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Mental Health • Alcohol & Drug Prevention and Treatment Programs

May 12, 2010

California Department of Mental Health
MHSA Oversight and Accountability Commission
1300 17th Street – Suite 1000
Sacramento, CA 95811

Re: Prevention and Early Intervention (PEI) Plan and Expenditure Request

Kings County is pleased to submit the County's Prevention and Early Intervention Three-Year Program and Expenditure Plan.

In addition, we are submitting a Prudent Reserve Expenditure Request to be considered for approval by the Commission *at the same time* as the PEI plan review for Kings County.

I would like to express my appreciation of the Commission's ongoing support and technical assistance during this planning and development process. Should you have any questions, please don't hesitate to call me at the below listed number.

Respectfully submitted,



Mary Anne Ford Sherman, Director
Behavioral Health Administration

Enclosures

Mental Health Services Act (MHSA)
 Community Services and Supports (CSS) and Prevention and Early Intervention (PEI)
 FY 2009/10 Prudent Reserve Funding Request

County: KINGS

Date: 05/03/2010

Instructions: Utilizing the following format please provide a plan for achieving and maintaining a local Prudent Reserve.

Most Recent Annual Approved Funding Level

A. CSS Annual Funding Level for Services	\$	\$2,570,052	
B. PEI Annual Funding Level for Services	\$	\$684,327	
Total (A + B):			\$ <u>\$3,254,379</u>

C. Less: Total Non-Recurring Expenditures CSS and PEI	-	\$276,906	
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Subtract any identified non-recurring expenditures for CSS and/or PEI, included in A and B above.

D. Plus: Total Administration CSS and PEI	+	\$479,720	
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Enter the total administration funds requested for CSS and/or PEI.

E. Sub-total			<u>\$3,457,193</u>
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F. Maximum Prudent Reserve (50%)			<u>\$1,728,597</u>
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Enter 50%, or one-half, of the line item E sub-total. This is the estimated amount the County must achieve and maintain as a local Prudent Reserve by June 30, 2011.

G. Prudent Reserve Balance from Prior Approvals			<u>\$1,447,473</u>
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Enter the total amounts previously approved through Plan Updates for the local Prudent Reserve.

Amounts Requested to Dedicate to Local Prudent Reserve

H. Plus: CSS Component
 Enter the Sub-total amount of funding requested for CSS in H.

*FY 2009/10	Unapproved Funds	\$	\$0	
	Unspent Funds	\$	\$0	
*FY 2008/09	Unapproved Funds	\$	\$0	
	Unspent Funds	\$	\$0	
FY 2007/08	Unapproved Funds	\$	\$0	
	Unspent Funds	\$	\$0	
	Sub-total:			+ <u>\$0</u>

I. Plus: PEI Component
 Enter the Sub-total amount of funding requested for PEI in I.

FY 2007/08	Unapproved Funds	\$	\$281,124	
	Unspent Funds	\$	\$0	
	Sub-total:			+ <u>\$281,124</u>

J. Total Amount Requested to Dedicate to Local Prudent Reserve \$281,124
Enter the sum of lines H and I.

K. Prudent Reserve Balance \$1,728,597
Enter the sum of G and J.

L. Prudent Reserve Shortfall to Achieving 50% (Describe below) \$0

Subtract line K from line F. A positive amount indicates that the County has not dedicated sufficient funding to the local Prudent Reserve. Please describe how the County intends to reach the 50% requirement by June 30, 2011; for example indicate future increases in CSS planning estimates that will be dedicated to the local Prudent Reserve before funding any program expansion.

Signature _____

Name and Title _____

**Per WIC Section 5892 (b), Counties shall not exceed 20% of the average amount of funds allocated to the County for the previous five years.*



**Kings County
Behavioral Health Department**

450 Kings County Drive, Suite 104
Hanford, CA 93230

**MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION
THREE-YEAR PROGRAM AND EXPENDITURE PLAN**

IN ACCORDANCE WITH THE
DMH PROPOSED GUIDELINES
INFO NOTICE 07-19 AND 08-23

MAY 11, 2010

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN

ACKNOWLEDGEMENTS

Kings County Behavioral Health (KCBH) wishes to thank the many consumers, family members, and other community members who gave their time and energy to this process. Their words of wisdom and stories of optimism, wellness, resiliency and recovery have shaped every component of this plan.

In addition, KCBH wishes to recognize the contributions of the members of the MHSA Planning Council who helped guide the development of the planning process and the creation of this plan.

Prepared by Resource Development Associates

Project Team:

Mary Anne Ford Sherman, KCBH, Director
Ronda Braithwaite, KCBH, MHSA Coordinator

Jennifer Susskind, RDA, Project Lead
Diana Sanders, RDA
Rima Spight, RDA

Table of Contents:

A.	PEI Component of the Three-Year Program and Expenditure Plan Face Sheet (Form # 1)	3
B.	PEI Community Program Planning Process (Form # 2)	4
C.	PEI Project Summary (Form # 3)	21
	1. Project #1: Intervention for Depression and Anxiety (Young Children and Families)	
	2. Project #2: Youth Wellness Center (School-aged Youth and Transitional-aged Youth)	
	3. Project #3: Mental Health Liaison (All Ages)	
	4. Project #4: Promotores Mental Health Outreach (All Ages)	
	4. Project #5: Grandparents as Parents Support and Respite (Older Adults)	
D.	PEI Revenue and Expenditure Budget Worksheet (Form # 4)	56
E.	PEI Administration Budget Worksheet (Form # 5)	63
F.	Prevention and Early Intervention Budget Summary (Form # 6)	66
G.	Local Evaluation of a PEI Project (Form # 7)	67
H.	Appendices	74

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

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

County Name: Kings	Date: April 2010
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COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):

County Mental Health Director	Project Lead
Name: Mary Anne Ford Sherman	Name: Ronda Braithwaite
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Mailing Address: 450 Kings County Drive, Suite 104 Hanford CA 93230	

AUTHORIZING SIGNATURE

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

Signature _____

County Mental Health Director

Date

Executed at 450 Kings Dr., Hanford, CA 93230, California

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form No. 2

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

County: Kings

Date: 4/1/2010

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

Mary Anne Ford Sherman, the Director of Kings County Behavioral Health (KCBH), lent her vision and leadership to this community planning process. Under her direction, the Planning Team, composed of Ms. Sherman, Ronda Braithwaite, the MHSA Coordinator, and Resource Development Associates (RDA), a consulting firm with extensive mental health planning expertise, conducted a comprehensive, transformation-driven process rooted in community participation. The Planning Team was charged with:

- Planning the framework and design;
- Convening the MHSA Planning Council;
- Conducting community outreach;
- Conducting the discovery phase: Community Assessment of Needs and Assets;
- Strategy development and research into best practices; and
- Developing Consensus on PEI projects.

b. Coordination and management of the Community Program Planning Process

Working in tandem, Ms. Braithwaite and Jennifer Susskind of RDA provided day-to-day management of the planning process, and in an attempt to garner participation across the myriad ethnic, cultural and geographic communities in Kings, developed an inclusive outreach strategy involving phone and email notifications, publically posted flyers, newsletters and media announcements. Beginning with a list of participants from past MHSA planning efforts, the MHSA outreach database grew to include over 330 individuals.

