs of students, this is especially true in Kern County. For example, the number-one source of referrals to adolescent drug treatment programs in the United States is the juvenile justice system. Unfortunately this is often too late, as the teen has already been abusing substances for several years. Approximately 67 percent (four-out-of-five) of youth involved in the juvenile justice system have a pre-existing substance abuse problem. Thus, the prevention and early intervention services through SAPs in Kern County school districts intend to provide the prevention and reduction of the key problems identified by stakeholders in our county.

According to a recent report by the National Center for Chronic Disease Prevention and Health Promotion, “Left untreated, mental health disorders in children and adolescents lead to higher rates of suicide, violence, school dropout, family dysfunction, juvenile incarcerations, alcohol and other drug use, and unintentional injuries. Schools play a vital role in creating safe, nurturing school environments and providing care to students with emotional or behavioral problems.” (National Center for Chronic Disease Prevention and Health Promotion: <http://www.cdc.gov/HealthyYouth/mentalhealth/>).

The Kern SAP project will provide on-site mental health screening, consultation, and evaluation, school-based mental health services, address problems of depression, suicide, violence, needs behind truancy and school failure, mental health services to those uninsured, resources sites to include rural county areas, parenting and family intervention and skill building, and training to educators and providers about early identification of signs and symptoms of mental health and substance abuse related problems. Because SAPs include each of these features, we believe the SAP project is sufficient to address the intended outcomes desired by stakeholders. The types of SAP elements that will be implemented will be driven by local needs assessment (see attached draft SAP needs Assessment form), and it will include the option of selecting from a menu of interrelated evidenced-based prevention programs and activities. Specific examples include:

- Teaching Prosocial Skills (TPS)/Aggression Replacement Training (addresses violence/aggression, anger)
- Parent Project (addresses parenting skills to establish appropriate boundaries, reduce drug use, truancy, family stability)
- Brief Intervention (addresses substance abuse issues)
- Project SUCCESS -- **S**chools **U**sing **C**oordinated **E**fforts to **S**trengthen **S**tudents) A SAMHSA Model Program, NREPP (a comprehensive SAP model)

Student Assistance Programs implementation partners will include the Kern County Superintendent of Schools, Kern County Mental Health Service providers, school educators and counseling personnel, Family Resource Centers, Network for Children, and school community partners to deliver culturally and linguistically competent services.

The SAP project will be delivered in Kern’s K-12<sup>th</sup> grade school sites to provide improved access to services and better outcomes for children and families, as many of the most underserved children and families in our community would not typically seek out a traditional mental health clinic due to concerns, for example, of negative stigma, lack of transportation, or trust of unfamiliar service systems, such as the public mental health system. Because of the reputation the schools have, addressing issues on-site early will cause less problems for the youth and help to keep these youth from decompensating to the point of needing intensive treatment. The site based Student Assistance Team (SAT) will be the focus for screening students to determine the need for prevention and early intervention programs and activities. The Kern SAP project will focus on capacity building efforts across all Kern County school sites to enhance already established Student Assistance Teams so that they can add cost-effective and evidence-based peer helping programs (Peer Conflict Mediation, Peer Tutoring, Link Crew, Safe School Ambassadors), and it will focus the intensive interventions, such as Brief Intervention, Teaching Prosocial Skills and Parent Project, in the areas of greatest need to improve outcomes, reduce juvenile delinquency, school failure, drop-outs, and youth violence/aggression.

Additionally, because the schools are already home to youth from all cultures/ethnicities in our county. Many of the people we, as a mental health system, are unable/ill-able to serve will be able to be outreached to and served through this program. The schools are familiar with each of the cultures in the community and have methods in place for working with youth in a way that is most appropriate for them. We expect this to help close the gap for these groups and keep the youth who otherwise would not of been seen, out of crisis and in school.

Kern County has 47 K-12 school districts, 269 school sites. The following table shows the exact number of districts, school sites and current number of districts with SAPs.

<b>Number of school districts in Kern</b>	<b>TOTAL</b>	<b>47</b>
Elementary (K-8 only)		35
High School only (9-12 only)		4
Unified School Districts (K-12)		8
<b>Number of school sites in Kern</b>		<b>269</b>
Elementary (K-6)		155
Middle/Junior High		44
High School only (9-12 only)		32
Alternative/Community Schools		27
K-12 school sites		3
Special Education		2

Other	6
<b>Number of Student Assistance Programs (SAPs) in place in Kern County school districts?</b>	
Elementary (K-6)	28
Middle/Junior High	30
High School only (9-12 only)	9

based on 2007-08 CDE Annual Report; 2008-2009 Report not available yet

The Kern PEI SAP project will expand to serve these geographic areas with the highest penetration of schools and districts that have high numbers of children and youth from unserved and underserved ethnic/cultural groups including high poverty, low academic achievement and high rates of suspension and drop-outs, high number of children in foster care, high rates of student violence, high rates of suicide, high rates of substance use, and high number of children and youth at risk of experiencing juvenile justice involvement.

An evaluation and tracking procedure will be created to help measure underserved populations, priority areas to be served, and to track progress on all performance outcomes. Further project development and implementation will:

- Establish program location and activities
- Establish partnership arrangements, using the following tools: (contract(s), MOUs/MOAs)
- Establish partnership monitoring agreements to assure program is implemented with fidelity.
- Recruit and train school site and community partner staff, and student volunteers/peer helpers
- Identify participants or target populations
- Establish referral or response mechanisms when appropriate

This PEI program will include the following key elements:

- Outreach and ongoing engagement activities
  - Enhance existing local Parent Project website ([www.kernparentproject.org](http://www.kernparentproject.org))
  - Newspaper ads
  - Radio/TV PSAs

### Key SAP Program components

- **Universal Components:**
  - School site Student Assistance Teams/Student Intervention Teams
  - School site peer helping programs (Peer Conflict Mediators, Peer Buddies/Link Crew, Safe School Ambassadors)
- **Selective Population Components:**
  - **Teaching Prosocial Skills (TPS)** Aggression Replacement Training (addresses violence/aggression, anger)
    - Frequency: TPS is an intensive ten-week life-skills program in which the youth attends one-hour group sessions three times per week. The TPS curriculum consists of three components: Structured Learning

Training (The Behavior Component), Anger Control Training (The Emotional Component), and Moral Reasoning (The Values Component).

- **Parent Project** (addresses parenting skills to establish appropriate boundaries, reduce drug use, truancy, family stability)
  - Frequency: One session a week for 10 weeks, 2-3 hours per session
- **Brief Intervention** (addresses substance abuse issues)
  - Frequency: Intensive, one to five sessions, as needed.
- **Project SUCCESS** -- **S**chools **U**sing **C**oordinated **E**fforts to **S**trengthen **S**tudents) A SAMHSA Model Program, NREPP (a comprehensive SAP model)
  - Frequency: An individual assessment and time-limited individual sessions or group counseling for students following participation in the Prevention Education Series. There are seven different counseling groups for students to participate in. Parent Support Groups are offered either through self-or other referrals to focus on issues raised by those in attendance. The program also strongly recommends the formation of a Parent Advisory Group to provide a forum for parents to share ideas for the program and to establish priorities for Project SUCCESS activities to address parents' concerns. **IN-SCHOOL CURRICULUM:** The Prevention Education Series has a series of eight prevention education/small discussion groups delivered in class on topics such as being an adolescent, correcting erroneous beliefs, and problem-solving/decision-making skills for dealing with pressure and stress. **PARENT TRAINING:** The Parent Empowerment Series consists of four parenting workshops, preceded by a large kick-off meeting.

#### **Partnership mechanisms:**

- The Kern SAP Coordinator of the project will meet with all key stakeholders to establish a representative PEI Steering/Advisory Committee that will collaboratively create a set of guidelines and criteria for selection of sites to be served, a process for funding site/community based programs/activities in order to maximize the impact of the funding on the highest need and underserved areas in Kern County. Extra outreach efforts will be made to ensure members of our minority groups (Latino, Asian Indian, African American, LGBT, etc) are involved.

KCSOS will utilize an existing web-based data tracking system, ETO (Efforts to Outcomes) which was launched in March 2009. Additionally, KCSOS will work with TLC to finalize a pre/post parent survey for all services for students and parents/families (involved in Parent Project classes, TPS) that will help us track the number of students and parents served annually, measure progress on outcomes/milestones and track implementation of key program elements.

#### **The key milestones for this PEI Program are:**

- Identification of specific program locations: January 2010
- Formal contract/agreement to operate program: December 2010
- Program implementation, with initial enrollment: January 2010
- Establishment of initial outcome data collection: March 2010

- Review of outcome data with Steering Committee/Advisory Committee/Stakeholder Partners: Quarterly meetings with PEI Steering Committee starting in January 2010, and the Kern SAP Coordinator will meet quarterly with Kern County Mental Health MHSA staff that are currently involved in the implementation of other MHSA components, such as CSS and WET. The meeting will provide for updates about the project's progress and allow opportunity to discuss barriers and solutions. Additionally, this will be an opportunity to educate, inform and support children and families that may qualify for other existing MHSA programs.
- Program review and reauthorization: Annually/end of three year plan and as required by Kern County Mental Health.

#### 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	
<b>Student Assistance Team Core Team Training</b> for school staff at targeted school in rural and underserved areas to identify needs (total student population=14,732)	Individuals: 300 Families: 250	Individuals: 525 Families: 200	12
<b>Parent Project</b> (Parent Project Senior for parents of adolescents; Loving Solutions for Parents of K-5; Teen Component for students gr. 6-12)	Individuals: 170 Families: 500	Individuals: 15 Families: 400	12
<b>Teaching Prosocial Skills</b> (Aggression Replacement Training)	Individuals: 30 Families: 0	Individuals: 75 Families: 0	12
School site-based SAPs (Peer Conflict Mediation; Peer Buddy/Link Crew; Peer Mentoring; Support Groups) at targeted schools in rural and underserved areas	Individuals: 500 Families: 0	Individuals: 25 Families: 60	12
<b>Project Success</b> ( <u>S</u> chools <u>U</u> sing <u>C</u> oordinated <u>E</u> fforts to <u>S</u> trengthen <u>S</u> tudents) [SAMHSA Model Program, NREPP]	Individuals: 25 Families: 0	Individuals: 75 Families: 0	12
<b>Brief Intervention</b>	Individuals: 25 Families: 0	Individuals: 25 Families: 0	12
<b>TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED</b>	<b>Individuals: 1,050 Families: 750</b>	<b>Individuals: 740 Families: 660</b>	

## **6. 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 primary physical health, a variety of social services, and substance abuse treatment services. We believe that these community partners are key in the strengthened network of care we are building. Students identified through this project whose need goes beyond the scope of prevention or the low intensity, short duration focus of early intervention will be linked to appropriate assessment and treatment resources. Some examples of these organizations involved include:

- Family Resource Centers
- Network for Children
- Alliance Against Family Violence and Sexual Assault
- Community Action Partnership of Kern
- Insights Living Health Center
- Clinica Sierra Vista
- Mercy Hospitals of Bakersfield
- Kern County Mental Health Consumer/Family Learning Center
- NAMI – Outspoken Young Minds
- Kern Regional Center
- First 5 of Kern
- Kern County Department of Human Services
- Kern County Probation Department
- Kern County Public Health Department
- Richardson Special Needs
- Kern County Consortium, SELPA
- Henrietta Weill Child Guidance Clinic
- College Community Services
- The Dream Center
- Housing Authority of Kern

## **7. Collaboration and System Enhancements**

Historically, it has been difficult to provide mental health services directly on school campuses. The SAP project will be operated under a contract with the Kern County Superintendent of Schools office (KCSOS), and this agency will assure that the goals and community needs are met. KCSOS has been providing SAPs locally and will be able to expand to the schools and communities of our most underserved. Further, we believe that KCSOS will best meet the goals of this project because they have a twenty-year track record of working in close partnership with school, non-profit organizations and Family Resource Centers through the Network for Children and School Community Partnerships to deliver culturally and linguistically competent services to children and families while leveraging other

prevention and intervention funds to maximize resources. Examples of resources for this project to be leveraged include provision of training and staff time, facility space, and supplies.

KCSOS will provide training to initiate and support SAPs that will provide this school-based early identification, referral, and support to at-risk youth and families. KCSOS will collaborate with schools and family resource centers to build local capacity to deliver evidence-based prevention and early intervention programs designed to serve these children and families in their neighborhood school and community.

The SAP project will include specific and formal collaboration with community-based mental health and social services to assure that services are available to high priority populations, and that referrals for follow-up mental health treatment services are timely and appropriate.

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. Monitoring of outcomes for this project will be done in a community process that includes an MHSA Advisory Committee. Data will be reviewed and analyzed of the rates of violence, suicide, suspension and drop-outs, and alcohol and narcotic use. The evaluation process will also include stakeholder and participant input and feedback. This process will allow us to consider future extension of this project or other programs to achieve desirable individual, system and community outcomes.

## **8. Intended Outcomes**

### **Individual Outcomes**

- Improved resilience and protective factors
- Improved mental health status
- Decreased substance use
- Increased school attendance
- Improved knowledge and access to community resources
- Decreased incidence of suicide and attempts
- Decreased incidence of student violence

### **System and Program Outcomes**

- Increased number of prevention programs and intervention activities in schools
- Increased number of students and families identified as needing prevention and early intervention services
- Increased number of students and families who participate in prevention programs and early intervention services
- Increased access and participation of students and families from ethnic and culturally underserved populations
- Increased collaboration between schools and mental health providers, as measured by coordinated service plans

## **9. Coordination with Other MHSA Components**

The Kern SAP Coordinator of the project will meet with all key stakeholders to establish a representative PEI Advisory Group that will collaboratively create a set of guidelines and criteria for selection of sites to be served, a process for funding site/community based programs/activities in order to maximize the impact of the funding on the highest need and underserved areas in Kern County.

The Kern SAP Coordinator will meet quarterly with Kern County Mental Health MHSA staff that are currently involved in the implementation of other MHSA components, such as CSS and WET. The meeting will provide for updates about the project's progress and allow opportunity to discuss barriers and solutions. Additionally, this will be an opportunity to educate, inform and support children and families that may qualify for other existing MHSA programs.

## **10. Additional Comments (optional)**

### **Attachments:**

The next section is a draft needs assessment for school sites to determine exact types of SAP elements in place in Kern County, areas of need, and gaps in prevention and early intervention programs, mental health services, substance abuse services.