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form No. 2

Through emails and/or phone calls, these individuals were notified of all information relevant to PEI and the planning process. Guided by the MHSA Planning Council and stakeholder feedback, the Planning Team continuously tailored planning events to reach a broader, more representative sampling of Kings County residents.

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

The MHSA Planning Council was established to assure that stakeholders contributed to all levels of the planning process. The MHSA Planning Council helped to further identify key stakeholders who could contribute valuable insight on specific populations; reviewed the results of the PEI needs assessment; guided the development of PEI strategies; and reviewed the proposed projects described in this plan in order to ensure that it responded to stakeholder priorities. During the Planning Process, the Planning Council met three times. A formal list of members is included below:

Name	Affiliation
Anthony Gracian	BH Advisory Board
Catherine Kemp	Local Child Care Planning Council
Cee Hice-Douglas	BH Advisory Board
Danette Welch-Hughes	BH Advisory Board
Debra Allen	BH Advisory Board
Dee Avila	BH Advisory Board
Fabiola DeCaratachea	Kings County First 5
Jean Scanlan	BH Advisory Board
Joe Neves	BH Advisory Board, Kings County Board of Supervisors
Karen McConnel	Director of Special Services, Hanford USD
Kathy Cruz	Corcoran Family Resource Center
Mary Gonzales-Gomez	BH Advisory Board
Nell Lobdell	Kings Partnership for Prevention
Pat Oliver	BH Advisory Board
Peri Neos	BH Advisory Board
Sharon DeMasters	Commission on Aging
Sue Braz	BH Advisory Board, Champions Recovery Alternatives
Susan Steward	Kings County Office of Ed. Foster Youth Services
Tina Garcia	BH Advisory Board, Child Protective Services
Tom Doyle	BH Advisory Board
Vincent Peterson	BH Advisory Board

2. Explain how the county ensured that the stakeholder participation process

PEI COMMUNITY PROGRAM PLANNING PROCESS**Form No. 2****accomplished the following objectives (please provide examples):**

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

Situated in the center of California, Kings County is home to a diverse ethnic, cultural, geographic, and economic community. A Naval Air Station, three State prisons, and agricultural/ranch lands are the largest employers, and are also responsible for many of the transitions experienced by community members. For example, seasonal farming accounts for almost 20% of jobs countywide. In many cases, employment is not guaranteed year-round, and farm-workers must travel to different locations depending upon crops' growing seasons. As another example of transition, many families move to the County following a relative's incarceration, and face particular challenges due to relocation and family separation. Kings is also home to many family members of military personnel deployed overseas.

Given the complexity and the variety socio-economic and geographic conditions experienced by County residents, the Planning Team prioritized efforts to reach communities that had been identified during the CSS planning process as underserved.

High levels of poverty, unemployment and rural isolation affect many residents of Kings County. Public Transportation is limited, and was repeatedly identified as a barrier to both participation in services and planning activities. To help mitigate this issue, Key Informant Interviews were conducted by phone and focused-discussion groups were held in comfortable, accessible community locations at times most convenient for participants. Conversations with Child Welfare workers, Behavioral Health staff, the Commission on Aging, law enforcement and emergency personnel all contributed to a greater understanding of the needs of populations most vulnerable to the negative effects of these particular life challenges. Gift cards were provided as a gesture of appreciation to focus group participants.

PEI COMMUNITY PROGRAM PLANNING PROCESS**Form No. 2**

Almost 45% of the Kings County population is Hispanic/Latino, with a reported 37% speaking little to no English. To engender participation from this large, underrepresented group, the Planning Team identified key Spanish-speaking community members to aid in outreach for events. Of particular note, the Planning Team would like to thank Fabiola DeCaratachea, First 5, and Anita Solis, Migrant Education, for their outreach for the Spanish speaking focus group and the PEI Community Prioritization Meeting. In addition to a monolingual Spanish focus group, simultaneous Spanish translation services were provided at the Prioritization Meeting. As a result of making planning activities more accessible for this community, over one-fifth of all participants were Latino/Hispanic.

Demographics	% Population, 2000	% Planning Participants
Race/ethnicity		
White	39.7%	60.1%
Hispanic	46.0%*	22.5%
Black	8.3%	6.0%
Asian/Pacific Islander	3.1%	<1%
American Indian	1.3%	3.4%
Multiracial/other	1.6%	7.2%

(source: census)

It should be noted that despite the language-specific focus groups and language interpretation at meetings, more work needs to be done to bring the Spanish-speaking community to the planning table.

Kings County is home to the Tachi Yokut Tribe, which has lived in the San Joaquin Valley for centuries. The tribe runs the Tachi Palace Hotel and Casino and several community programs, including the Inter Spirit Drug and Alcohol Program, an Indian Health Services Medical Clinic, an early education center and a youth after school program. The planning process included a focus group with Tribal Administrators and Native American service providers of the Santa Rosa Rancheria. The Planning Team wishes to thank Julian Garza of Owens Valley Career Development, Tribal TANF for assisting with the outreach for this focus group.

PEI COMMUNITY PROGRAM PLANNING PROCESS**Form No. 2**

Targeted outreach to the TAY and senior populations yielded relatively high amounts of participation from both groups. Special meetings were set up to ensure that community members felt comfortable sharing their personal information. Focus groups with TAY provided an opportunity for discussion on their own experiences and that of peers, while a focus group with older adults concentrated on mental health prevention and early intervention respective to aging.

Demographic information was collected at all events, and reviewed continuously to help guide the outreach effort. Participants were asked to provide their age, gender, ethnic/cultural background and could chose to self-identify as a consumer, family member or both. A copy of the demographic form is included in Appendix F.

- 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 Planning Team used multiple mediums to inform residents about the PEI planning process and to educate them about the goals and opportunities provided by MHSA. The following are specific examples of outreach activities implemented to attract a wide range of participation:

1) Community Newsletters and Planning Updates

The Planning Team initiated the planning process in November 2009 by publishing a two-page, color newsletter summarizing the CSS planning process and introducing the PEI component. The newsletter was emailed or mailed to a list of participants from earlier planning processes as well as a wide variety of stakeholders with PEI-related interests, such as school administrators, early childhood specialists, etc. Prior to all meetings, planning updates were sent by email, with flyers stating meeting dates and times attached. In addition, the Planning Team posted the newsletter at Family Resource Centers, Libraries, at the Oak Wellness Center and in County buildings. An introductory letter accompanying the newsletter invited service providers to post newsletters and flyers about the first MHSA Planning Council. In an effort to reach the broadest

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form No. 2

spectrum of people possible, press releases announcing planning events were sent to local media outlets, including Kings County's local news source, the Hanford Sentinel.