**Assessing Availability of Mental Health Services for Students and Their Families:  
A survey for Kern County school sites with students 0 through 21 years-of-age**

**A. SCHOOL SITE AND PERSON(S) COMPLETING THE SURVEY**

1. Name of School \_\_\_\_\_ School District \_\_\_\_\_

\_\_\_\_\_ *Street Address* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip*

2. Date Survey Completed \_\_\_\_\_ School Year Survey Completed \_\_\_\_\_

3. Student enrollment during the current school year is \_\_\_\_\_

4. Age Groups and Grade Levels in School *(Check all that apply.)*

Infants	Grade 7
Preschool	Grade 8
Kindergarten	Grade 9
Grade 1	Grade 10
Grade 2	Grade 11
Grade 3	Grade 12
Grade 4	Other type of school (Alternative,
Grade 5	Charter, Private, etc) <i>(Specify below)</i>
Grade 6	
Special Education Programs at the School Site (but <b>not including speech therapy</b> ) <i>If checked, please list special education programs below.</i>	Special Education Students who are more than 18 years old through 21 years-of-age

5. List of Special Education Programs at School Site *(not including speech therapy)*

6. Survey completed by \_\_\_\_\_

*Name (last, first)* \_\_\_\_\_ *Job Title* \_\_\_\_\_  
Telephone \_\_\_\_\_ Email address \_\_\_\_\_

Mailing Address \_\_\_\_\_  
\_\_\_\_\_ *Street Address* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip*

**Survey completed with information provided by:**  
*(Please list all who provided information in addition to yourself.)*

_____	_____
<i>Name (last, first)</i>	<i>Job Title</i>
_____	_____
<i>Name (last, first)</i>	<i>Job Title</i>
_____	_____
<i>Name (last, first)</i>	<i>Job Title</i>
_____	_____
<i>Name (last, first)</i>	<i>Job Title</i>
_____	_____
<i>Name (last, first)</i>	<i>Job Title</i>

**Assessing Availability of Mental Health Services for Students and Their Families:  
A survey for Kern County school sites with students 0 through 21 years-of-age**

**B. MENTAL HEALTH SERVICES CURRENTLY PROVIDED AT SCHOOL**

The definition of “**evidence-based**” from the guidelines for Prevention and Early Intervention Mental Health Services is below:

An evidence-based practice is a strategy that has been or is being evaluated and meets the following two conditions:

- Has some quantitative and qualitative data showing positive outcomes, but does not yet have enough research or replication to support generalized positive public health outcomes.
- Has been subject to expert/peer review that has determined that a particular approach or strategy has a significant level of evidence of effectiveness in public health research literature

Check the **PREVENTIVE MENTAL HEALTH STRATEGIES** that are available **FOR ALL STUDENTS** at the school site. If the strategy is used at school, indicate if the strategy is “evidence-based” and/or if the strategy *as it is used at school*, has been evaluated.

<b>Prevention Strategy</b>	<b>Is the strategy used evidence-based?</b>	<b>Has the strategy as used at the school been evaluated to determine effectiveness?</b>
Improving school climate	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Preventing bullying	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Mental health screening	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Preventing Suicide	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Classroom instruction about alcohol and other drug use prevention	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Classroom instruction about mental health and mental illness	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Social & emotional learning	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Conflict mediation	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Peer Counseling	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Crisis Counseling	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Parenting Education <b>(Parent Project)</b>	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Student Assistance Programs	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Other (specify)	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Other (specify)	___ yes ___no ___ don't know	___ yes ___no ___ don't know

**Assessing Availability of Mental Health Services for Students and Their Families:  
A survey for Kern County school sites with students 0 through 21 years-of-age**

2. Check the **PREVENTIVE MENTAL HEALTH STRATEGIES** that are provided **FOR SELECTED STUDENTS** at the school site. If the strategy is used at school, indicate if the strategy is evidence-based\* and/or if the strategy *as it is used at school*, has been evaluated.

\*See definition on page 2.

<b>Prevention Strategy</b>	<b>Is the strategy used *evidence-based?</b>	<b>Has the strategy used been evaluated to determine effectiveness?</b>
Individual counseling for students at risk for developing mental health needs	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Group counseling for students at risk for developing mental health needs	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Counseling for parents of students at risk for developing mental health needs	___ yes ___no ___ don't know	___ yes ___no ___ don't know
School failure and/or dropout prevention	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Prevention of gang activity	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Alcohol and other drug abuse counseling or brief interventions	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Crisis counseling	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Reducing stress related to trauma and violence	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Peer counseling	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Crisis counseling	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Anger management or non-violent conflict resolution counseling	___ yes ___no ___ don't know	___ yes ___no ___ don't know
Other (specify)	___ yes ___no ___ don't know	___ yes ___no ___ don't know

**Assessing Availability of Mental Health Services for Students and Their Families:  
A survey for Kern County school sites with students 0 through 21 years-of-age**

3. Check the **EARLY INTERVENTIONS** that are available at school in response to individual students who seek help and to parents and caregivers who seek assistance; early identification from voluntary screenings, referrals from teachers, social workers and law enforcement? If the strategy is used at school, indicate if the strategy is evidence-based\* and/or if the strategy *as it is used at school*, has been evaluated. \*See definition on page 2.

<b>Early Intervention</b>	<b>Is the strategy used *evidence-based?</b>	<b>Has the strategy used been evaluated to determine effectiveness?</b>
Individual counseling for students who ask for help	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Group counseling for students who ask for help	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Family counseling for students and their families who seek help	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Interventions for students who exhibit signs of early onset of mental illness	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Interventions for parent/care givers of students who exhibit signs of early onset of mental illness	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Alcohol and other drug abuse counseling	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Individual counseling for special education students with mental health needs (e.g. pre 26.5 interventions)	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Other	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Other	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Other	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Other	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know

**Assessing Availability of Mental Health Services for Students and Their Families:  
A survey for Kern County school sites with students 0 through 21 years-of-age**

4. Check the **TREATMENT SERVICES** that are available for students who have mental health diagnoses? If the treatment is used at school, indicate if the strategy is evidence-based\* and/or if the strategy *as it is used at school*, has been evaluated.

\*See definition on page 2.

<b>Treatment Services</b>	<b>Is the strategy used *evidence-based?</b>	<b>Has the strategy used been evaluated to determine effectiveness?</b>
Individual counseling for students with mental health diagnoses	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Group counseling for students with mental health diagnoses	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Day Treatment services at school for students with mental health diagnoses	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Family counseling for students with mental health diagnoses and their families	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Treatment services for alcohol and drug abuse	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Sessions with a Psychiatrist at school	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Other	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Other	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know
Other	___ yes ___ no ___ don't know	___ yes ___ no ___ don't know

**Assessing Availability of Mental Health Services for Students and Their Families:  
A survey for Kern County school sites with students 0 through 21 years-of-age**

**C. REFERRAL AND LINKAGE FOR STUDENTS/FAMILIES WITH HIGH LEVELS OF  
NEED**

1. Is there a protocol for all school staff members that clearly defines when and how to refer students for needed mental health services? (For example through Student Assistance Team/Student Intervention Team?)

- Yes
- No
- I don't know

2. When students and/or families are referred for mental health services, who responds to the referrals?

- School-employed mental health providers at the school site respond to referrals.
- Mental health providers who are employed by community organizations and stationed at the school respond to referrals.
- No mental health professionals are at the school site; referrals must be made to offsite organizations or mental health providers working at other locations.
- Other (Explain)

3. Do mental health providers who receive referrals respond promptly to non-emergency self-referrals and referrals from school staff and family members?

- Yes
- No
- I don't know

4. Do mental health providers who receive referrals respond immediately to self-referrals and referrals from school staff and family members when the problems are life-threatening (e.g. potential suicide or pose a danger to others)?

- Yes
- No
- I don't know

5. Are barriers to obtaining needed mental health services minimized for students and families?

- Yes
- No
- I don't know

6. Are protocols in place to protect the confidentiality of students' health and mental health records without interfering with prompt access to needed services?

- Yes
- No
- I don't know

7. What could be done to improve access for students and their families to assessments, early interventions, and/or treatments for mental health needs?

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**Assessing Availability of Mental Health Services for Students and Their Families:  
A survey for Kern County school sites with students 0 through 21 years-of-age**

**D. SCHOOL-COMMUNITY INTEGRATION OF MENTAL HEALTH CARE**

1. Which best describes the extent to which mental health services for students enrolled in regular education that is delivered at school and in other settings in the community **ARE INTEGRATED**?

- Fully integrated
- Usually integrated
- Somewhat integrated
- Seldom integrated
- Never integrated
- I don't know

2. Which best describes the extent to which mental health services required by AB3632 (26.5) for students enrolled in special education **ARE INTEGRATED** when delivered at school and in other settings in the community?

- Fully integrated
- Usually integrated
- Somewhat integrated
- Seldom integrated
- Never integrated
- I don't know

3. If you selected somewhat, seldom or never integrated in item 1 or 2 above, what do you suggest be done to improve the integration of mental health services for students and their families?

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**E. COMMUNITY COLLABORATION TO PROVIDE MENTAL HEALTH SERVICES**

1. Which best describes the extent to which there is collaboration between providers of mental health services at the school site and providers in the community?

- Highly collaborative
- Somewhat collaborative
- Not very collaborative
- Not at all collaborative
- I don't know

Highly collaborative would mean there is regular dialogue about the student's progress between the appropriate personnel at school and the mental health providers in the community. This assumes that privacy and confidentiality of health and education records are protected and appropriate signatures have been obtained before sharing information.

Not at all collaborative would mean there is no communication between professionals who are providing services to the same student.

2. If you selected somewhat, not very or not at all collaborative, what do you suggest be done to improve collaboration between the providers of mental health services at school and the community providers?

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**Assessing Availability of Mental Health Services for Students and Their Families:  
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**F. SUPPORTIVE POLICIES/INTERAGENCY MEMOS OF UNDERSTANDING**

1. Which best describes the extent to which there are school district policies that support collaboration between providers of mental health services at the school site and providers in the community?

- School Board policies are in place that support collaboration between mental health providers at school sites and in the community
- School District has contractual arrangements/memos of understanding with the County Department of Mental/Behavioral Health to provide mental health services for students and their families
- The School District has contractual arrangements/memos of understanding with Community Based Organizations to provide mental health services for students and their families.
- The school site Principal provides leadership by collaborating with providers of mental health services in the community.
- There are no policies in place that support collaboration between school providers of mental health services and providers in the community
- I don't know

2. What policies and administrative supports would improve collaboration between the providers of mental health services at school and the community providers?

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3. What policies and administrative supports would improve access to mental health care for students and their families?

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PLEASE RETURN THE COMPLETED SURVEY TO:

US Mail:

**Kern County Superintendent of Schools Office**  
1300 17<sup>th</sup> Street- University Square 5<sup>th</sup> Floor  
Attention: Daryl Thiesen, Prevention Programs Coordinator II  
Bakersfield CA. 9331-4533

Fax:

661-636-4329 (Fax #)  
Attention: Daryl Thiesen, Prevention Programs Coordinator II

Email:

dathiesen@kern.org

County: KERN

PEI Project Name: FUTURE FOCUS

Date: Sept. 1, 2009

1. PEI Key Community Mental Health Needs	Age Group			
	Children and TAY	Transition-Age TAY	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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At-Risk Children, TAY and Young Adult Populations	<input 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 checked="" 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 TAY	Transition-Age TAY	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input 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 TAY in Stressed Families	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
4. Children and TAY at Risk for School Failure	<input type="checkbox"/>	<input type="checkbox"/>		
5. Children and TAY at Risk of or Experiencing Juvenile Justice Involvement	<input type="checkbox"/>	<input checked="" type="checkbox"/>		

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

### **Data Review and Analysis**

To help inform the identification and selection of Key Community Mental Health Needs and Priority Populations, the PEI Transition Aged Youth (TAY)'s Workgroup conducted an in-depth review of available data sources. The MHSA Coordinator and Workgroup Chairs shared the information provided by the CSS planning process on key needs and priority populations helpful to prevention and early intervention planning. Other important data reviewed and analyzed included data provided from the United Way of Kern, County Vocational Services, Kern County Network for Children, New Life Living Center, NAMI, Bakersfield Homeless Shelter, Department of Human Services, Probation Department, Kern County Superintendent of Schools, Clinica Sierra Vista, Housing Authority of Kern, and personal stories from TAY. This data was reviewed and analyzed in conjunction with presentations and discussion regarding specific strategies to address the key needs and priority populations of TAY throughout Kern County.

### **Stakeholder Input**

Stakeholder input was obtained throughout the planning process. Even as workgroups began to meet and plan, stakeholders were encouraged to send comments and suggestions via telephone, email, or in person to the MHSA Coordinator, Support Team, or Workgroup Chairs, regardless of their ability to participate in the PEI workgroups. All input from the stakeholder process was used to select the Key Community Mental Health Needs and Priority Populations that each project addresses.

The PEI TAY Workgroup was inclusive of key PEI stakeholders and our stakeholder input diverse. TAY workgroup members included individuals of Vocational services, Kern County Superintendent of Schools, Kern County Network for Children, TAY community programs, housing organizations, CASA, Homeless shelters, human services, probation, LGBTQ, consumers, foster TAY, both public and private mental health and substance abuse treatment providers, and the faith community.

This stakeholder workgroup met together on 7/30/08, 9/3/08, 9/17/08, 10/1/08, 10/21/08, 10/28/08, 11/13/08, and 12/1/08. Building on the input provided in the CSS planning process, PEI workgroup participants discussed and analyzed diverse data as well as their own experiences with key needs and priorities for TAY in Kern from diverse populations. Forty-nine initial needs and topics were noted. These were further grouped into themes in order to help prioritize for this project. The key needs and priority populations identified in the CSS planning that appeared relevant to the PEI planning included housing issues for TAY, mentoring, education/vocational training, system supports, access/stabilization, and centralized points of care. Expanding on these, this PEI workgroup discussed community capacity, strengths, existing resources, gaps in services, and review of strategies and practices they thought would best address and provide positive outcomes for key prevention and early intervention needs for TAY in our county.

Through this extensive review and input process, the key needs and priority populations recommended included early identification of, and intervention for TAY at risk for mental health and substance abuse problems, depression and suicide, and homelessness. The populations presented as most at risk were TAY in stressed families, TAY exposed to trauma, and increased risk of experiencing juvenile justice involvement.

The group discussed the importance of certain factors, including but not limited to addressing the most at-risk TAY those who are turning 18 and transitioning out of foster care and other system supports and into adulthood. These TAY typically have few to no life

skills for how to find food, shelter, and other necessities for living on their own; as well as a lack of familial and other positive social supports to assist their transition. The group unanimously agreed that the best way to address this is to provide safe shelter with training on life skills to keep these TAY off the streets and out of crisis so they are able to learn and absorb the skills and information necessary to help them successfully live on their own. Once key needs and priority populations were identified, stakeholders presented potential strategies and projects that they believed would work with our community and that would achieve the desired outcomes. These strategies included identifying TAY at-risk, reduce risk factors, prevent the exacerbation of a possible mental, behavioral, or substance abuse problem, or intervene early to increase the support and life skills and training with TAY. Given the unanimous agreement among stakeholders about both the key needs and priority populations identified, only one possible solution was devised by the stakeholder group, our Future Focus program. The stakeholders recommended this one program to be presented to the PEI Taskforce for vote on the highest strategies to include in the Kern PEI Plan. The Future Focus proposal received 100% of the votes for this age group and population.

This input and analysis revealed that these were some of the key needs and priority populations for our county. It became obvious that these needs fit together as one project, and that the services provided under the Future Focus Program would accurately address the needs and intended outcomes identified by stakeholders.