2) *Key Informant Interviews (17 interviews conducted)*

Early in the planning process, KCBH identified a list of stakeholders with knowledge of key community mental health needs and priority populations. In late 2009, these individuals were interviewed about their role in the mental health system, and asked to identify current age specific PEI needs and gaps in PEI-related services to underserved communities. In addition, the interviewees were asked to recommend strategies for addressing these gaps. A copy of the Key Informant Interview Protocol is included in Appendix D. As the table below demonstrates, interviews were held with a broad range of stakeholders including consumers and family members, behavioral health staff and community providers, representatives of geographically dispersed Family Resource Centers, public health officials, police and probation, First 5, and elected officials.

Name	Affiliation
Brenda Johnson, Chuck Garon, Rich Smith, Kathy Brown	Kings View Counseling Services
Steve Brum, Dan Beair, Kelly Zuniga	Kings County Probation Department
Dean Hoover	Hanford Police Department, Crisis Intervention Team Coordinator
Devondria Sanchez	KCBH Patient's Rights Advocate
Dr. Lori DeCarvalho	Adventist Health Behavioral Health Services
Joe Neves	BH Advisory Board, Kings County Board of Supervisors
Judy Newton	Program Director, United Cerebral Palsy
Karen McConnell	Director of Special Services, Hanford USD
Kathy Cruz	Corcoran Family Resource Center
Keith Winkler	Director of Public Health
Lisa Watson	Executive Director, First 5
Minetta Costa	Program Manager, California Forensic Medical Group
Nell Lobdell	Director, Kings Partnership for Prevention
Sharon DeMasters	Director, Commission on Aging
Sherry Johnson, LCSW	Director, MH Services, Naval Air Station, Child Abuse Prevention Coordinating Council
Sue Wiezenhaus-Braz	Champions Recovery Alternatives, Hannah's House
Tina Garcia	Program Manager, Kings County Human Services, CPS

3) *Focused-Discussion Groups (11 groups, 139 participants)*

PEI COMMUNITY PROGRAM PLANNING PROCESS**Form No. 2**

Under the direction of KCBH, RDA facilitated eleven discussion groups to encourage meaningful conversation between individuals within specific target populations such as Behavioral Health staff, Child Welfare, consumers, family members, TAYs, seniors, Native Americans and Latinos. Similar to Key Informant Interviews, participants were asked a series of questions about the strengths and challenges of the behavioral health system and how to address those challenges. These groups provided community members with a safe place to share experiences, and collectively deliberate solutions. Focus groups were facilitated by Jennifer Susskind and Diana Sanders.

- **5150 Forum 6 participants** A discussion group held with members of the local 5150 Forum acknowledged the success they experienced building collaboration between police, emergency personnel, Kings View and Behavioral Health, while also recognizing the need for greater system development.
- **Behavioral Health and Kings View Staff 15 participants** Detailed the prevention needs of the County and discussed how increasing staff cultural competence would help them to engage a greater portion of the community in mental health services.
- **Child Welfare Services 6 participants** Shared the challenges faced by foster youth and youth and parents involved in CPS. Spoke eloquently about child abuse, neglect, poverty, unemployment, isolation, cultural assimilation and parental substance abuse, and expressed interest in developing closer ties between CPS and Behavioral Health.
- **Commission on Aging 16 participants** Spoke about issues of aging, transition, loss, depression, isolation, and how to overcome older adults' feeling of shame and the stigma often associated with seeking help.
- **Consumer Group 15 participants** Gave invaluable insight into the needs and opportunities in the current mental health system, as well as highlighting the strengths of consumers participating in their own wellness.
- **Family Member Support Group 11 participants** Offered perspective on how mental and emotional issues affect the whole family.

PEI COMMUNITY PROGRAM PLANNING PROCESS**Form No. 2**

- **FRC/First 5/Early Childhood 8 Participants** Discussed the importance of healthy early childhood growth and development, and the need for screening and identification of issues before enrollment in school.
- **K-12 18 participants** Described the needs of school-age children and support for their families.
- **Native American/Santa Rosa Rancheria 9 participants** Spoke about the need for greater cultural competence and increased services on the Rancheria, and how to increase collaboration between the Native American community and County Behavioral Health.
- **Spanish-Speakers 16 Participants** Examined the effects of geographic and cultural isolation, the lack of culturally specific community centers and services, and postulated on how to overcome stigma through education and bridge building efforts.
- **Transition Age Youth 19 participants** Shared the stress of growing up in a household undergoing transition, facing peer pressure, anger, and of the high number of teens participating in risky behaviors.

4) PEI Strategy Roundtables

After completing the interviews and focus groups, the planning team analyzed the qualitative participant data and quantitative mental health, public health, census and social service data to get a comprehensive picture of community needs. The Planning Team presented the needs assessment to the second MHSA Planning Council, along with an initial list of community-generated potential PEI strategies. To see the results of this qualitative needs assessment, see the PPT slides in Appendix H. During the second Planning Council meeting, in January 2010, members were invited to participate in strategy roundtable meetings.

The 4 strategy roundtables addressed the following age groups: 1) young children and their families; 2) transitional age youth; 3) adults and general populations; and 4) older adults. Each roundtable meeting included between 6 – 10 participants with age-specific experience. In

PEI COMMUNITY PROGRAM PLANNING PROCESS**Form No. 2**

addition, each group included family and consumer representation. During each strategy roundtable, participants were asked the following questions:

- *Which needs are most critical to providing high quality, outcome oriented services in Kings County?*
- *Which strategies are most applicable and feasible in Kings County?*
- *Are there any other strategies that have not been identified?*
- *Are there opportunities to leverage resources and community strengths to support these programs?*

The Strategy Roundtables resulted in a list of 6 – 8 emerging PEI strategies for each of the 4 age groups. Following the strategy roundtables, the Planning Team sought additional evidence based practices that aligned with the strategies and researched financial and practical feasibility and leverageable resources.

5) Community Prioritization Meeting

On February 19, 2010, the Planning Team facilitated a Community Prioritization Meeting to present the emergent PEI strategies and elicit guidance on which strategies best responded to the unique needs of Kings County. The meeting began with a PowerPoint presentation reviewing PEI goals, guidelines and funding amounts and presenting the 6 – 8 emergent strategies in each age group. In small groups, participants discussed the strategies and selected their top two choices for each age group. Group representatives reported their top strategies back to the whole room and a recorder tallied up the most popular strategies.