#### Key Community Mental Health Needs

- Psycho-Social Impact of Trauma
- At-Risk Children, TAY and Young Adult Populations
- Suicide Risk

#### Priority Populations

- Trauma Exposed Individuals
- Children and TAY in Stressed Families
- Children and TAY at Risk of or Experiencing Juvenile Justice Involvement

### 3. PEI Project Description:

#### FUTURE FOCUS

We selected the Future Focus project based on stakeholder recommendation and research information that indicated evidence of success in improving outcomes for each of the needs and intended outcomes provided by the PEI stakeholders. The Future Focus project intends to address and significantly prevent and reduce the negative impact associated with escalating mental and behavioral health issues, including but not limited to substance abuse, depression and suicide, homelessness, and subsequent potential criminal involvement and incarceration for TAY transitioning out of the public system and into adulthood.

Adult housing programs are not a “good fit” for most young people and usually require SSI eligibility, for which the majority of TAY do not qualify. Housing programs that do exist for TAY have very limited availability. For example, the waiting list for Scattered Sites housing, one of the few housing options for TAY through the Kern Department of Human Services, is two years long. TAY turning 18 and “aging out” of foster care, probation, or the mental health system need immediate and safe shelter so they can stabilize and gather resources to successfully live as independent adults and avoid crises. While there are numerous resources to assist TAY with this transition, including: employment, education, mental health treatment, and other services, it is very difficult for TAY to focus on future goals when they do not have a place to stay; many TAY have nowhere to live the day they emancipate. When TAY have nowhere to go, they end up in crisis, in the hospital, or in the jail system; which in turn begins a cycle of their dependence on the system and increased need for more intensive services. By providing safe, stable, transition housing from the beginning coupled with skills training specifically matched to their needs we can avoid this problem and help many TAY from needing specialty mental health services over the long term.

The program would fund supportive prevention and early intervention services for youth housed in a shelter for short-term, temporary housing (up to 90 days). All program elements are completely voluntary and designed to help youth successfully transition into adulthood. The youth in our community greatly need these services to establish themselves as independent adults but have a difficult time learning the skills needed on their own and without a safe place to stay.

The supportive housing is intended as a very temporary, short-term safety net for at risk youth to enter so they are open to the focused prevention and early intervention services being offered. The providers for this program have existing housing facilities that would not require PEI funding to cover the housing costs associated with program implementation. While the physical location of the program, which will have to go through an RFP process, is yet to be determined there are a number of partners already identified to provide the necessary services to the TAY.

The funding from this program would go to provide the staffing necessary to provide skills training, brief interventions, and other necessary service aspects the TAY need in order to successfully transition (described below). The KCMH MHSA TAY team will provide direct services to the TAY in a case management and brief therapy capacity to help determine what other services each TAY needs to successfully transition into adulthood and the community. Based upon this process and the treatment plan created, the Department of

Human Services, Community-based service providers, Kern County Network for Children, the Dream Center, Vocational Services, and other community partners yet to be identified will be used to help provide the skills and services the TAY need and want.

The program will be located in the Greater Bakersfield Area in order to be most centralized and convenient for not only the TAY it will house, but also be centrally located around all of the community partners and existing services. By placing the program in Bakersfield it will be easier for the youth in finding work, completing skills training, and maintaining contact with the support systems they currently have in place. Additionally, there is more transportation flexibility in Bakersfield with the public transit system and the ability to use bike paths and other methods to travel that are not typically available in our outlying areas. Even though the physical location would be in Bakersfield, the program would be available for TAY from anywhere within Kern County.

The Future Focus Project will utilize extra efforts to ensure participation of some of our most unserved and underserved populations. These populations, as identified by the workgroup and CSS needs assessment, are the most underserved and most needy TAY in our county: Latino/Hispanic, African American, and LGBTQ who also fit into the priority populations identified. Special outreach efforts will be made to include and ensure that these youth are comfortable in the program. We understand that each of these special groups will require special efforts in order to build trust and successfully engage in the program. The staff hired will be competent and well versed in these populations will be placed and available in the programs and at the community partner sites to make this program most successful in helping these special groups of youth.

There are a few implementation steps that will occur in order to get this program started, including a RFP process for the few sites in town that could house this project (a couple have already expressed an interest). The location chosen would have a contract with the County for the services they would provide as well as how they would assist the Department and community partners in this project. Most community partners are already in place and readily available to provide their portion of the services once the location is chosen. Upon implementation, the site location would begin collecting data on the population entering the program as well as their progress and outcomes. All other policies and procedures necessary or appropriate to ensure effective implementation of the project will be created and utilized.

Because of the overwhelming need for a program like this in Kern County, intensive outreach to find clients is not a current concern. The greatest concern will be filtering those who would fit the program and ensuring that the program included the most unserved and underserved populations we have not been able to reach in the past. Clients would be in the program for up to 90 days, they would be enrolled in a number of other community programs simultaneously that fit their needs for education, training, and life skills. We expect that most youth will need life skills training, crisis/mental health stabilization skills, assistance with acquiring educational/vocational interests, and support in finding a permanent housing solution before being ready to integrate back into the community. There will be other support type groups and brief therapy available to those who show a need or would benefit from such services.

In order to most effectively address the needs identified by our stakeholders regarding the best methods for prevention and early intervention for TAY, the PEI Future Focus program will provide a range of PEI services (explicitly described below) for TAY ages 18 to 25 who are homeless or at risk of homelessness who are housed temporarily (up to 90 days) in a supportive shelter program.

This program will provide PEI services in a safe, stable, age-appropriate environment from which the TAY can move forward toward healthy independence. TAY in this program will be linked to programs that facilitate connections to peers, adult mentors, and the community, to aid the TAY in being supported, involved, and connected. Screenings will be offered to all TAY to assess needs and referrals made to community resources. Outcome goals include preventing homelessness and other crises for TAY in transition by providing safety, stability, and resources for high-risk TAY who are turning 18 years of age and have no other support system. Additionally, the intention is for the prevention of TAY entering into crises and identifying mental health concerns early before there is a need for more serious, long-term attention by the System of Care. The basic set up of the program will be to do the following upon enrollment:

- Screening and Assessment of the individual to determine any pre-existing conditions and to help staff get the story of the person so they can best assist the youth with the most appropriate services. This screening will help the clinician determine what interventions, therapy, and skills training will best fit the needs of the individual to increase engagement and success of the youth.
- Create a Plan for how to best use the following so the individual can live independently:
  - Housing Education
    - How to find housing, renter's rights, and maintain housing once obtained will be trained to the youth
  - Education/Vocational Training
    - Youth will be trained how develop a resume, apply and interview well for work, apply for school, and more specific techniques based on each individuals interests and skill sets
  - Life Skills training
    - General groups and individualized training will be used including the following skills:
      - Grocery shopping
      - Cooking
      - Laundry
      - Transportation
      - Cleaning
      - Budgeting and Finance management
  - Brief Therapy
    - Using evidence-based models such as Solution-Focused and Cognitive-Behavioral Therapy
  - Socialization
    - Regular activities will be scheduled to assist the youth in creating their own social support networks that can assist each of them as they transition into independence
  - Develop community support systems
    - Information on how to find and utilize pre-existing community resources such as:
      - Consumer/Family Learning Center
      - Suicide Hotline
      - Employment Services
- Provide basic case management to help the process flow for the individual

- ❑ Work with the youth to successfully integrate into the community as an adult
- ❑ Youth will be required to attend life skills training group and brief therapy as part of the program to ensure proper engagement

We expect to begin the RFP process for the location upon approval of the plan and to have a contract in place no later than six months after approval from the state. Beyond that point it is difficult to estimate the initial enrollment dates since we do not yet know which location will receive the contract for services. Data will be collected and reviewed at least semi-annually by the MHSA Support team and advisory committee. The data elements that will be collected will be defined by the analyst following plan approval. These three entities would together review the data semi-annually to determine if there was a need for any changes in programming or data collection to ensure positive results for the priority populations identified. The advisory committee would be comprised of TAY, consumers, family members, community members, community-based providers, contractors, department staff, and other interested/invested parties.

#### 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	
TAY SHELTER Individuals: Single TAY Families: Parenting Teens	Individuals: 125 Families: 25	Individuals: Families:	12
<b>TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED</b>	<b>Individuals: 125 Families: 25</b>	<b>Individuals: Families:</b>	

#### 6. 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 primary physical health, a variety of social services, and substance abuse treatment services. We believe that these community partners are key in the strengthened network of care we are building. Transition Aged Youth identified through this project whose needs go beyond the scope of prevention or the low intensity, short duration focus of early intervention will be linked to appropriate assessment and treatment resources. Some examples of these organizations involved include:

- Alliance Against Family Violence and Sexual Assault
- Bethany Homeless Services
- Clinica Sierra Vista
- College Community Services

- Community Action Partnership of Kern
- Employer's Training Resource
- Family Resource Centers
- Henrietta Weill Child Guidance Clinic
- Housing Authority of Kern
- Insights Living Health Center
- Kern County Consortium, SELPA
- Kern County Department of Human Services
- Kern County Mental Health Consumer/Family Learning Center
- Kern County Probation Department
- Kern County Public Health Department
- Kern Regional Center
- Mercy Hospitals of Bakersfield
- NAMI – Outspoken Young Minds
- Network for Children
- The Dream Center
- United Way

## **7. Collaboration and System Enhancements**

There have been a number of resources available to TAY for at least the past few years. However, these organizations typically run as a single entity and there has been little to no collaboration up until now. This project will bring the resources from a number of local community agencies together through this project to assist the TAY who are most at risk.

This project will utilize an RFP process to identify the main implementing partner (actual housing) who can assure the goals and community needs will be met. Outreach and identification of participants will be collaborated with the following agencies and groups: Department of Human Services, Employer's Training Resource, Kern County Network for Children, Probation, community mental health providers, and other community entities as mentioned above. Individuals participating in this project who need and/or want additional services outside of this program will be referred to the most appropriate community agency. Referral protocols will be developed once the contract is established.

Monitoring of outcomes will be done in a community process that includes the MHSA Support Team, staff currently working on the project, and the advisory committee for the project. This process will allow us to consider future extension of this project or other programs to achieve the desirable outcomes.

Our project includes specific and formal collaboration with community-based mental and physical health clinics and services to assure that services are available to these populations, and to ensure that referrals for follow up treatment and services are timely and

appropriate. These relationships exist with the Department MHSA TAY team, Clinica Sierra Vista (community physical and mental health provider), and College Community Services. Each of these relationships are established throughout Kern County so that the clients can receive the treatment they need and desire in the area of the County they are most familiar or comfortable.

We anticipate that this program will be an ongoing PEI project, depending on the program review assessment of the extent to which this project meets the identified outcomes by the Advisory Committee semi-annually.

## **8. Intended Outcomes**

### **Individual Outcomes**

- **Youth will be able to successfully transition into adulthood as measured by the following:**
  - Improved mental health status
  - Decreased substance use
  - Improved knowledge about available community resources
  - Increased independence and self-sufficiency
  - Decreased incidence of suicide and attempts
  - Decreased incidence of homelessness
  - Decreased crises and hospitalizations

### **System and Program Outcomes**

- Increased number of TAY identified as needing prevention and early intervention services
- Increased number of TAY who participate in prevention programs and early intervention services
- Increased access and participation of TAY from ethnic and culturally underserved populations
- Increased collaboration between mental health providers, community providers, and community supports, as measured by coordinated service plans

## **9. Coordination with Other MHSA Components**

The coordinator of the project will meet quarterly with Kern County Mental Health MHSA staff that are currently involved in the implementation of other MHSA components, such as CSS and WET. The meeting will provide for updates about the project's progress and allow opportunity to discuss barriers and solutions. Additionally, this will be an opportunity to educate, inform, and support TAY that may qualify for other existing MHSA programs.

## **10. Additional Comments (optional)**

County: KERN

**PEI Project Name: INTEGRATED PHYSICAL AND BEHAVIORAL HEALTHCARE PROJECT**

Date: Sept. 1, 2009

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 checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

2. PEI Priority Population(s) Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input 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"/>	<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"/>

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

### **Data Review and Analysis**

To help inform the identification and selection of Key Community Mental Health Needs and Priority Populations, the PEI Adult's Workgroup conducted an in-depth review of available data sources. The MHSA Coordinator and Workgroup Chairs shared the information provided by the CSS planning process on key needs and priority populations helpful to prevention and early intervention planning. Other important data reviewed and analyzed included data provided from the US Census Bureau, State Department of Mental Health, Kern County Mental Health, California State University, Bakersfield, National Alliance on Mental Illness, NAMI Frontline, Ethnic Media, Alliance against Family Violence and Sexual Assault, and local community mental and physical healthcare providers. This data was reviewed and analyzed in conjunction with presentations and discussion regarding specific strategies to address the key needs and priority populations of children and families throughout Kern County.

### **Stakeholder Input**

Stakeholder input was obtained throughout the planning process. Even as workgroups began to meet and plan, stakeholders were encouraged to send comments and suggestions via telephone, email, or in person with the MHSA Coordinator, Support Team, or Workgroup Chairs, whether or not individuals were able to participate in the PEI workgroups. All input from the stakeholder process was used to select the Key Community Mental Health Needs and Priority Populations that each project addresses.

The PEI Adult's Workgroup was inclusive of key PEI stakeholders and our stakeholder input diverse. Adult's workgroup members included individuals of consumers and family members, private and non-profit adult and family mental health and substance abuse services and advocacy organizations, the local Behavioral Health Board, local Colleges/Universities, homeless shelter, Alliance against Family Violence, medical providers and hospitals, LGBTQ representatives, Spanish radio media, both public and private mental health and substance abuse treatment providers, and the faith community.

This stakeholder workgroup met together on 7/24/2008, 8/13/2008, 9/4/2008, and 10/20/2008. Building on the input provided in the CSS planning process, PEI workgroup participants discussed and analyzed diverse data as well as their own experiences with key needs and priorities for adults and their families in Kern from diverse populations. Forty-eight initial needs and topics were noted. These were further grouped into themes in order to help prioritize for this project. The key needs and priority populations identified in the CSS planning that appeared relevant to the PEI planning were mental health education for the community (anti-stigma), generalized prevention and early intervention services where people are at, and targeted prevention strategies through education. Expanding on these, this PEI workgroup discussed community capacity, strengths, existing resources, gaps in services, and review of strategies and practices they thought would best address and provide positive outcomes for key prevention and early intervention needs for our county.

Through this extensive review and input process, the key needs and priority populations recommended included early identification of, and intervention for adults and their families who are experiencing disparities in access and are at risk of suicide because of the onset of serious psychiatric illness.

The group discussed the importance of certain factors, including but not limited to addressing the most at-risk adults and families in the outlying and Latino communities where there is great stigma for seeking out specialty mental health services. The group felt it was

important to find a way to reach these un-/underserved individuals where they are at to provide prevention and early intervention services before they hit a crisis.

Once key needs and priority populations were identified, stakeholders presented potential strategies and projects that they believed would work with our community and that would achieve the desired outcomes. These strategies included an integrated physical and behavioral healthcare model, a Navigator/Promotoras model, anti-stigma education campaigns, and peer support/assistance models. The stakeholders recommended that three of the four models be presented to the PEI Taskforce for vote on the highest strategies to include in the Kern PEI Plan. The group decided that the peer support/assistance models and Navigator/Promotoras models could really fit under the same category. The Integrated physical and behavioral healthcare model held the largest majority of votes for this age group (over 71%).

As a result of this input and analysis, the projects provided within the integrated physical and behavioral health care model appeared to best meet each of the key needs and intended outcomes desired by stakeholders.

#### Key Community Mental Health Needs

- Disparities in Access to Mental Health Services
- Suicide Risk

#### Priority Populations

- Individuals Experiencing the Onset of Serious Psychiatric Illness

### 3. PEI Project Description:

#### Integrated Physical and Behavioral Healthcare

We selected the Integrated Physical and Behavioral Healthcare project based on stakeholder recommendation and research information that indicated evidence of success in improving outcomes for each of the needs and intended outcomes provided from the PEI stakeholders. The Integrated Physical and Behavioral Healthcare project intends to address and significantly prevent and reduce the negative impact associated with escalating mental and behavioral health issues, including but not limited to substance abuse, depression and suicide, and loss of work for adults and their families.

Complaints of headaches, difficulty sleeping, gastrointestinal pain, “nerves,” and even unusual behavior or disorganized thinking, are presented to the medical doctor before any thought may be given by the patient or their family to seek specialty mental health services. Such services are viewed by many, and overwhelmingly in some Kern County cultures, to be exclusively for the “loco” or “lazy” and those with shameful family heritage. Add to this bias, the logistical demands of missing work for lengthy screening, assessment, treatment planning, and other services, the notion of in-home services, and the effort to “link” a health center patient to mental health care becomes usually hypothetical.

Prevention, before the onset of serious and untenable consequences is simply unavailable to patients in a specialty mental health setting. It is the primary care physician and the community health center that, near-blind, try to improvise solutions and defer the need for more complicated and daunting enrollment in the mental health services. An increase in the coordination between primary care and behavioral health care may significantly decrease the risk of both physical and mental health complications.

Data from EQRO (the External Quality Review Organization) and the County of Kern analysis indicate three primary underserved populations, based on the percentage of individuals eligible to receive Medi-Cal versus those who actually seek or receive service, with Latino adults as the most underserved population in Kern County. Latino adults account for less than 34 percent of specialty mental health recipients, even while they make up 60.5 percent of the local Medi-Cal eligible population. It may be inferred from this and other evidence that Latino adults are among the most likely group of individuals to defer behavioral health and family issues to their community health provider, or conceal this challenge altogether.

When Kern County Mental Health initially wrote their Community Services & Supports Plan, a Mobile Brief Services System Development project was written into the plan. This program plan places mental health staff in outlying area clinics that are primarily Hispanic/Latino, non-English speaking clients who needed only brief interventions and did not meet the qualifications as Seriously Mentally Ill. Stakeholders in the PEI planning process discussed the appropriateness of utilizing the Kern MHSA Mobile Brief Services program inside Community Health Centers to reach the goal of increasing access with these unserved/underserved individuals in need of brief mental health assistance. The program will make specific outreach to groups our system considers un-/underserved, for example, Latinos, Asian Indians, Filipinos, and African American individuals have been largely unserved in our outlying communities. This team will work with local experts in each area to ensure these groups are served appropriately. As a part of this Integrated Physical and Behavioral Healthcare project, the Mobile Brief Services program providers may integrate into this PEI component

program. They will work directly with the Community Health Centers to provide the expertise and support that Primary Care Physicians need to address the prevention and early intervention needs of those seen in the clinics. This will be an additional support to the contractor staff that will be co-located with the physicians.

This Project will be located in the Community Health Centers (to be determined by RFP) in Kern County in areas both urban and rural, where strong demographic evidence exists demonstrating significant underuse and underrepresentation of qualified individuals and families receiving behavioral health care, due to cultural, economic, geographic, or other causes. This includes addressing the specific types of mental health needs increasing with military veterans who have been exposed to extreme and often traumatic life events. The participating Community Health Centers will provide bibliographic material, consumer-friendly self-assessments or surveys, and literature about the prevalence, needs, and treatments for people with substance related, mental health, or co-occurring conditions. Physicians will be trained to include assessment for mental health and substance-related disorders in their standard exams. Physicians are able to triage with on-site licensed mental health staff, or make an appropriate referral to the co-located mental health provider(s) for a separate follow up with the individual. Effective screening tools will be used to identify co-occurring conditions. Mental health screening for depression, personality and mood disorders, and other tests related to specific evidence-based practices will be available and within the scope of provider practice. Psychiatric assessment will also be provided to all patients referred for medication evaluation and management. In addition to outcomes of screenings and assessments from each relevant discipline, providing an outcome summary, physician and mental health providers interface formally through multidisciplinary staff meetings, “grand rounds” trainings, collaborative consultation and triage, and in exchange of written records.

#### 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	
Integrated Physical and Behavioral Healthcare	Individuals: 900 Families:	Individuals: Families:	12
<b>TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED</b>	<b>Individuals: 900</b> <b>Families:</b>	<b>Individuals:</b> <b>Families:</b>	

#### 5. Alternate Programs

Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3).

## **6. 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 primary physical health, a variety of social services, and substance abuse treatment services. We believe that these community partners are key in the strengthened network of care we are building. Adults and children identified through this project whose needs go beyond the scope of prevention or the low intensity, short duration focus of early intervention will be linked to appropriate assessment and treatment resources. Some examples of these organizations involved include:

- Alliance Against Family Violence and Sexual Assault
- Bethany Homeless Services
- Clinica Sierra Vista
- College Community Services
- Community Action Partnership of Kern
- Employer's Training Resource
- Family Resource Centers
- Henrietta Weill Child Guidance Clinic
- Housing Authority of Kern
- Insights Living Health Center
- Kern County Consortium, SELPA
- Kern County Department of Human Services
- Kern County Mental Health Consumer/Family Learning Center
- Kern County Probation Department
- Kern County Public Health Department
- Kern Regional Center
- Mercy Hospitals of Bakersfield
- NAMI Network for Children
- United Way of Kern

## **7. Collaboration and System Enhancements**

While Kern County has made a handful of efforts to provide culturally competent and effective services to our outlying and Latino communities, these efforts have been a bit scattered and therefore, less effective. These communities tend to not trust government agencies or new groups coming in and require different approaches than we typically use.

This project will utilize an RFP process to identify the main implementing partner who can assure the goals and community needs will be met. Outreach and identification of participants will be collaborated with the following agencies and groups: Department of Mental Health, community mental health providers, community health clinics, and other community entities as mentioned above. Individuals

participating in this project will need and want additional services in some cases. Referral protocols will be developed once the contract is established.

Monitoring of outcomes will be done in a community process that includes the MHSA Support Team, staff currently working on the project, and the advisory committee for the project. This process will allow us to consider future extension of this project or other programs to achieve the desirable outcomes.

Our project includes specific and formal collaboration with community-based mental and physical health clinics and services to assure that services are available to these populations, and to ensure that referrals for follow up treatment and services are timely and appropriate. These relationships exist with the Department MHSA Adult teams, Clinica Sierra Vista (community physical and mental health provider), and College Community Services. Each of these relationships are established throughout Kern County so that the clients can receive the treatment they need and desire in the area of the County they are most familiar or comfortable.

We anticipate that this program will be an ongoing PEI project, depending on the program review assessment of the extent to which this project meets the identified outcomes by the Advisory Committee semi-annually.

## **8. Intended Outcomes**

The Kern County Integrated Physical and Behavioral Healthcare project seeks, to the extent possible, to address and resolve:

- Stigma of patients with behavioral health needs seeking physical healthcare and/or relief from emotional and mental health challenges.
- Greater penetration and identification of individuals in the community with behavioral health needs, including those in segments of the population that are known to be more reticent about seeking direct behavioral health care for themselves or their family, prior to the need for specialty mental health services.
- Improve the capacity to serve and understand behavioral health co-occurring complaints in community health care centers, such that physicians and mid-level providers become more accustomed and comfortable treating such co-occurring conditions, as part of their obligation and commitment to helping underserved communities.
- Support the unique time, assistance, and other logistic needs of many behavioral health patients, intimidated or overwhelmed in the traditional community health care setting so that they also receive better physical health care.
- Provide friendly and direct access to specialty mental health services and other conduits to the social services and related community resources, for those with specialty need.

## **9. Coordination with Other MHSA Components**

There are currently two Mobile Brief Services teams in Kern County, one staffed in western Kern County by the Mental Health Department, and another staffed in eastern Kern County by a mental health contract provider organization. These teams will work together with the selected provider(s) of the Integrated Physical and Behavioral Healthcare project to provide services directly in the community health centers.

County: KERN

PEI Project Name: SENIOR VOLUNTEER OUTREACH

Date: Sept. 1, 2009

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 checked="" type="checkbox"/>
2. Psycho-Social Impact of Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input 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 checked="" type="checkbox"/>

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

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

### **Data Review and Analysis**

To help inform the identification and selection of Key Community Mental Health Needs and Priority Populations, the PEI Older Adult's Workgroup conducted an in-depth review of available data sources. The MHSA Coordinator and Workgroup Chairs shared the information provided by the CSS planning process on key needs and priority populations helpful to prevention and early intervention planning. Other important data reviewed and analyzed included data provided from Aging and Adult Services, The Arthritis Association, College Community Services, 2005 and 2007 Census, Bakersfield Police Department, California State University of Bakersfield (CSUB)'s Social Work and Psychology Departments, and KCMH's Older Adult Team. This data was reviewed and analyzed in conjunction with presentations and discussion regarding specific strategies to address the key needs and priority populations of older adults throughout Kern County.

### **Stakeholder Input**

Stakeholder input was obtained throughout the planning process. Throughout the workgroups and planning process that took place over several weeks, stakeholders were encouraged to send comments and suggestions via telephone, email, or in person with the MHSA Coordinator, Support Team, or Workgroup Chairs, whether or not individuals were able to participate in the PEI workgroups. All input from the stakeholder process was used to select the Key Community Mental Health Needs and Priority Populations that this project addresses.

The PEI Older Adult's Workgroup was inclusive of key PEI stakeholders. Older Adult's workgroup members included individuals from Aging and Adult Services, consumers and family members, private and non-profit older adult mental health and substance abuse services and advocacy organizations, the local Behavioral Health Board, local senior centers, law enforcement, medical providers and hospitals, public and private mental health and substance abuse treatment providers, LGBTQ individuals, and the faith community.

This stakeholder workgroup met together on 7/15/08, 8/7/08, 8/28/08, and 9/26/08. Building on the input provided in the CSS planning process, PEI workgroup participants discussed and analyzed diverse data as well as their own experiences with key needs and priorities for older adults in Kern from diverse populations. One hundred and three initial needs and topics were noted. These were further grouped into themes in order to help prioritize for this project. The key needs and priority populations identified in the CSS planning that appeared relevant to the PEI planning included outreach to the homebound/isolated, intergenerational activities, overall health and wellness, and prescription drug abuse/misuse. Expanding on these, this PEI workgroup discussed community capacity, strengths, existing resources, gaps in services, and review of strategies and practices they thought would best address and provide positive outcomes for key prevention and early intervention needs for our county.

Through this extensive review and input process, the key needs and priority populations recommended included early identification of and intervention for older adults at risk for mental health and substance abuse problems, and depression and suicide. The populations presented as most at risk were older adults who have experienced trauma and those who are homebound/isolated.

The group discussed the importance of certain factors, including but not limited to addressing the most at-risk older adults who are homebound or have isolated themselves, recommending projects that have shown success in improving outcomes for the needs identified, the ability to provide culturally and linguistically appropriate services, accessible services to all, including free services, older adults working with individuals they know and trust, and that referrals to services be open and available but not forced upon the individuals.

Once key needs and priority populations were identified, stakeholders presented potential strategies and projects that they believed would work with our community and that would achieve the desired outcomes. These strategies included identifying older adults at-risk, reduce risk factors, prevent the exacerbation of a possible mental, behavioral, or substance abuse problem, or intervene early to increase the support and pro-social skills and interactions with families and peers. The strategies presented and discussed included Screening for Mental Health Inc, Allostatic Change Model, Applied Suicide Intervention Skills Training, Coping with Traumatic Events – Self-Help Guide, Senior Peer Counseling – Santa Monica Model, National Center for Trauma-Informed Care (NCTIC), The Road to Resilience, One-Stop Career Center (intergenerational model), Healthy Aging Program, Healthy Prescriptions Program, Adaptive Aquatics Program. The stakeholders recommended three of these models to be presented to the PEI Taskforce for vote on the highest strategies to include in the Kern PEI Plan: Senior Peer Counseling-Santa Monica Model, Healthy Aging Program, and Healthy Prescriptions Program. The Senior Peer Counseling-Santa Monica model held the highest majority of votes from stakeholders at 70 percent for this age group and population.

As a result of this input and analysis, the Senior Peer Counseling (Senior Volunteer Outreach) PEI project appeared to best meet the identified needs and intended outcomes desired by stakeholders.

### Key Community Mental Health Needs

- Psycho-Social Impact of Trauma
- Disparities in Access to Mental Health Services
- Suicide Risk

### Priority Populations

- Trauma Exposed Individuals
- Isolated Older Adults

### 3. PEI Project Description:

#### SENIOR VOLUNTEER OUTREACH

We selected the Senior Volunteer Outreach project based on stakeholder recommendation and research information that indicated evidence of success in improving outcomes for each of the needs and intended outcomes provided from the PEI stakeholders. Rather than focus on one or two key needs, the Senior Volunteer Outreach project intends to address and significantly prevent and reduce the negative impact associated with escalating mental and behavioral health issues, including but not limited to substance abuse, isolation, and depression and suicide.

It is recognized that a high percentage of older adults tend to isolate themselves from others due to loss, illness, grief, loneliness, and substance abuse. As a result of the isolation, there is a high risk for the individual to decompensate mentally and require specialty services. The PEI project intends to address the specific needs of this population by developing a Senior Volunteer Outreach Program that will outreach to those most in need throughout the county. Recognizing that this particular population is increasing in number with prolonged longevity, it was determined that additional services are needed to prevent hospitalization and institutionalization. Presently, there are 110,000 older adults (60 years of age +) living in Kern County.

The program will utilize community volunteers to make contact with the at-risk older adults. A Volunteer Coordinator will recruit, train, and coordinate the program. An Analyst will manage the local evaluation component of this program. Trained volunteers will use peer-counseling techniques to socialize with the senior and watch for early signs of problems or decompensation. Local community providers in the communities of program implementation will coordinate the volunteers in their area as well as provide the local fiscal and training support to volunteers.

The *Santa Monica Peer Counseling for Seniors* is a model that has been considered an effective outreach and intervention approach for this population. This model has been an effective practice since 1977 and recognized as such both nationally and internationally. A significant amount of data and evidence supports its effectiveness in a variety of community and cultural settings. The California Department of Mental Health (DMH) and the American Society on Aging have both recognized the program for being a highly effective tool for training volunteers, as well as improving outcomes for isolated older adults. The program provides for comprehensive training of volunteers and other involved persons in peer counseling for a variety of cultural populations.

Similar programs have been used in small areas of our county, as well as across the country. Stakeholders believe that using the base model and expanding the program with MHSa principles to reach the entire county would be the best way of achieving the community desired outcomes for this population.