Asking community members to engage in small group discussions and collectively come to agreement on priority strategies resulted in individuals putting aside their advocacy roles and instead focusing on what was needed in the community as a whole. Furthermore, group discussions allowed community members to come to a deeper understanding of PEI projects, and many substantive suggestions from the meeting were incorporated into the proposed strategies. All worksheets from the meeting and the tally of votes supporting each project are included in the Appendices (J - K).

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form No. 2

6) Community Survey

A community survey was distributed at the first MHSA Planning Council meeting, asking members to prioritize key mental health needs, as defined by PEI guidelines, and which communities were most underserved in Kings County. Over thirty surveys were collected, and responses closely paralleled findings from the Key Informant Interviews and Focus Groups.

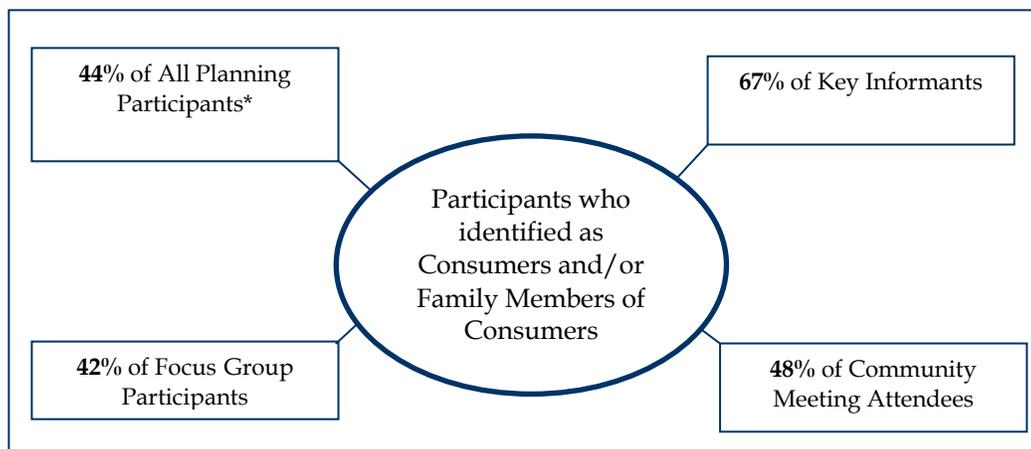
The resulting PEI Projects, described in this plan, reflect the broad input on community needs from the key informant interviews and focus groups; the more specific recommendations from the strategy roundtables; and the specific priorities of the community prioritization meetings.

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

Kings County Behavioral Health is committed to incorporating consumer and family member voice in service design and delivery. Understanding the challenges faced by consumers and their family members not only helps KCBH provide appropriate services and supports for those with mental illness, but their input can also help the department to understand how best to prevent mental illness in the first place. Consumer and family participation was encouraged throughout the planning process. In addition to the outreach strategies listed previously, all activities were aggressively advertised through the consumer-run Oak Wellness Center. This method resulted in high participation from consumers and their families, as shown in the table below.

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form No. 2



**Total % includes Planning Council members and Strategy Roundtable in addition to the opportunities for stakeholder involvement listed above*

Providing a safe space was crucial for eliciting honest discussion from consumers. An initial attempt at scheduling a focus group with consumers at the behavioral health building was rescheduled due to a shortage of participation. However, a second focus group held at the Oak Wellness Center met with great success— over 15 people participated.

A family focus group was also well-attended. The meeting revealed a deep desire for additional support for families members. Participants gave valuable insight into the frustration they experienced trying to understand a loved one's diagnosis and navigating the complex behavioral health system.

Overall, 44% of planning participants identified as consumers and/or family members of consumers.

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

PEI COMMUNITY PROGRAM PLANNING PROCESS**Form No. 2**

- 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

Understanding that mental illness effects not just the individual, but the community as a whole, the Planning Team strove to include community members representing all stakeholder groups in the County. Special effort was made to involve stakeholders with particular knowledge of young children with social, emotional and behavioral issues (First 5, United Cerebral Palsy, KCAO and Head Start, child care providers); at-risk youth (school administrators, school psychologists, special education teachers, juvenile probation and TAYs themselves); and those who often come in contact with people at the point of crisis (emergency workers, primary care providers and law enforcement; adult and child protective services).

As noted in the Section 2b, 44% of all participants self-identified as consumers and/or family members of consumers.

Providers of health and social services emerged as one of the most active stakeholder groups. Multiple interviews and focus groups were held with community and KCBH mental health providers, public health officials, foster care providers, and child protective services. Many participants stressed the need for developing greater outreach, referral and identification procedures between the different agencies.

A focus group with school staff helped to identify common challenges faced by youth in Kings, and involved participants from school districts all over the County including Shelly Baird, a school that teaches independent living and self-care to children with special needs.

Law enforcement was another key stakeholder group involved in the planning process, as they have knowledge of youth touched by the juvenile justice system, gang involved youth, incarcerated adults and their families, and individuals suffering from a mental or emotional break.

PEI COMMUNITY PROGRAM PLANNING PROCESS**Form No. 2**

Many other stakeholder groups contributed their time and energy to the planning process. The following is a partial list of organizations whose representatives participated in the planning activities:

Adventist Health	Kings County Child Care Planning Council
Area Agency on Aging	Kings County Jail
Avenal Community Health Center	Kings County Library
Avenal Family Connection	Kings County Local Child Care Planning Council
California Forensic Medical Group	Kings County Office of Education
Center for Independent Living, Visalia	Kings County Partnership for Prevention
Central Union School District	Kings County Public Guardian/ Veterans Services
Champions Recovery Alternatives	Kings County Public Health Department
Child Protective Services	Kings LOE SELPA
City and County Police Departments	Kings Rehab
Commission on Aging	Kings Rehabilitation Center
Corcoran Family Resource Center	Lemoore Naval Air Station
County Family Resource Centers	Lemoore Naval Air Station Family Support Center
County Probation	Lemoore Union High School District
Department of Public Safety	Migrant and Seasonal Head Start
First 5	Migrant Education
Hanford Elementary School District	Oaks Wellness Center
Hanford Joint Union High School District	Office of Education Foster Youth Services
Human Services Agency, CPS	Owens Valley Career Development Center/Tribal TANF
IHSS, County Public Authority	Santa Rosa Rancheria
Inter-Spirit Drug and Alcohol Program	United Cerebral Palsy
Kings Community Action Organization	United Way

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

Throughout its progression, the planning process provided an ideal vehicle for increasing community knowledge of both MHSA principles, and how an individual's needs and preferences can translate into real systems change. The Planning Team took every opportunity to spread awareness about phases of the planning process, opportunities to participate, funding availability and the goals of the PEI component. All worksheets and presentations began with the following definition:

The Purpose of Prevention and Early Intervention

- Engage persons prior to development of serious mental illness or emotional disturbance.

PEI COMMUNITY PROGRAM PLANNING PROCESS**Form No. 2**

- Alleviate the need for additional mental health treatment.
- Transition those with identifiable need to extended mental health treatment.

Prevention occurs prior to a diagnosis of mental illness.

- Universal targets the general population
- Selective targets groups whose risk of developing mental illness is higher than average

Early Intervention is directed toward individuals and families for whom a short-duration, low-intensity intervention is appropriate to improve a mental health problem or concern very early in its manifestation

- Reducing need for more intensive services
- Preventing mental health problem from getting worse

All outreach letters, flyers and email notifications included a summary of PEI definitions, guidelines, funding opportunities, and constant updates on how each activity contributed to development of the final plan. To aid in informed decision-making at the Community Prioritization meeting, participants were given results of the community needs assessment, educational materials listing different interventions, and a simple cost comparison to help stakeholders determine which potential PEI programs made the most sense for the community to invest in. Samples of the education and outreach tools have been included in the Appendices (A – C)

Furthermore, members of the Planning Team made themselves available by phone or email and at every meeting, distributed business cards and public comment cards inviting participants to share sensitive or confidential information and feedback about the planning process.

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

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

PEI COMMUNITY PROGRAM PLANNING PROCESS**Form No. 2**

The PEI planning process relied heavily on findings from the CSS plan. A core group of motivated stakeholders emerged during the CSS Community Planning Process. These stakeholders helped identify additional individuals and organizations who could lend valuable insight into the PEI Planning Process. Lessons from the CSS process also aided in the development of the outreach strategies, specifically, that a multifaceted approach must be utilized to reach all of the different ethnic, cultural and geographic communities in Kings County.

The CSS plan noted that consumers and family members have not historically participated in community forums in large numbers. The Planning Team worked to counteract this lack of mobilization by hosting planning activities in familiar, accessible venues where people would feel safer sharing personal information. The success of this strategy is illustrated by the high levels of consumer and family member participation described in section 2b.

By reviewing the plan and related documents, the Planning Team was able to draw on discoveries already made and come to a deeper understanding of community needs and opportunities. Participants in the PEI planning process reiterated many of the goals originally stated in the CSS plan, including:

- Increasing community knowledge regarding early signs of mental and behavioral issues;
- Further developing formal systems to engage underserved communities;
- Strengthening partnerships between providers and stakeholder groups;
- Enhancing linkages between FRCs, Behavioral Health and the Santa Rosa Rancheria
- Mitigating barriers in access due to geographic isolation and the limited availability of transportation; and
- Encouraging consumer and family member inclusion in decision-making and treatment.

PEI COMMUNITY PROGRAM PLANNING PROCESS**Form No. 2**

- 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.

The success of this planning effort is best demonstrated by the consistent participation and diversity of stakeholders. In spite of a growing sense of alarm about the current budget crisis, participants remained engaged and directed toward positive strategies. Community members spoke time and again about their vision for a system where tools for the early identification of mental health issues were wide-spread and readily available, where intervention was timely and appropriate, and community members experiencing SMI or SED experienced high quality of life. Many stakeholders participated in multiple events during different stages of the planning process. Recorded from sign-in sheets, the following totals show community participation during the various planning activities:

First MHSA Planning Council and Kick-Off Meeting	36 Attending
Key Informant Interviews	17 Completed
Focus Groups	11 Completed (139 participants)
Strategy Roundtables	20 Attending
Community Prioritization Meeting	59 Attending

Overall, 6.5% of participants were transition age youth, 17.5% were older adults, 44% were consumers and/or family members of consumers, and 39.8% represented ethnic/cultural groups previously identified as underserved.

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

- a. The date of the public hearing:

The public hearing was held on Monday, May 3, 2010. Jennifer Susskind, of Resource Development Associates, gave a brief presentation on the planning process and the proposed PEI projects. Following the presentation, the Mental Health board invited additional comments and input from community members. Following the hearing, the Mental Advisory Board voted unanimously to approve the PEI plan.

PEI COMMUNITY PROGRAM PLANNING PROCESS**Form No. 2**

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

On April 1, 2010, Kings County Behavioral Health released a draft of the PEI Component of the Three-Year MHSA Program and Expenditure Plan. The Plan was posted to the County's MHSA website, distributed to the Oaks Wellness Center, and sent electronically to the Kings County Mental Health Advisory Board and MHSA Steering Committee, and to a list of all stakeholders who had participated in the MHSA planning process to date.

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

The following public comments were made following the Plan presentation:

1. There was a concern that in the draft plan the estimated number of children to be screened was too optimistic. Partner agency experience with conducting developmental screening suggested lower rates of participation, and stakeholders wanted to make sure that County providers could meet stated objectives. **Response:** Based on community feedback, expected number of screenings were reduced to approximately 450 annually. This represents a full-time Recovery Support Coordinator conducting a minimum of 9 screenings and appropriate follow-ups each week.
2. There was concern that in the draft plan the estimated number of families to receive multidisciplinary team consultations was too high because each meeting would likely last more than 30 minutes and that families might need to return for follow-up visits. **Response:** The planning team changed the anticipated duration of each meeting to 45 minutes, and by meeting from 8am – 12pm, felt that the teams could still accommodate 5 families monthly. Based on the assumption that some families might return for follow-up visits, the anticipated number of families was reduced from 120 to 100.
3. Several participants stated that they were happy to see that the promotores model would be adapted for use in Kings County. It was suggested that this model would work well in Corcoran and Avinal. **Response:** None

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form No. 2

The following comments were received in writing:

1. I am happy to see that services will be community based. **Response:** None
2. The value of the Devereux tools is the strategies that go with the program. The problem we have found with many tools is that they do not have the ability to increase the capacity of the community. They are not strength-based. They screen but then there is no continuity of care that involves the family and the teachers and the support and implementation from the paraprofessional. The reason why this tool was developed was because there was not enough money to provide professionals for every child that needed service. The tool develops the capacity of the community so the professionals can focus on the children who really need intensive series. It is preventive. I would hope that DECA could be added as one of the tools for the preschoolers and the infant toddler tool from Devereux as well in addition to the DESSA that you have listed for continuity of care. **Response:** DECA has been added as a potential screening tool.
3. I would like Parent and Me and UCP added as one of the sites where screenings would take place. **Response:** P&M and UCP were added as locations for screening.

d. The estimated number of participants:

According to sign-in sheets, 32 individuals attended the public hearing. Confidential demographic forms revealed that 17% of public hearing participants indentified as consumers; 47% as family members of consumers; 83% as adults 18 – 59 and 17% were 60 years or older; 60% were female, 20% were Hispanic/Latino; 10% were African American; and 7% were native American; 63% were White/Caucasian.