Assigning volunteers to specific seniors is a non-traditional means of assessing the needs and issues of the client and providing linkage to appropriate services when needed. Research has shown that increased socialization with older adults can prevent the onset of mental decline that can result in a crisis. For the most isolated older adults, a non-professional engaging with them in their home may

be the only successful way to be aware of and meet their needs prior to a mental or behavioral crisis. Should specialty mental health services be needed, individuals will be referred appropriately to the older adult mental health team, geographically appropriate community provider, or the outreach team of the community aging and adult services department.

The PEI Senior Volunteer Outreach project will expand to serve these geographic areas with the highest penetration of isolated older adults from unserved and underserved ethnic/cultural groups, high poverty, high rates of suicide, low social support, and high rates of substance use. These areas lie mostly in our Eastern/Mountain communities and Western Kern communities. Every attempt will be made to ensure that the volunteers in this program are culturally competent and appropriate for the community they will be serving. The Volunteer Coordinator will work with the Geographic Providers in each area in order to best ensure the implementation. Additionally, the *Santa Monica Peer Counseling Program* has training components covering the importance of cultural competency and how to use the model effectively in a number of cultural settings.

The Geographic Providers that will oversee the coordinators in Western Kern County communities (Arvin, Lamont, Delano, Shafter, McFarland, et al.) are very familiar with the communities and cultural norms of those communities. Volunteers in these areas will need to be largely Spanish-speaking as well as competent in the cultures of the communities they are in. We expect to make continued and extra efforts to recruit and retain individual volunteers who are Spanish-speaking and culturally competent for these communities. Some of our outlying areas, including Delano, have a relatively high Filipino population that has also been largely unserved. We hope to meet the needs of this population through this program as well.

The same efforts will be given in the mountain and desert regions of Eastern Kern County (Tehachapi, Lake Isabella, Mojave, Ridgecrest, et al.) to ensure that volunteers are familiar with the cultures and languages of the areas they serve so they can be most effective in preventing further mental decline in the isolated individuals they encounter.

The effectiveness of these outreach and matching efforts of volunteers to communities will be monitored and evaluated to ensure that our most un-/underserved older adults are being reached effectively.

#### 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	
Senior Volunteer Outreach	Individuals: 800 Families:	Individuals: 100 Families:	12
<b>TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED</b>	<b>Individuals: 800</b> <b>Families:</b>	<b>Individuals: 100</b> <b>Families:</b>	

## **6. 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 primary physical health, a variety of social services, and substance abuse treatment services. We believe that these community partners are key in the strengthened network of care we are building. Older adults identified through this project whose need goes beyond the scope of prevention or the low intensity, short duration focus of early intervention will be linked to appropriate assessment and treatment resources. Some examples of these organizations involved include:

- Adaptive Aquatics
- Adult Protective Services
- Aging and Adult Services
- Alliance Against Family Violence and Sexual Assault
- Arthritis Association
- Clinica Sierra Vista
- College Community Services
- Community Action Partnership of Kern
- Housing Authority of Kern
- Insights Living Health Center
- Kern County Mental Health Consumer/Family Learning Center
- Kern County Public Health Department
- Kern County Senior Centers (geographically appropriate)
- Memorial Home Health Services
- Mercy Hospitals of Bakersfield
- NAMI
- Senior Serve/Elder Connection

## **7. Collaboration and System Enhancements**

This program will be operated under a contract, likely with Aging and Adult Services who will work directly with remote coordinators at our community-based contract locations (College Community Services and Clinica Sierra Vista) in rural areas of Kern County. A large portion of the outreach and identification of individuals for this will be through collaboration with the above-mentioned agencies; although, we are also counting on a number of other community organizations and stakeholders to assist in this process (see organization list in question 6).

The Senior Volunteer Outreach project will include specific and formal collaboration with community-based mental health and social services to assure that services are available to high priority populations, and that referrals for follow-up mental health treatment services are timely and appropriate.

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. Monitoring of outcomes for this project will be done in a community process that includes an MHSA Advisory Committee. Data will be reviewed and analyzed of the rates of suicide, crisis/hospital use, prescription drug misuse, and satisfaction of peer volunteer services. The evaluation process will also include stakeholder and participant input and feedback. This process will allow us to consider future extension of this project or other programs to achieve desirable individual, system, and community outcomes.

## **8. Intended Outcomes**

### **Individual Outcomes**

- Improved resilience and protective factors
- Improved mental health status
- Decreased substance use
- Increased social interaction
- Improved knowledge and access to community resources
- Decreased incidence of suicide and attempts
- Decreased incidence of crises/hospitalizations

### **System and Program Outcomes**

- Increased access and participation of older adults from ethnic and culturally underserved populations
- Increased collaboration between community agencies and mental health providers, as measured by coordinated service plans

## **9. Coordination with Other MHSA Components**

The Senior Volunteer Outreach Coordinator of the project will meet quarterly with Kern County Mental Health MHSA staff that are currently involved in the implementation of other MHSA components, such as CSS and WET. The meeting will provide for updates about the project's progress and allow opportunity to discuss barriers and solutions. Additionally, this will be an opportunity to educate, inform, and support older adults that may qualify for other existing MHSA programs.

## **10. Additional Comments (optional)**

**PEI Revenue and Expenditure Budget Worksheet**

**Form No. 4**

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

County Name: Kern Date: 9/1/09  
 PEI Project Name: Student Assistance Programs  
 Provider Name (if known): Kern County  
 Intended Provider Category: County Agency  
 Proposed Total Number of Individuals to be served: FY 08-09 \_\_\_\_\_ FY 09-10 3,200  
 Total Number of Individuals currently being served: FY 08-09 \_\_\_\_\_ FY 09-10 0  
 Total Number of Individuals to be served through PEI Expansion: FY 08-09 0 FY 09-10 3,200  
 Months of Operation: FY 08-09 \_\_\_\_\_ FY 09-10 9

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 09-10	Total
<b>A. Expenditure</b>			
<b>1. Personnel (list classifications and FTEs)</b>			
<b>a. Salaries, Wages</b>			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
<b>b. Benefits and Taxes @ %</b>	\$0	\$0	\$0
<b>c. Total Personnel Expenditures</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>2. Operating Expenditures</b>			
<b>a. Facility Cost</b>	\$0	\$0	\$0
<b>b. Other Operating Expenses</b>	\$0	\$0	\$0
<b>c. Total Operating Expenses</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>3. Subcontracts/Professional Services (list/itemize all subcontracts)</b>			
School Provider(s)	\$0	\$546,852	\$546,852
Geographical Provider(s)	\$0	\$624,480	\$624,480
_____	\$0	\$0	\$0
<b>a. Total Subcontracts</b>	<b>\$0</b>	<b>\$1,171,332</b>	<b>\$1,171,332</b>
<b>4. Total Proposed PEI Project Budget</b>	<b>\$0</b>	<b>\$1,171,332</b>	<b>\$1,171,332</b>
<b>B. Revenues (list/itemize by fund source)</b>			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
<b>1. Total Revenue</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>5. Total Funding Requested for PEI Project</b>	<b>\$0</b>	<b>\$1,171,332</b>	<b>\$1,171,332</b>
<b>6. Total In-Kind Contributions</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

**BUDGET NARRATIVE**  
**MHSA PEI**  
**Student Assistance Programs**

**ESTIMATED PERSONNEL**

No Salaries, Wages, and Benefits are budgeted in this program.

**OPERATING EXPENSES**

No Operating Expenditures are budgeted in this program.

**SUBCONTRACTS/PROFESSIONAL SERVICES**

The Kern County Superintendent of Schools (KCSOS): \$546,852. This funding represents a contract with KCSOS to provide coordination and supervision of the project at each selected school site. This will allow for implementation at four high need schools and an additional eight average to high needs schools in Kern County. KCSOS will review local and statewide data to determine the most appropriate school sites for implementation based on high rates of the following: suspension and drop-out, foster children, student violence, suicide, substance use, and youth at risk of juvenile justice involvement. The schools will oversee training of faculty and counselors organizing and running the various groups listed in the program description (Parent Project, Teaching Prosocial Skills, Project Success, etc). The schools will ensure proper training of the faculty operating the groups as well as to provide stipends to faculty spending the extra time doing so. The school will be responsible for adapting school materials to ensure cultural and age appropriateness depending on the students involved. KCSOS will also collect data at regular intervals (specific times yet to be determined) to ensure the groups and implemented programs are successfully providing the prevention and early intervention services needed.

Geographic Providers: \$624,480. This funding represents contracts with our geographic providers to provide counseling, brief therapy, and referrals on the selected school sites. This contract will go out to RFP. Geographic Providers represent the variety of community-based organizations, which are already providing services in each of our 11 geographic areas. Providers will be selected to go to the school sites and provide prevention-based counseling, brief therapy, and any necessary referrals by a licensed clinician in their area of expertise at each of the 15 schools for two days a week. Additionally, the clinicians will assist KCSOS in training the schools/staff in early recognition of signs and symptoms and when referral is appropriate. Our local geographic providers are experts at working on prevention and early intervention techniques with our youth and already have relationships with the schools that we hope will be further enhanced via this program. The providers will work closely with both KCMH and KCSOS to ensure a seamless and integrated system of services for the students involved in the program.

**TOTAL PROPOSED PEI BUDGETS**

A. The overall expenditure level for this program is \$1,171,332.

B. No other revenues are anticipated for this program.

**TOTAL FUNDING REQUESTED FOR PEI PROJECT: \$1,171,332.**

**PEI Revenue and Expenditure Budget Worksheet**

**Form No. 4**

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

County Name: Kern Date: 9/1/09  
 PEI Project Name: Future Focus  
 Provider Name (if known): Kern County  
 Intended Provider Category: County Agency  
 Proposed Total Number of Individuals to be served: FY 08-09 \_\_\_\_\_ FY 09-10 150  
 Total Number of Individuals currently being served: FY 08-09 \_\_\_\_\_ FY 09-10 0  
 Total Number of Individuals to be served through PEI Expansion: FY 08-09 0 FY 09-10 150  
 Months of Operation: FY 08-09 \_\_\_\_\_ FY 09-10 9

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 09-10	Total
<b>A. Expenditure</b>			
<b>1. Personnel (list classifications and FTEs)</b>			
<b>a. Salaries, Wages</b>			
MH Therapist I/II/III (.25)	\$0	\$16,471	\$16,471
MH Recovery Specialist I/II/III (1)	\$0	\$50,078	\$50,078
Substance Abuse Specialist I/II/III (.5)	\$0	\$24,915	\$24,915
Office Services Technician (.2)	\$0	\$7,029	\$7,029
<b>b. Benefits and Taxes @ 39 %</b>	\$0	\$38,412	\$38,412
<b>c. Total Personnel Expenditures</b>	\$0	\$136,905	\$136,905
<b>2. Operating Expenditures</b>			
<b>a. Facility Cost</b>	\$0	\$15,000	\$15,000
<b>b. Other Operating Expenses</b>	\$0	\$6,800	\$6,800
<b>c. Total Operating Expenses</b>	\$0	\$21,800	\$21,800
<b>3. Subcontracts/Professional Services (list/itemize all subcontracts)</b>			
Geographical Provider(s)	\$0	\$415,416	\$415,416
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
<b>a. Total Subcontracts</b>	\$0	\$415,416	\$415,416
<b>4. Total Proposed PEI Project Budget</b>	\$0	\$574,121	\$574,121
<b>B. Revenues (list/itemize by fund source)</b>			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____		\$0	\$0
<b>1. Total Revenue</b>	\$0	\$0	\$0
<b>5. Total Funding Requested for PEI Project</b>	\$0	\$574,121	\$574,121
<b>6. Total In-Kind Contributions</b>	\$0	\$160,800	\$160,800

## BUDGET NARRATIVE

### MHSA PEI

#### Future Focus

#### ESTIMATED PERSONNEL

Costs for salaries and wages amount to \$98,493. It includes costs for:

##### **Mental Health Therapist I/II/III, .25 FTE at \$16,471.**

This position will provide the counseling, brief therapy, and facilitate any necessary referrals for TAY entering the program as either a walk-in or as a person utilizing the shelter component. The person will be familiar with local resources and community providers that could benefit the TAY and assist in their transition. They will also provide assessments for the youth to help identify any problems or issues early on, and work with the youth to develop a plan involving skills training and brief therapy to assist the TAY in their transition.

##### **Mental Health Recovery Specialist I/II/III, 1 FTE at \$50,078.**

Recovery Specialists are our expert front line staff. They will provide basic case management for TAY entering the program including screening, WRAP planning, and skills training for a successful transition. These staff will be the core support for the youth and are experts in prevention and community integration for our TAY.

##### **Substance Abuse Specialist I/II/III, .5 FTE at \$24,915.**

These positions will provide the support and training to the community-based providers, Recovery Specialists, and other associated staff about substance use/abuse in TAY. Because we know many at risk TAY use and/or abuse substances, these staff will provide education, groups, and support to youth to assist them in making better decisions to support their independence into adulthood.

##### **Office Services Technician, .2 FTE at \$7,029.**

This position will provide the coordination between the multiple agencies involved and gather and direct data collection on outcomes for further analysis. They will oversee the proper storage of charts, plans, and other confidential data of the TAY in the program.

#### **Employee Benefits**

Benefits and Taxes. Benefits are estimated at \$38,412 and include FICA, health and dental coverage, SDI, workers compensation insurance, state and federal payroll taxes.

#### **OPERATING EXPENSES**

Total Operating Expenses amount to **\$21,800**.

A. Facility Cost. **\$15,000**.

B. Other Operating Expenses. Other operating expenses are estimated at **\$6,800** and include costs for flexible funds, supplies, travel & training, medical labs, data processing, client support, phones, and IT.

#### **SUBCONTRACTS/PROFESSIONAL SERVICES**

Geographical Providers: \$415,416. This represents the costs to contract, through RFP, with local community-based providers to provide space for groups, classes, skills training, and in-kind refuge for 30 TAY. They will provide 24-hour supervision and support to the TAY staying at the facility and referral to outside agencies and supports as necessary. The providers will train the youth how to cook their meals, do laundry, and other necessary life skills on-site. The provider(s) will be responsible for ensuring proper linkage for youth services and skills training as well as data collection for the outcomes identified by the plan. These providers will work with our MHSA TAY team to ensure that all youth will be successfully transitioned into independent adulthood.