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

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

County: Kings

PEI Project Name: WE CAN

Date: March 2010

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

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

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

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

WE CAN (Wellness & Empowerment Children and Adolescent Network) targets Kings County preschool, elementary, middle and high school age children. The project is designed to provide age-appropriate universal screening to children. Those identified from screenings or by educators, pediatricians and providers as having social, emotional or behavior-related issues will receive prevention-related team-oriented services and more intensive, individualized, short-term interventions. For those children and youth exhibiting even more serious prodromal signs of mental illness and emotional disturbances, **WE CAN** will provide referrals to more comprehensive treatments. One of the central tenants of this project is to create an open-door, welcoming environment for ANY child and family to enter, and for families to clearly understand and navigate service delivery systems. Nonetheless, the Behavioral Health Department recognizes that limited resources require establishing outreach and community education priorities. Therefore, the following priority populations will be targeted:

Preschool age children: Prevention literature clearly indicates that for children with social, emotional and behavioral related issues, the earlier the identification and the earlier the intervention, the better and longer-lasting the results.¹ Several Kings County health and wellbeing indicators suggest that very young children are underserved and at-risk of both physical and psychological developmental disorders. Out of 58 counties in California, Kings County ranks:

- 49 in infant mortality, nearly double the infant death rate Healthy People National Objective (7.2 per 1000 live births) For Hispanics, the County ranks 52 in infant mortality (7.6 per 1000 live births).
- 57 in births to adolescent mothers. This rate is nearly twice the California average.
- 48 in prenatal care, with 27% of pregnancies having late or no prenatal care, nearly three times the Healthy People National Objective and twice the State average.

¹ Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services News, July 2009.

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

- 58 in breastfeeding initiation during early postpartum, the only county in California scoring below the Healthy People National Objective.
- 49 in persons under 18 living in poverty, 23% compared to 17% statewide average.²

Interviewees for the PEI Planning Process and focus group participants corroborated the need to prioritize very young children. The Planning Team heard about multiple incidents of young children being expelled from preschool. According to one First 5 Stakeholder, *“There are not a lot of mental health services for young children. We have young children with severe behavioral issues who have been expelled. We have existing childcare providers, physicians, who are not adept at dealing with behavior issues. Equipping the community with skills would be great”* Another stakeholder concurred, *“Children are not receiving early screenings. They are not recognized until they get into kindergarten.”* While the needs of young children are a priority, the community made it clear that child care providers and parents need to be the targets of education and outreach. One child care provider explained: *“If we can’t get parents to understand the importance of social emotional and brain development, we can’t do prevention.”* Another described her experience with Kings County parents, particularly the many young parents in the County with few role models and resources: *“I’ve seen a lot of out of control children, and their parents just ignore them. They don’t know what to do.”*

Anecdotal reports from the PEI Community Planning Process suggest that preschool age children that live in the towns of Corcoran, Kettleman City and Avenal and in the unincorporated rural areas of the County are particularly underserved. Armona and Home Garden, too, have large pockets of low-income families with limited access to child development information or services. Organizations such as Kings County Action Organization and First 5 maintain Head Start and Family Resource Center in these underserved communities, which can serve as hubs for identifying very young children with developmental needs. **WE-CAN** staff will conduct screenings at these locations; but perhaps more critically, will outreach to low income medical clinics, WIC offices, food banks, and community-based

² California Department of Public Health and California Conference of Local Health Officers, County Health Status Profiles, 2009,

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

child care centers to educate families and providers about the importance of early identification and intervention. During a focus group with early childhood providers, the following statement received much support. *“We need to equip child care providers with tools; this would increase the quality of early childhood education, not just mental health”*

Children in stressed families and at-risk of school failure, juvenile justice involvement and suicide:

While **WE CAN** has a universal prevention component that encourages all children and youth to receive screening, the project includes the formation of Multidisciplinary Teams (MDTs), which will work specifically with children who have been identified as living in stressed families and with those who have been identified as at-risk of school failure, juvenile justice involvement and suicide. Children and families in crisis will receive more intensive, short-term interventions as well. A variety of Kings County indicators have led to the prioritization of at-risk youth:

- As described above, adolescents in Kings County are participating in risky sexual behavior, such that 1 in 16 adolescent girls become mothers (as opposed to 1 in 27 of California’s adolescent girls).
- Kings County is home to three State prisons. Children of families who move to Kings County to be closer to incarcerated loved ones experience trauma of separation; early exposure to drugs and/or violence; and stigma.³
- Kings County is also home to the US Navy’s largest master jet base. Families of the deployed experience extreme stress. In one study, one-third of military children are at high risk for psychosocial illness.⁴
- Juvenile misdemeanor arrest rates in Kings County are nearly three times higher than the State; in 2008, Kings had an arrest rate of 62 per 1000 (CA = 28 per 1000).⁵
- Juvenile felony arrest rates in Kings County are significantly higher than those of the State; in 2008, Kings had a juvenile felony arrest rate of 17.4 per 1000 (CA = 14.1)⁶

³ Johnson, Elizabeth Inez and Jane Waldfogel. *Children of Incarcerated Parents: Cumulative risk and children’s living arrangements* (2002) http://www.northwestern.edu/ipr/jcpr/workingpapers/wpfiles/johnson_waldfogel.pdf

⁴ Flake, Eric M and Davis, Beth Ellen et al “The Psychosocial Effects of Deployment on Military Children” *Journal of Developmental and Behavioral Pediatrics*, August 2009, V. 30 Issue 4 pp 271-278

⁵ State of California Department of Justice, Juvenile Misdemeanor Arrests, 2008

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

- Drop-out and truancy rates are slightly higher than state average. Kings drop-out rate for 9 – 12 graders in 2008/09 was 16.4% (CA = 15.3%). The truancy rates in Kings in 2008/09 was 28% (CA= 24%)⁷
- Expulsions and suspensions rates were significantly higher in Kings. In Kings, 1.3% of students during 2008/09 were expelled (CA = 0.3%) and 20% were suspended (CA = 12.5%)⁸

One school psychologist described the Kings County priority populations in the following way: *“Families migrate to the area because of the prison and mental hospital. These families require intensive services. Also, here in Kings, there are economic issues for agricultural, migrant workers. We beat Appalachia for poverty and unemployment. Students are pulled out of school to get jobs or babysit. We have high teen pregnancy rates, high meth[amphetamine] use. For a small county, we have big county gang issues.”* A school administrator reiterated the need to provide early intervention to adolescents at-risk of juvenile justice involvement and substance use. *“We need something for those children who have just been caught with drugs or alcohol for the first time. There isn’t a program now.”* The lack of prevention services for these youth may in fact be why juvenile arrests are higher in Kings than in other counties.

Children and youth involved in Protective Services: In addition to targeting the children of deployed and incarcerated families, stakeholders who participated in the PEI Community Planning Process provided additional feedback about priority populations. For example, mental health providers, child care and early childhood specialists, and CPS staff repeatedly talked about the need to serve children involved in foster care and family reunification programs. Penetration rates in Kings County for foster children have historically been low, and stakeholders articulated that there needs to be a greater emphasis on identifying the social and emotional needs of such youth and their caregivers. At the same time, it was noted that there needs to be stronger ties between CPS and KCBH to ensure that screenings

⁶ State of California Department of Justice, Juvenile Felony Arrests, 2008

⁷ California Department of Education, Safe & Healthy Kids Program Office, 2007/08

⁸ California Department of Education, Safe & Healthy Kids Program Office, 2007/08

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

and mental health interventions do not result in long-term stigmatization or discrimination against youth in child protective services.

Children and youth living in rural and isolated areas: Another subpopulation that needs to be prioritized in Kings County are youth living in the more remote areas of the County. A shortage of transportation options was repeatedly identified as a barrier to seeking services. One stakeholder noted that while it is difficult for an adult to go to Hanford for an initial assessment at Kings View, it is even less likely that a parent with a child will be able to make it to Hanford for an appointment. By car, for example, it takes 58 minutes to drive from Avenal to Hanford. Without a car, to get to Hanford would be very challenging; public transit runs in each direction only 4 times per day. **WE CAN** will mitigate transportation-related barriers by providing screenings and interventions at multiple pre-school sites throughout the County and in its mobile *WE CAN VAN*. According to one stakeholder, *“Schools touch everyone across socio-economic and cultural divisions. Schools are the natural venue to provide services. Parents trust the schools and don’t have to go out of their way.”*

Youth from underserved cultural backgrounds: School-based services provide an opportunity to identify and support youth from underserved cultural backgrounds. In Kings County, Spanish-speaking and Native American youth are more likely to be at risk of school failure and juvenile justice involvement. For example, while 13% of white children, grade 9 – 11, drop out of school in Kings, 17% of Latinos and 36% of Native Americans drop out. This is a particularly alarming statistic, since the State drop-out rate for American Indian and Native Alaskans is only 20%.⁹ In terms of juvenile arrests, in 2008, a disproportionate were of African American and Latino youth. While 5% of Kings County youth between the ages of 10 – 17 are African American, 11% of juvenile arrests were of African American youth. While 52% of youth are Latino, over 60% of arrests were of Latino youth. Correspondingly, whites make up 36% of Kings County youth, but only 25% of arrests.¹⁰ (No specific data exist for Native American youth; at the State Department of Justice, they are identified as “other”). The data above suggests that Latino

⁹ California Department of Education, Safe & Healthy Kids Program Office, 2007/08

¹⁰ US Census, 2000 and State of California Department of Justice, 2008, all arrests.

Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)

and Native American youth are underserved by the school system, but over-represented in the juvenile justice system.

Native and Non-Native providers who participated in the PEI Community Planning Process noted that Native American youth are particularly at risk in Kings County. In a focus group at the Santa Rosa Rancheria, one youth advocate explained, *“We need more outreach. The services we have right now are not working as well as they could. We are not attracting the kids.”* Aside from intergenerational PTSD, which takes a tremendous toll on Native youth and adults, the Native American youth face an increasingly common challenge. Because incomes have recently risen due to casino proceeds, the schools that serve the tribal community have lost Title 1 funding for disadvantaged students. And yet, many of the socio-economic challenges that affect impoverished communities continue to impact the tribal community. A focus group at the Santa Rosa Rancheria revealed a strong desire on the part of participants and a critical need to prioritize culturally appropriate services for this community. With support from the ***In Common*** Project staff and in conjunction with recent well-received efforts to provide clinical services to the Rancheria, ***WE CAN*** will prioritize services to Tachi Yokut and other Native American youth.

Community Survey

In addition to data collected from the key informant interviews, focus groups, strategy roundtables and a community-wide meeting to prioritize potential strategies, members of the MHSA Planning Council were surveyed to find out which they believed were Kings County’s relevant MHSA Key Mental Health Needs and Priority Populations. For Key Mental Health Need, they were allowed to select two priorities. The following were their responses:

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

Key Mental Health Needs N = 32					
Disparities in Access	Psycho-Social Impact of Trauma	At-Risk Children, Youth, and Young Adult Populations	Stigma and Discrimination	Suicide Risk	Other
19	8	23	10	3	1

For Priority Populations, participants were allowed to select three priorities. The following populations were prioritized:

Priority Populations N = 31 ¹¹						
Underserved Cultural Populations	Individuals Experiencing Onset of Serious Psychiatric Illness	Children/Youth in Stressed Families	Trauma Exposed Individuals	Children/Youth at Risk for School Failure	Children/Youth at Risk of or Experiencing Juvenile Justice Involvement	Other
12	12	21	12	15	16	0

The project below, **WE CAN**, is specifically designed to respond to the MHSA Planning Council’s most selected key mental health needs and priority populations. The subsequent project, **In Common**, is designed to respond to the Planning Council’s second most selected mental health need: “Disparities in Access.”

¹¹ Not all respondents selected three priority populations. Some selected only two

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

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

**Kings County: WE CAN
(Wellness & Empowerment Children and Adolescent Network)**

“We don’t have a children’s system of care here. It would be great if we could have a system of care across the age spectrum, including for TAYs” – First 5 Key Informant Interview

WE CAN is a transformative, integrated systems approach to providing prevention and early intervention-related social, emotional and behavioral supports to children and their families and caregivers throughout Kings County. The system of care is designed to address the unique needs of three age

groups: 1) pre-school age children; 2) elementary school age children; and 3) middle and high-school age children. This PEI Project will be staffed by two FTE Prevention Services Coordinators—one targeting pre-school and elementary school age children and the other focusing on the needs of middle and high school students. The Prevention Services Coordinators will be supported by a FTE Recovery Support Coordinator. Children who have been identified as needing more direct intervention will receive short-term, one-on-one therapeutic services by a Licensed Clinician. **WE CAN** will be managed by the MHSA Coordinator/Program Manager, with oversight by Kings County Behavioral Health Director. The project will be managed in-house, by Kings County Behavioral Health Department, but services will be provided predominantly in community and school-based settings.

WE CAN will provide an open door to all Kings County children, parents/guardians and caregivers so that they may receive an as needed continuum of services, including: 1) universal screening; 2) selective team-oriented support; and 3) targeted early intervention.