#### **TOTAL PROPOSED PEI BUDGETS**

A. The overall expenditure level for this program is \$551,226.

B. No other revenues are anticipated for this program.

**TOTAL FUNDING REQUESTED FOR PEI PROJECT: \$551,226.**

**PEI Revenue and Expenditure Budget Worksheet**

**Form No. 4**

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

County Name: Kern Date: 9/1/09  
 PEI Project Name: Integrated Physical & Behavioral Healthcare  
 Provider Name (if known): Kern County  
 Intended Provider Category: County Agency  
 Proposed Total Number of Individuals to be served: FY 08-09 \_\_\_\_\_ FY 09-10 900  
 Total Number of Individuals currently being served: FY 08-09 \_\_\_\_\_ FY 09-10 \_\_\_\_\_  
 Total Number of Individuals to be served through PEI Expansion: FY 08-09 0 FY 09-10 900  
 Months of Operation: FY 08-09 \_\_\_\_\_ FY 09-10 12

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 09-10	Total
<b>A. Expenditure</b>			
<b>1. Personnel (list classifications and FTEs)</b>			
<b>a. Salaries, Wages</b>			
MH Therapist I/II/III (2)	\$0	\$131,770	\$131,770
Office Services Technician (1)	\$0	\$35,145	\$35,145
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
<b>b. Benefits and Taxes @ 39 %</b>	\$0	\$65,097	\$65,097
<b>c. Total Personnel Expenditures</b>	\$0	\$232,012	\$232,012
<b>2. Operating Expenditures</b>			
<b>a. Facility Cost</b>	\$0	\$30,000	\$30,000
<b>b. Other Operating Expenses</b>	\$0	\$14,400	\$14,400
<b>c. Total Operating Expenses</b>	\$0	\$44,400	\$44,400
<b>3. Subcontracts/Professional Services (list/itemize all subcontracts)</b>			
Geographical Provider(s)	\$0	\$622,704	\$622,704
	\$0	\$0	\$0
	\$0	\$0	\$0
<b>a. Total Subcontracts</b>	\$0	\$622,704	\$622,704
<b>4. Total Proposed PEI Project Budget</b>	\$0	\$899,116	\$899,116
<b>B. Revenues (list/itemize by fund source)</b>			
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
<b>1. Total Revenue</b>	\$0	\$0	\$0
<b>5. Total Funding Requested for PEI Project</b>	\$0	\$899,116	\$899,116
<b>6. Total In-Kind Contributions</b>	\$0	\$0	\$0

**BUDGET NARRATIVE**  
**MHSA PEI**  
**Integrated Physical and Behavioral Healthcare**

**ESTIMATED PERSONNEL**

Costs for salaries and wages amount to \$166,915. It includes costs for:

**Mental Health Therapist, 2 FTE at \$131,770.**

These two positions represent two licensed clinicians who will be available to community primary care physicians for consultation, training, and information sharing. They will work with the community clinics, doctors, and contractors on each side of our county to assist the doctors in being comfortable seeing, recognizing, and treating minor mental illness and emotional disturbances. The positions will be traveling positions so they can go wherever the doctors are most comfortable.

**Office Services Technician, 1 FTE at \$35,145.**

This position will provide the coordination between the multiple agencies involved and gather and direct data collection on outcomes for further analysis. They will oversee the proper storage of charts, plans, and other confidential data of the adults in the program. They will provide support and assistance to the therapists and work to recruit, schedule, and engage individuals involved in the advisory group for this project. Additionally, they will be the main point of contact for community clinics and doctors wanting to participate in the program as well as the main outreach to find interest in the community.

**Employee Benefits**

Benefits and Taxes. Benefits are estimated at \$65,097 and include FICA, health and dental coverage, SDI, workers compensation insurance, state and federal payroll taxes.

**OPERATING EXPENSES**

Total Operating Expenses amount to **\$44,400.**

A. Facility Cost: \$30,000

B. Other Operating Expenses. Other operating expenses are estimated at \$14,400 and include costs for flexible funds, office supplies, travel & training, medical labs, data processing, phones, and computers.

**SUBCONTRACTS/PROFESSIONAL SERVICES**

Geographical Providers: \$622,704. This represents the costs to contract, through RFP, with local community-based provider(s)/clinics that currently provide primary care services to some of our communities most un-/underserved populations. The contractor(s) will provide on-site mental health staffing and support to the primary care physicians in the form of education, tools, and diagnosis/treatment support. They will assist the doctors in becoming more comfortable screening, addressing, and treating minor mental illness to prevent unnecessary referrals or exacerbations of problems to the point that would require specialty mental health treatment. This funding will allow for the on-site support to be available at three distinct clinics (\$207,568/site).

**TOTAL PROPOSED PEI BUDGETS**

A. The overall expenditure level for this program is \$899,116.

B. No other revenues are anticipated for this program.

**TOTAL FUNDING REQUESTED FOR PEI PROJECT: \$899,116.**

**PEI Revenue and Expenditure Budget Worksheet**

**Form No. 4**

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

County Name: Kern Date: 9/1/09  
 PEI Project Name: Senior Volunteer Outreach  
 Provider Name (if known): Kern County  
 Intended Provider Category: County Agency  
 Proposed Total Number of Individuals to be served: FY 08-09 \_\_\_\_\_ FY 09-10 800  
 Total Number of Individuals currently being served: FY 08-09 \_\_\_\_\_ FY 09-10 \_\_\_\_\_  
 Total Number of Individuals to be served through PEI Expansion: FY 08-09 0 FY 09-10 800  
 Months of Operation: FY 08-09 \_\_\_\_\_ FY 09-10 12

Proposed Expenses and Revenues	<b>Total Program/PEI Project Budget</b>		
	FY 08-09	FY 09-10	Total
<b>A. Expenditure</b>			
<b>1. Personnel (list classifications and FTEs)</b>			
<b>a. Salaries, Wages</b>			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
<b>b. Benefits and Taxes @ %</b>	\$0	\$0	\$0
<b>c. Total Personnel Expenditures</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>2. Operating Expenditures</b>			
<b>a. Facility Cost</b>			
_____	\$0	\$0	\$0
<b>b. Other Operating Expenses</b>			
_____	\$0	\$0	\$0
<b>c. Total Operating Expenses</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>3. Subcontracts/Professional Services (list/itemize all subcontracts)</b>			
Aging & Adult Services	\$0	\$106,124	\$106,124
Geographic Provider(s)	\$0	\$522,492	\$522,492
_____	\$0	\$0	\$0
<b>a. Total Subcontracts</b>	<b>\$0</b>	<b>\$628,616</b>	<b>\$628,616</b>
<b>4. Total Proposed PEI Project Budget</b>	<b>\$0</b>	<b>\$628,616</b>	<b>\$628,616</b>
<b>B. Revenues (list/itemize by fund source)</b>			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
<b>1. Total Revenue</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>5. Total Funding Requested for PEI Project</b>	<b>\$0</b>	<b>\$628,616</b>	<b>\$628,616</b>
<b>6. Total In-Kind Contributions</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

**BUDGET NARRATIVE**  
**MHSA PEI**  
**Senior Volunteer Outreach**

**ESTIMATED PERSONNEL**

No Salaries, Wages, and Benefits are budgeted in this program.

**OPERATING EXPENSES**

No Operating Expenditures are budgeted in this program.

**SUBCONTRACTS/PROFESSIONAL SERVICES**

Aging and Adult Services: \$106,124. This represents the cost to contract with Aging and Adult Services to provide overall program coordination and training according to the Santa Monica Peer Counseling Model. The funding will support one full time program coordinator who has worked with this model in the past and has the expertise in coordinating and recruiting volunteers as well as training. They will provide the initial and continual training in the curriculum, oversight and technical assistance to site coordinators at our Geographical Providers, and community outreach and collaboration efforts. They will also be responsible for program adaptation to meet the needs of the various cultural groups in our communities.

Geographical Providers: \$522,492. This represents the costs to contract, through RFP, with local community-based provider(s)/clinics that currently provide mental health and other services to each of our 11 geographic areas. These funds will allow for local programs in 6 distinct geographical areas across our county. We expect these 6 main sites to be able to further outreach to most if not all of the other geographical areas in our county. The contracts will allow funding for local half time case coordinators for support, training, and organization of their own local volunteers, one day a week of a licensed therapist for the clients and volunteers, as well as a quarter time secretary for organizing data and maintaining an active list of clients. Volunteers for each area will be based from these provider sites and organized by an on-site coordinator. They will ensure volunteers are being properly reimbursed for meal and travel costs as well as to provide local support and training to volunteers on an on-going basis.

**TOTAL PROPOSED PEI BUDGETS**

A. The overall expenditure level for this program is \$628,616.

B. No other revenues are anticipated for this program.

**TOTAL FUNDING REQUESTED FOR PEI PROJECT: \$628,616.**

## PEI Administration Budget Worksheet

Form No. 5

County:     Kern    Date:     9/1/2009    

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2008-09	Budgeted Expenditure FY 2009-10	Total
<b>A. Expenditures</b>					
<b>1. Personnel Expenditures</b>					
a. PEI Coordinator		0.5	\$0	\$83,556	\$83,556
b. PEI Support Staff		0.25	\$0	\$8,786	\$8,786
c. Other Personnel (list all classifications)					
Administrative Coordinator		1	\$0	\$57,871	\$57,871
Department Analyst		0.1	\$0	\$5,478	\$5,478
d. Employee Benefits			\$0	\$60,719	\$60,719
e. Total Personnel Expenditures			\$0	\$216,410	\$216,410
<b>2. Operating Expenditures</b>					
a. Facility Costs				\$12,750	\$12,750
b. Other Operating Expenditures				\$5,900	\$5,900
c. Total Operating Expenditures			\$0	\$18,650	\$18,650
<b>3. County Allocated Administration</b>					
a. Total County Administration Cost			\$0	\$0	\$0
<b>4. Total PEI Funding Request for County Administration Budget</b>			\$0	\$235,060	\$235,060
<b>B. Revenue</b>					
1 Total Revenue			\$0	\$0	\$0
<b>C. Total Funding Requirements</b>			\$0	\$235,060	\$235,060
<b>D. Total In-Kind Contributions</b>			\$0	\$0	\$0

**BUDGET NARRATIVE  
MHSA PEI  
PEI Administration**

**ESTIMATED PERSONNEL**

Costs for salaries and wages amount to \$155,691. It includes costs for:

**PEI Coordinator, .5 FTE at \$83,556.**

This administrative position will oversee the contract development, program implementation, and other coordination activities between the department and all potential and eventual contractors in the community. They will work with the contractors and analysts to review outcomes and other relevant data and report to the system of care and community. They will be responsible for ensuring community sharing of information and annual reporting.

**Administrative Coordinator, 1 FTE at \$57,871.**

This position will work directly under the PEI coordinator as the main contact for contract development and contract monitoring for all PEI projects. They will work closely with the contracts and purchasing divisions of the County to ensure the contracts are developed expediently upon approval and monitor each contract to ensure quality of service in each program plan. They will also be responsible for data collection and reporting to the PEI coordinator on the program outcomes and other standard data (number of clients, program efficacy, etc.).

**Department Analyst, .1 FTE at \$5,478.**

This position will oversee the of outcomes data for each of the programs in the plan. They will work with the coordinators for analysis and reporting. They will report outcomes to the various advisory groups, behavioral health board, and system administrators.

**Office Services Technician, .25 FTE at \$8,786.**

This position will provide support to the coordinator and analyst relating to the development and implementation of the PEI plan. They will maintain an active list of interested and involved stakeholders as well as assist in setting up meetings and advisory groups relating to the PEI plan.

**Employee Benefits**

Benefits and Taxes. Benefits are estimated at \$60,719 and include FICA, health and dental coverage, SDI, workers compensation insurance, state and federal payroll taxes.

**OPERATING EXPENSES**

Total Operating Expenses amount to **\$18,650**.

A. Facility Cost. **\$12,750**.

B. Other Operating Expenses. Other operating expenses are estimated at **\$5,900** and include costs for flexible funds, office supplies, travel & training, data processing, client support, phones, and computers.

**TOTAL PROPOSED PEI ADMINISTRATION BUDGETS**

A. The overall expenditure level for administration is \$235,060.

B. No other revenues are anticipated for this program.

**TOTAL FUNDING REQUESTED FOR PEI Administration: \$235,060.**

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

County:                     Kern                    

Date:           9/1/2009          

PEI Work Plans			FY 09/10 Required MHSA Funding	Estimated MHSA Funds by Type of Intervention			Estimated MHSA Funds by Age Group			
No.	Name	Universal Prevention		Selected/ Indicated Prevention	Early Intervention	Children, Youth, and Their Families	Transition Age Youth	Adult	Older Adult	
1.	1 Student Assistance Programs		\$1,171,332	\$665,946	\$505,386	\$1,171,332				
2.	2 Future Focus		\$574,121	\$574,121			\$574,121			
3.	3 Integrated Physical & Behavioral Healthcare		\$899,116	\$899,116		\$89,912	\$89,912	\$629,381	\$89,911	
4.	4 Senior Volunteer Outreach		\$628,616	\$562,611	\$66,005				\$628,616	
5.										
6.										
7.										
8.										
9.										
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17.										
18.										
19.										
20.										
21.										
22.										
23.										
24.										
25.										
26.	<b>Subtotal: Work Plans<sup>a/</sup></b>		<b>\$3,273,185</b>	\$0	\$2,701,794	\$571,391	\$1,261,244	\$664,033	\$629,381	\$718,527
27.	<b>Plus County Administration</b>		<b>\$235,060</b>							
28.	<b>Plus Optional 10% Operating Reserve</b>		<b>\$350,824</b>							
31.	<b>Total MHSA Funds Required for PEI</b>		<b>\$3,859,069</b>							

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

58.82%

**Exhibit G**

Prevention and Early Intervention Prudent Reserve Plan  
FY 2007/08 – FY 2009/10 PEI MENTAL HEALTH SERVICES ACT

County: KERN

Date: 9/1/2009

Instructions: Utilizing the following format please provide a plan for achieving and maintaining a prudent reserve.

1. Requested FY 2009/10 PEI Funding	\$3,273,185
2. Plus: PEI Administration	\$235,060
3. Sub-total	\$3,508,245
4. Maximum Prudent Reserve (50%)	\$1,754,123
5. Amount requested to dedicate to Prudent Reserve through this Plan	
A. FY 07/08 Allocation	+\$1,754,123
6. Prudent Reserve Balance	\$1,754,123

**County: Kern**

**Date: 9/1/2009**

**PEI Project Name: Senior Volunteer Outreach**

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

Kern County Mental Health will be evaluating and reporting on the Senior Volunteer Outreach program.

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

This project was selected based on input during the stakeholder process indicating the large gap between the number of older adults in Kern County, and the availability of prevention and early intervention services currently available, especially for those who are isolated and have experienced trauma. It was noted that these individuals, including many who reside in the outlying areas of the county, are the most unserved in Kern County. This program will be implemented in several geographic areas throughout the County, and the focus will be given to the fidelity of the model in order to produce positive outcomes.

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

Expected Person/Family-Level Outcomes:

- ◆ Older Adults who participate in our Senior Volunteer Outreach program will be more able to manage the stressors in their life through increased socialization and connection with community supports.
- ◆ Older Adults participating will see an improvement in their overall wellness/mental health through the increase in socialization.
- ◆ Older Adults from our Hispanic/Latino communities will see a benefit from and report satisfaction with the culturally competent services.

Expected Program/System-Level Outcomes:

- ◆ Community services and supports will become more available and used by Older Adults participating in the Senior Volunteer Outreach Program.
- ◆ Through the referrals in this program current systems and supports will improve for Older Adults.
- ◆ Older Adults participating in the Senior Volunteer Outreach Program will experience fewer crises and hospitalizations.

*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
<b>ETHNICITY/ CULTURE</b>							
African American	30	30				30	30
Asian Pacific Islander	20	20				20	20
Latino	125	125				125	125
Native American	10	10				10	10
Caucasian	300	300				300	300
Other (Indicate if possible)							
<b>AGE GROUPS</b>							
Children & Youth (0-17)							
Transition Age Youth (16-25)							
Adult (18-59)							
Older Adult (>60)	500	500				500	500
<b>TOTAL</b>	500	500				500	500
Total PEI project estimated <b>unduplicated</b> count of individuals to be served							500

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

**Person/Family-Level Outcomes:**

<b>Outcome</b>	<b>What</b>	<b>How</b>	<b>When</b>
Older Adults who participate in our Senior Volunteer Outreach program will be more able to manage the stressors in their life through increased socialization and connection with community supports.	Number of Older Adults receiving Peer Counseling (increase over time)	Tracking log used by Peer Counselors	Logged each visit, compiled and reported quarterly
	Functionality of Older Adults (increase over time)	Activities of Daily Living Scale	Given at first meeting and then quarterly thereafter
Older Adults participating will see an improvement in their overall wellness/mental health through the increase in socialization.	Social Isolation (decrease over time)	Santa Monica Peer Counseling Program Tool	Assessed at first meeting and then quarterly thereafter
	Symptoms of Depression (decrease over time)	Santa Monica Peer Counseling Program Tool	Assessed at first meeting and then quarterly thereafter
	Participation in Community/Social activities (increase over time)	Tracking log used by Peer Counselors	Logged each visit, compiled and reported quarterly
Older Adults from our Hispanic/Latino communities will see a benefit from and report satisfaction with the culturally competent services.	Number of Hispanic/Latino Older Adults receiving Peer Counseling (increase over time)	Tracking log used by Peer Counselors	Logged each visit, compiled and reported quarterly
	Percent of Hispanic/Latino Older Adults expressing satisfaction with Peer Counseling Services (increase over time)	Satisfaction Survey (in English and Spanish, as preferred by client)	Surveyed each quarter, data reported annually
	Number of Hispanic/Latino Older Adults able to access community supports (increase over time)	Tracking log used by Peer Counselors	Logged each visit, compiled and reported quarterly

**Program/System-Level Outcomes:**

<b>Outcome</b>	<b>What</b>	<b>How</b>	<b>When</b>
Community services and supports will become more available and used by Older Adults participating in the Senior Volunteer Outreach Program.	Experienced barriers to using supports and system programs (decrease over time)	Satisfaction Survey (in English and Spanish, as preferred by client)	Surveyed each quarter, data reported annually
Through the referrals in this program current systems and supports will improve for Older Adults.	Number and type of referrals made by Peer Counselors (increase over time)	Tracking log used by Peer Counselors	Logged each visit, compiled and reported quarterly
	Percent of referrals used by Older Adults (increase as number increases)	Tracking log used by Peer Counselors	Logged each visit, compiled and reported quarterly
	Satisfaction with access to support systems (increase over time)	Satisfaction Survey (in English and Spanish, as preferred by client)	Surveyed each quarter, data reported annually

**5. How will data be collected and analyzed?**

At project implementation a PEI Analyst will be hired at part time to coordinate with the Senior Volunteer Outreach Coordinator regarding the collection of all types of data mentioned above. The Coordinator will collect all data from the Peer Counselors on a regular basis and send it to the Analyst monthly for compilation and reporting.

The Analyst will develop and submit reports quarterly/yearly (as appropriate) to the KCMH management team and the state on the progress of each above-mentioned outcome.

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

Culturally competent Peer Counselors will be sought and assigned to regions of the county most appropriate. The counselors will be fluent in the clients preferred language. Most specifically Spanish-speaking counselors will be sought for the Hispanic/Latino communities.

Each volunteer will be screened for cultural awareness of the community they are serving prior to placement. In addition, all volunteers will be trained in confidentiality, cultural competency, and general mental health awareness and skill sets.

In addition, part of the Coordinator's duties will be to use a basic matching system to most appropriately match volunteers to clients based on cultural preferences. Kern County is largely a "rural" county with a majority of outlying areas and smaller communities of varying cultures. The coordinator will use this information to find and use the most appropriate Peer Counselors from each geographic area. The satisfaction of the clients in cultural competent service by the Peer Counselors will be measured and reported on yearly.

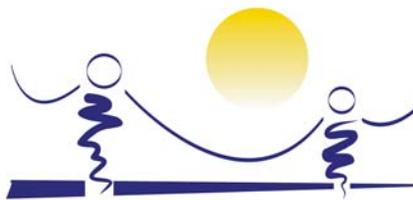
**7. What procedure will be used to ensure fidelity in implementing the model and any adaptation(s)?**

In order to ensure the fidelity of the Santa Monica Peer Counseling Program, each volunteer will be required to complete the training course. In addition, volunteers will meet monthly with the Coordinator to review training techniques and overcome barriers to proper peer counseling.

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

Reports will be posted to the KCMH public Mental Health website. Additionally, the MHSA Support Team constructed an extensive database of stakeholders from previous and current MHSA efforts. All reports will be sent via email to stakeholders quarterly as compiled. Hard copies will be made available to any interested individuals. Once the annual report is completed, a stakeholder meeting will take place in order to share outcomes and encourage feedback from all interested parties. Also, information will be shared in the local Behavioral Health Board public meeting.

Mental Health Services Act (MHSA)  
Prevention and Early Intervention (PEI)  
Workgroup Co-Chairs Information Packet



**Kern County Mental Health Department**

*Working together toward  
Hope, Recovery and Independence*

Kern County Mental Health Department  
MHSA Prevention and Early Intervention  
Glossary

**MHSA Stakeholder Taskforce:** The larger group of stakeholders (consumers, family members, KCMH staff, Contractor staff, community members, etc.) who will meet and be the final decision-makers of which ideas go into the submitted plan.

**Workgroup (Children, TAY, Adult, or Older Adult):** The smaller sub-groups from the taskforce charged with brainstorming and creating plans for each of the age group populations directly affected by the programs in the PEI Plan.

**Voting Protocol:** The rules are changing; we will go over them verbally, we are trying to ensure integrity of the procedures so that the plans are fair and representative of all involved stakeholders.

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

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

**Prevention:** Programs and services defined by the Institute of Medicine (IOM) as universal and selective, both occurring prior to a diagnosis for a mental illness.

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

**Service:** A part of a project or plan, the actual product that would be provided within the prevention or early intervention category. This would be the tangible product that could be measured for effectiveness following implementation.

**Project:** A single idea that could include multiple similar services or services at a specific location falling under the Prevention or Early intervention categories. There will be a minimum of four projects in the plan (at least one per age group).

**Plan:** This will be the final document submitted to the state. The plan will include all projects and services therein created and approved by both the workgroup and taskforce.

**Program:** Is part of what can make up a project. The program can include a multitude of services.

## **Background**

The MHSA represents a comprehensive approach to the development of community-based mental health services and supports for the residents of California. The MHSA addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support the local mental health system. To provide for an orderly implementation of MHSA, DMH has planned for sequential phases of development for each of the five components. Ultimately, all five components will be integrated into the counties' Three-Year Program and Expenditures Plans with a continuum from prevention and early intervention to comprehensive, intensive interventions for those in need.

The five components are:

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



### **Prevention and Early Intervention: Key to Transformation**

Prevention and Early Intervention approaches in and of themselves are transformational in the way they restructure the mental health system to a “help-first” approach. Prevention programs bring mental health awareness into the lives of all members of the community through public education initiatives and dialogue. To facilitate accessing supports at the earliest possible signs of mental health problems and concerns, PEI builds capacity for providing mental health early intervention services at sites where people go for other routine activities (e.g., health providers, education facilities, community organizations). Mental health becomes part of wellness for individuals and the community, reducing the potential for stigma and discrimination against individuals with mental illness.

The PEI programs described in these guidelines align with the transformational concepts inherent in the MHSA and the PEI policies adopted by the Mental Health Services Oversight and Accountability Commission (OAC). The concepts follow:

#### **Community Collaboration**

The goal of community collaboration is to bring members of the community together in an atmosphere of support to systematically address community wellness or solve existing and emerging problems by those related groups. The PEI community program planning process is intended to bring together various stakeholders, including groups of individuals and families, agencies, organizations and businesses to share information and resources to accomplish a shared vision for PEI.

To facilitate ongoing community collaboration processes, from the planning through implementation and evaluation, the process is accessible and inclusive. The PEI Component of the Three-Year Program and Expenditure Plan also needs to be user-friendly to allow for meaningful stakeholder input and involvement.

#### **Cultural Competence**

Improving access to mental health programs and interventions for unserved and underserved communities and the amelioration of disparities in mental health across racial/ethnic and socioeconomic groups are priorities of the MHSA. Therefore, cultural competence must be emphasized in PEI programs.

Cultural Competence means incorporating and working to achieve cultural competence goals into all aspects of policy-making, program design, administration and service delivery. Each system and program is assessed for the strengths and weaknesses of its proficiency to achieve these goals. The infrastructure of a service, program or system is transformed, and new protocol and procedure are developed, as necessary to achieve these goals.

#### Individual/Family-driven Programs and Interventions, with Specific Attention to Individuals from Underserved Communities

In an individual/family-driven system, adults and families of children and youth identify their needs and preferences that lead to the programs and services that will be most effective for them. Their needs and preferences drive the policy and financing decisions that affect them.

Increasing opportunities for participants to have greater choices over types of programs and interventions, providers, and how service dollars are spent, empowers participants, facilitates recovery, and shifts the incentives towards a system that promotes learning, self-monitoring and accountability. Increasing choice protects individuals and encourages quality. (Source: The President's New Freedom Commission on Mental Health – *Achieving the Promise Transforming Mental Health Care in America*.)

#### Wellness Focus, Which Includes the Concepts of Resilience and Recovery

Programs and interventions are designed with an understanding that many mental health problems are preventable, early intervention is cost effective in terms of dollars and human suffering, and recovery is expected.

Resilience refers to the personal qualities of optimism and hope, and the personal traits of good problem solving skills that lead individuals to live, work and learn with a sense of mastery and competence. Research has shown that resilience is fostered by positive experiences in childhood at home, in school and in the community. When children encounter negative experiences at home, at school and in the community, mental health programs and interventions that teach good problem solving skills, optimism and hope can build and enhance resilience in children. (Source: California Family Partnership Association, March 2005.)

Recovery refers to the process in which people who have a mental health problem are able to live, work, learn and participate fully in their communities. For some individuals, recovery means recovering certain aspects of their lives and the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery in service planning encourages and supports hope.

#### Integrated Service Experience for Individuals and their Families

Recent racially/ethnically and culturally specific interviews with key informants and focus groups on PEI priorities reaffirmed the complex needs of underserved communities. While PEI funds will not be able to provide all of the needed services, PEI programs can place mental health services in locations where participants obtain other critical supports, can help link participants to other needed services and assist participants in navigating other systems. Of particular importance are programs in the areas of substance abuse prevention and treatment; community, personal and sexual violence prevention and intervention; and basic needs, such as food, housing and employment. Working with other organizations and agencies to leverage resources for comprehensive mental health programs and coordinated services is a PEI principle as well.

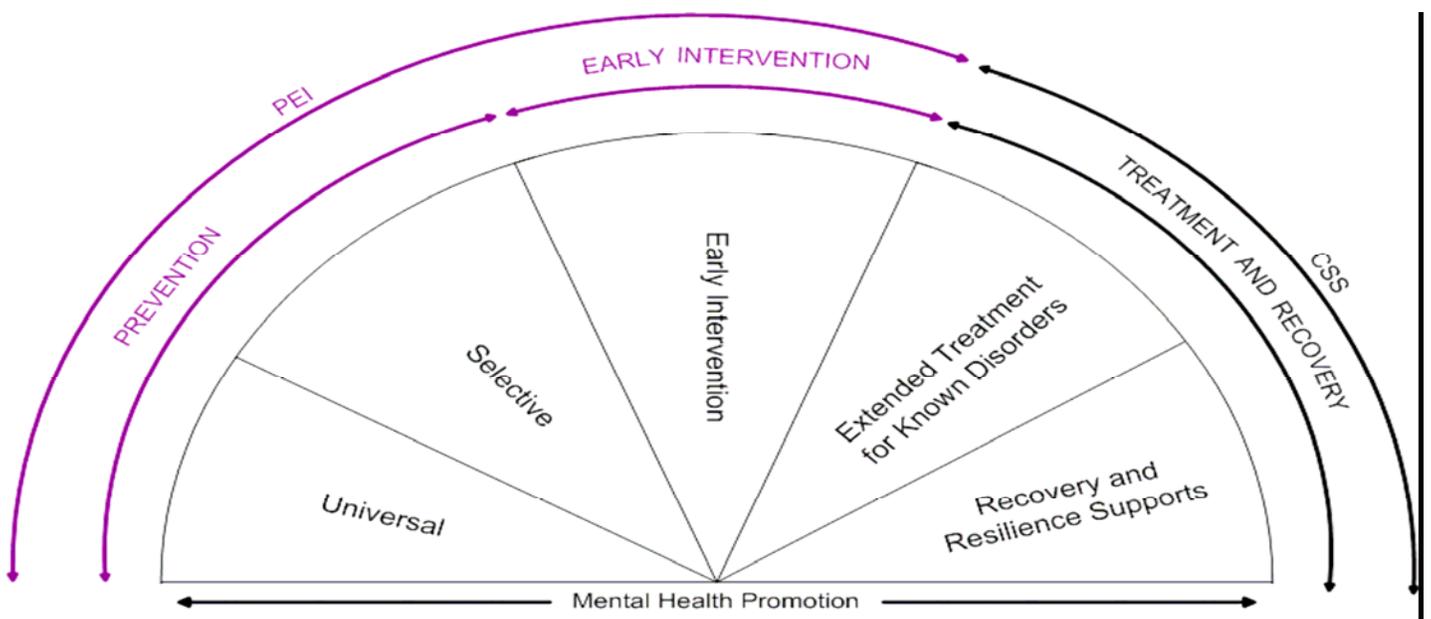
#### Outcomes-based Program Design

There is a significant amount of flexibility in the local design of PEI projects, placing the emphasis on intended outcomes for individuals and families; programs and systems; and communities. PEI projects should include a combination of programs based on a logic model and a high likelihood of effectiveness (evidence-based practices, promising practices, locally proven practices, optimal point of intervention) to achieve PEI outcomes, use a methodology to demonstrate outcomes and advance program improvement and learning.

<b>PEI Key Community Mental Health Needs</b>
<b>Disparities in Access to Mental Health Services</b>
PEI efforts will 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.
<b>Psycho-Social Impact of Trauma</b>
PEI efforts will reduce the negative psycho-social impact of trauma on all ages.
<b>At-Risk Children, Youth, and Young Adult Populations</b>
PEI efforts will increase prevention efforts and response to early signs of emotional and behavioral health problems among specific at-risk populations.
<b>Stigma and Discrimination</b>
PEI will reduce stigma and discrimination affecting individuals with mental health illness and mental health problems.
<b>Suicide Risk</b>
PEI will increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide.

<b>PEI Priority Populations</b>
<b>Underserved Cultural Populations</b>
PEI projects address those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, etc.) and would benefit from Prevention and Early Intervention programs and interventions.
<b>Individuals Experiencing Onset of Serious Psychiatric Illness</b>
Those identified by providers, including but not limited to primary health care, as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service.
<b>Children/Youth in Stressed Families</b>
Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of care-giving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.
<b>Trauma-Exposed</b>
Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.
<b>Children/Youth at Risk for School Failure</b>
Due to unaddressed emotional and behavioral problems.
<b>Children/Youth at Risk of or Experiencing Juvenile Justice Involvement</b>
Those with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through Community Services and Supports (CSS).

Mental Health Intervention Spectrum Diagram



Source: Adapted from Mrazek and Haggerty (1994) and Commonwealth of Australia (2000)

**Prevention**

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

MHSA purposes, IOM's **Indicated** prevention category fits into the operational definition for Early Intervention, as explained in the next section).

Prevention interventions may be classified according to their target groups (IOM):

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

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

Prevention in mental health involves reducing risk factors or stressors, building protective factors and skills and increasing support. Prevention promotes positive cognitive, social and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances. MHSA calls for an approach to prevention that is integrated, accessible, culturally competent, strengths-based, effective, and that targets investments with the aim of avoiding costs (in human suffering and resources) for treatment services.

Generally, there are no time limits imposed on prevention programs. Cost sharing is a viable option for many prevention programs, especially those that serve multiple purposes (e.g., universal access to voluntary early childhood or maternal depression screening; youth development; constructive parenting education; social and support groups; health guidance).

There may be a role for PEI funds to be used in mental health oriented activities within broad community-wide health promotion approaches targeting one or more PEI priority populations when these are collaboratively planned, funded and implemented with other organizations and achieve PEI mental health outcomes at the individual/family, program/system or community levels.

The PEI Resource Materials are organized in the following sections:

PEI Priority Populations (all are inclusive of Underserved Cultural Populations):

1. Trauma-Exposed Individuals
2. Individuals Experiencing Onset of Serious Psychiatric Illness
3. Children and Youth in Stressed Families
4. Children and Youth at Risk for School Failure
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement

Key PEI Community Needs:

6. Suicide Prevention

## 7. Reduction of Stigma and Discrimination

### Early Intervention

Early Intervention is directed toward individuals and families for whom a short-duration (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services; or to prevent a mental health problem from getting worse. (Examples: mental health consultation/with interventions in child care environments; parent-child interaction training for children with behavioral problems; anger management guidance; and socialization programs with a mental health emphasis for home-bound older adults with signs of depression)

For individuals participating in PEI programs, the Early Intervention element:

- Addresses a condition early in its manifestation
- Is of relatively low intensity
- Is of relatively short duration (usually less than one year)
- Has the goal of supporting well-being in major life domains and avoiding the need for more extensive mental health services
- May include individual screening for confirmation of potential mental health needs

Please refer to the Mental Health Intervention Spectrum shown on Page 6.

### Prevention and Early Intervention as a Whole

An objective of PEI is to increase capacity for mental health prevention and early intervention programs led by appropriately trained and supervised individuals in organizations and systems where people in the community currently go for purposes other than mental health treatment services.

PEI programs have the following characteristics:

- 1) Consistent with MHS transformational principles; potential program participants and their families are involved in planning; implementing and evaluating PEI programs.
- 2) Programs are often designed and implemented in collaboration with other systems and/or organizations.
- 3) Programs are generally delivered in a natural community setting (e.g., tribal/Native American center, refugee resettlement agency, infant/toddler programs, preschool and school, family resource center, juvenile justice probation department, comprehensive services for home-bound older adults, primary health care, community clinic or health center, community-wide wellness center).
- 4) Programs link 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 another appropriate mental health services provider. Programs help individuals navigate systems (e.g., understand Medi-Cal or private health plan benefits and identify providers) to obtain needed services.
- 5) Programs recognize the underlying role of poverty and other environmental and social factors that impact individuals' wellness, therefore programs also help link individuals and family members to other needed

services provided by grassroots organizations and local agencies, particularly in the areas of substance abuse treatment; community, family or sexual violence prevention and intervention; and basic needs, such as food, housing and employment.

6) Programs are consistent with non-supplant requirements, collaboration and leveraging principles and all MHSA statutory and regulatory requirements.

PEI funding is to be used to achieve specific PEI outcomes for individuals, programs/systems and communities. PEI funding is to be used to prevent mental health problems or to intervene early with 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 Individuals Experiencing At Risk Mental

State (ARMS) or First Onset of a Serious Psychiatric Illness with Psychotic Features

There is an exception for use of PEI funds for the type of program and interventions described in the PEI Resource Materials for individuals experiencing ARMS or First onset of a serious psychiatric illness with psychotic features, (or similar programs with comparable effectiveness). The standards of low intensity and short duration do not apply to services for individuals experiencing ARMS or first onset of a serious psychiatric illness with psychotic features that receive this type of transformational intervention.

Further Distinction of PEI from CSS

Some of the CSS Workplans (particularly in the Outreach and Engagement element) contain a variety of partnerships with non-mental health entities to improve the identification of mental health issues, enhance referral relationships, co-locate services and build the capacity of these entities to deliver mental health services. Many county CSS plans, for example, include partnerships with racial/ethnic and cultural community-based entities and/or with health care sites. These CSS Outreach and Engagement efforts have many elements in common with the recommended PEI programs. What distinguishes these CSS activities from PEI programs?

Distinction in Intent and Practice: The intent of the CSS outreach and engagement programs was to reduce the barriers to services for individuals who would otherwise qualify for CSS mental health services; i.e., persons with serious mental illness or children/youth with serious emotional disturbances. To distinguish, the intent of the PEI programs 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.

MHSA Prevention & Early Intervention Workgroup Recommended Plan Worksheet

Plan Name: \_\_\_\_\_ Priority Number: \_\_\_\_\_

Workgroup (check one):  Children (0-17)  TAY (18-25)  Adults (26-59)  Older Adults (60+)

Age Group				Key Needs				Priority Population					Holistic		Financially Feasible		P or EI		Measurable Outcomes				
Children (0-17)	TAY (18-25)	Adults (26-59)	Older Adults (60+)	Disparities in access	Psycho-social trauma impact	At risk 0-25	Stigma & discrimination	Suicide risk	Underserved cultural	First break	0-25 in stressed families	Trauma-exposed	0-25 at risk for school failure	0-25 in juvenile justice	Community integration	Family integration	High	Low	Prevention	Early Intervention	Yes,	No	Maybe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Plan Details (estimated/approximated):

What	What is the plan going to do?											
	What are the expected measurable outcomes?											
	What equipment/supplies will be necessary?											
Who	Who is will be involved in the implementation? List as many as applicable.	<table border="1"> <thead> <tr> <th>Name of Organization</th> <th>Type of Organization</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Name of Organization	Type of Organization								
		Name of Organization	Type of Organization									
Who will provide the staffing and support?												
How	How many people will it serve yearly?											
	How will the plan be marketed?											
	How many staff will be required?											
When	When will the services be offered (how often)?											
Where	Where will the services be provided? Specific or type of location.											
Why	Why should this plan be implement? Why is it necessary?											
How Much	How much will it cost per year?											

## Contact Details

Who		Why
MHSA Coordination Team	Jennifer Arnold, LMFT MHSA Coordinator (661) 868-6813 <a href="mailto:jarnold@co.kern.ca.us">jarnold@co.kern.ca.us</a>	Questions regarding public relations, releases, statements, general questions on who is in charge of what, meeting dates, and any other information relating to the general public or staff.
	Amy Grundvig Technical Analyst (661) 868-6676 <a href="mailto:agrundvig@co.kern.ca.us">agrundvig@co.kern.ca.us</a>	Any technical questions about forms, charts, tables, processes, analysis, and the like. Details on where meetings will be held, where to get copies of documents, processes and procedures, or any other MHSA technical questions.
	Quang Nguyen MHSA Accountant (661) 868-6696 <a href="mailto:dnguyen@co.kern.ca.us">dnguyen@co.kern.ca.us</a>	Questions related to MHSA monies. Anything regarding when, how much, and who will receive which monies.
Children Workgroup	Deanna Cloud (661) 868-6707 <a href="mailto:dcloud@co.kern.ca.us">dcloud@co.kern.ca.us</a>	Questions relating to work being done in the Children's workgroup prior to the final taskforce meeting.
	Linda Hoyle (661) 322-1081 <a href="mailto:lhoyle@hwmcgc.org">lhoyle@hwmcgc.org</a>	
	Chris Reilly (661) 845-3717 <a href="mailto:reillyc@clincasierravista.org">reillyc@clincasierravista.org</a>	
TAY Workgroup	Cathy Monsibais (661) 868-6465 <a href="mailto:cmonsibais@co.kern.ca.us">cmonsibais@co.kern.ca.us</a>	Questions relating to work being done in the TAY's workgroup prior to the final taskforce meeting.
Adult Workgroup	Bill Brooks (661) 822-3081 <a href="mailto:bbrooks@provcorp.com">bbrooks@provcorp.com</a>	Questions relating to work being done in the Adult's workgroup prior to the final taskforce meeting.
	Laurie Slate (661) 868-5059 <a href="mailto:lslate@co.kern.ca.us">lslate@co.kern.ca.us</a>	
	Bill Walker (661) 868-8155 <a href="mailto:bwalker@co.kern.ca.us">bwalker@co.kern.ca.us</a>	
Older Adult Workgroup	Paul Rozell (661) 868-1013 <a href="mailto:prozell@co.kern.ca.us">prozell@co.kern.ca.us</a>	Questions relating to work being done in the Older Adult's workgroup prior to the final taskforce meeting.
	Peg Walker (661) 868-5050 <a href="mailto:pwalker@co.kern.ca.us">pwalker@co.kern.ca.us</a>	

Kern County Mental Health Department  
MHSa Prevention and Early Intervention  
Workgroup Planning Process

<b>What</b>	<b>Who</b>	<b>How</b>	<b>When</b>	<b>Where</b>	<b>Why</b>
PEI Q&A	Amy, Jennifer	Icebreaker	1 <sup>st</sup> workgroup meeting	TBD	Questions to stir up creativity and clarify PEI
First Brainstorming Session	Workgroup	Write down every idea that comes to mind, even if it sounds crazy or impossible. - Place Post-its on board	1 <sup>st</sup> workgroup meeting	3"x3" Post-it notes on Whiteboard	Use Post-It notes to avoid criticizing ideas too early, which would hinder creativity -Seeing other's ideas on the board will stir up new ideas.
Preliminary List of Ideas	Amy, Jennifer	Make list of ideas from the notes on the whiteboard	1 <sup>st</sup> workgroup meeting	MS Word	To present to the group in the following session
Organize and critique the Preliminary List of Ideas	Amy, Jennifer	Using the Feasibility Rubric for Brainstorming Ideas (PEI Rubric)	After the 1 <sup>st</sup> workgroup meeting	PEI Rubric	To present to the workgroup an organized list of their ideas and the feasibility of each one.
Present the Organized Preliminary List of Ideas	Amy, Jennifer, and Workgroup	Using the PEI Rubric	2 <sup>nd</sup> workgroup meeting	Handouts	For the group to review their list and comment on the critic
Work on the Organized Preliminary List of Ideas	Workgroup	Reviewing the ideas with the PEI Rubric	2 <sup>nd</sup> workgroup meeting	Verbally	Decide which ideas they want to keep and which they want to continue working on
Seconds Brainstorming Session	Workgroup	Finding solutions for unfeasible ideas that the group wants to pursuit	2 <sup>nd</sup> workgroup meeting	On big Post-it chart	Some unfeasible ideas will become feasible if done differently
Revise Idea Chart	Workgroup	Make changes and additions to chart	2 <sup>nd</sup> workgroup meeting	Whiteboard	To see a full view of possibilities
List of Feasible Ideas	Amy, Jennifer, and Workgroup	Make list of ideas	2 <sup>nd</sup> workgroup meeting	MS Word	To present to the group in the following session
Organize and Critique Second list of Feasible Ideas	Amy, Jennifer	Using the Rubric	Following days	PEI Rubric	To present to the workgroup an organized list of their ideas and the feasibility of each one.

Present Second List of Feasible Ideas	Amy, Jennifer	Using the PEI Rubric	3 <sup>rd</sup> workgroup meeting	Handouts	For the group to review their list and comment on the critic
Work on Second List of Feasible Ideas	Workgroup	Discussion	3 <sup>rd</sup> workgroup meeting	Verbally	Decide which ideas they want to keep
Approve Secondary List	Workgroup	Using anonymous prioritizing method	3 <sup>rd</sup> workgroup meeting	PEI Rubric	To have a list of feasible working plans
Define plan details	Workgroup	Decide what will be done, not how	3 <sup>rd</sup> workgroup meeting	Using standard plan frame form	Management will work on how to implement the plans
Submit list of recommended plans to the MHS Taskforce	Amy, Jennifer	Using plan frame form	Taskforce meeting	Handout	For the taskforce to review all plans in the same format
Notify Workgroups of approved plans	Jennifer	By e-mail and phone	Following taskforce meeting	E-mail	To keep everyone informed and on the same page
Voting by stakeholders	Stakeholders	By mail	Following taskforce meeting	Paper Ballot	To allow for anonymous voting that will deem a fair result for the plan.
Write plan	Amy, Jennifer	Using guidelines	After communication	Exhibits, forms	To submit for approval
Present plan the KCMH management	Amy, Jennifer, Quang	Using management meeting	Once written	Plan	To get approval, revisions and move forward
Make final plan	Amy, Jennifer	Taking guidelines and comments	After KCMH management approval	Exhibits and plan forms	To with state guidelines
BHB Notification	Jennifer	Share plan verbally	After KCMH management approval	BHB meeting	Communicate and seek approval
30 day comment period	Jennifer	Publishing on the public website	After BHB approval	MH Net and CMH Sites	CCRs, laws, Communication
Public stakeholder meetings	Amy, Jennifer	Meet and share plan	During 30 day comment period	Selected locations	To ask for comments and communicate
BHB Approval	Jennifer	Share plan verbally	After stakeholder meetings	BHB meeting	Seek approval
B.O.S. Approval	Jennifer and Jim	Share plan verbally	After BHB approval	B.O.S. meeting	Seek approval
Submit to state	Jennifer	Using designated communication pathways	After B.O.S. approval	Written plan	Seek approval for funding

Kern County Mental Health  
 MHSA Prevention and Early Intervention  
 Planning Timeline - Tentative



**Feasibility Rubric for Brainstorming Ideas**  
 Based on DMH PEI guidelines for approval of projects  
 Please check all that apply for each Idea

Idea	Age Group				Key Needs					Priority Population						Holistic	Financial Feas.	P or EI	Evaluatable?	Comments/Notes	Priority #	
	Children (0-17)	TAY (18-25)	Adults (26-59)	Older Adults (60+)	Disparities in access	Psycho-social trauma impact	At risk 0-25	Stigma & discrimination	Suicide risk	Underserved cultural	First break	0-25 in stressed families	Trauma-exposed	0-25 at risk for school failure	0-25 in juvenile justice							Community integration
Workgroup: <input type="checkbox"/> Children (0-17) <input type="checkbox"/> TAY (18-25) <input type="checkbox"/> Adults (26-59) <input type="checkbox"/> Older Adults (60+)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High to low	Prevention or early intervention	Yes, no, maybe							
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
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