Universal Screening

Universal social, emotional and behavioral screening for children and youth is an essential first step to identifying issues early on, before they lead to more serious and costly problems such as school failure, juvenile justice involvement and mental illness. With consent from guardian, **WE CAN’s** Recovery Support Coordinator will administer age-specific screenings and make appropriate referrals. The following screenings, with appropriate training funded through *PEI Training and Technical Assistance*, may be used:

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

- **Ages & Stages Questionnaires, Social-Emotional (ASQ-SE)** is a set of simple-to-use, age appropriate screening tools that identifies infants and young children whose social and emotional development require further evaluation to determine if referral for intervention services is necessary.¹²
- **Devereux Early Childhood Assessment (DECA)** measures 27 positive behaviors and 10 item behavioral concerns exhibited by preschoolers age 2 – 5. DECA identifies children who are low on protective factors in order to target classroom and home-based strategies; develops classroom design and instructional strategies based on the relative strengths of all children; and helps identify children with behavioral concerns so that these issues can be addressed prior to the development of behavioral disorders.¹³
- **Devereux Student Strengths Assessment: K – 8th Grade (DESSA)** is a 72-item, standardized behavior rating scale that assesses the social-emotional competencies that serve as protective factors for children in kindergarten through the eighth grade.¹⁴ In Kings County, the implementation of DESSA screenings will build upon the existing Devereux Early Childhood Assessment (DECA), which is currently provided by United Cerebral Palsy. The Devereux assessments focus on the identification of an individual child's social-emotional strengths and risks, and result in both individual and classroom-level prevention-related strategies.
- **TeenScreen** is a SAMHSA-recognized evidence-based screening tool that identifies middle and high school aged youth in need of mental health services due to risk for suicide and undetected mental illness. The program's main objective is to assist in the early identification of problems that might not otherwise come to the attention of professionals.¹⁵

¹² http://www.agesandstages.com/products/asqse_new.html

¹³ http://www.devereux.org/site/PageServer?pagename=deci_preschool

¹⁴ http://www.devereux.org/site/PageServer?pagename=dessa_index

¹⁵ http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=108

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

- **Eyberg Child Behavior Inventory (ECBI)** is a behavior rating scale that is used to gauge the frequency and variety of particular behaviors in conduct-disordered children (ages 2-16), and assess the degree that the behavior presents a problem in the home or at school.¹⁶

- **Child Behavior Check List (CBCL).** One of the more widely used diagnostic tools, CBCL consists of 20 items used to measure a social and emotional competencies, followed by 120 items used to assess various internalizing and externalizing behaviors related to mental and emotional well-being. There are two versions of CBCL, one for ages 2-3, and the other for 4-18 year olds.¹⁷ Similar to ASQ-SE, CBCL helps to identify children who may require further evaluation.

- **Parenting Stress Inventory** is a scoring system used to measure parental stress and early parent-child relationship issues that have been shown to impact normal mental and emotional development in young children. Primarily used on preschool-age children, this tool helps to identify families who may benefit from early interventions such as parenting classes¹⁸.

Prior to selecting specific screening tools, KCBH will convene a strategy roundtable with a local childhood development specialists to gather input for specific screening protocols and expectations. The group will help determine specific age targets and follow-up intervals, screening locations, and tools. The main objective will be to ensure that screenings are universally available throughout the County, but also that screenings reach isolated and underserved communities at appropriate developmental stages. The group will reconvene on an annual basis to evaluate extent and impact of screenings, develop partnerships for more extensive reach, and recommend adjustments to screening tools, locations and target populations.

WE CAN will include a formal set of referral protocol in order to successfully transition those who have been identified through universal screening as needing additional support. Additionally, Kings stakeholders have identified a need for ongoing community education about child brain development

¹⁶ <http://www.cebc4cw.org/assmt-ecbi>

¹⁷ <http://www.livestrong.com/article/35833-child-behavior-checklist-cbcl/>

¹⁸ <http://www3.parinc.com/products/product.aspx?Productid=PSI>

Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)

and early intervention. Parents, caregivers and teachers will be targets of this educational campaign. Prevention Services Coordinators, with support from bilingual *In Common* staff when appropriate, will conduct informative and stigma-busting parent workshops and provide ongoing resources to child care providers and teachers. The main objective will be to increase the number of appropriate referrals and to support parents in following through with such referrals. The Prevention Services Coordinators, as well as the MDT members (see below), will serve as an available resource to teachers and school administrators, in order to increase linkages, promote referrals, support individual students and improve school-wide social environments.

Screening Roles and Milestones:

- A Recovery Support Coordinator will conduct a minimum of 9 screenings per week, targeting underserved populations, for a total of approximately 450 screenings annually. Screenings will take place in home-based daycare centers, CPS, social service agencies, FRCs, Head Start pre-schools, health clinics, WIC offices, shelters and other locations.

Team-Oriented Support

This component of the **WE CAN** Project offers a team approach to services for children who have been identified through screenings or through other referral mechanisms as at-risk of school failure, juvenile justice involvement and/or emotional disturbance and mental illness. PEI funding will support two distinct Multidisciplinary Teams (MDTs): 1) for children 0 – 10 and their parents/guardians; and 2) for middle and high school aged children and their parents/guardians. Each collaborative team will be made up of WE CAN staff; childcare providers, teachers, or school administrators; and other critical providers such as CPS, Kings View, public health nursing or youth probation. The early childhood MDT will include staff from First 5, KCAO, UCP and other community-based child development specialists. For middle and high school aged MDTs, the children themselves will participate on the MDT. Participation on the MDT will require guardian consent and, for older children, voluntary consent.

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

The MDTs will receive referrals of children who have been identified through an initial screening.¹⁹ Providers will be encouraged to identify and screen children:

- exposed to domestic violence and other trauma;
- with parents who have SMI, SED and/or substance use disorders;
- at-risk of or are failing in school;
- at-risk of juvenile justice involvement;
- who bully or have been bullied; and/or
- at-risk of suicide.

Multi-Disciplinary Teams Improve Interagency Communications

“The lack of communication between schools and mental health service providers is limiting, preventing schools from effectively supporting any mental health treatment provided to kids. We never know if referrals for students are followed up.” – Public School Administrator

“We need to improve flow of information within county agencies and divisions. For example, we need current status of available programs and services with clear, consistent list of criteria for acceptance. It’s very confusing.” – Child Welfare/CPS Focus Group

“We need to close the relationship gaps between providers, to avoid duplication of efforts and inappropriate referrals. A team approach would help us with this.” – Behavioral Health Staff Focus Group

In Kings County, special focus will be paid to identifying children with parents who are or have been deployed in international conflict zones and whose parents are or have been incarcerated.

One of the roles of service providers in each age group’s MDT will be to develop prevention-related strategies that address County, district and school-wide challenges. Each team will first meet with individual families and then problem-solve larger systemic issues.

The MDTs will provide comprehensive prevention-related service coordination and help transition children to more intensive intervention as needed. The role of each team member will be to collectively do “whatever it takes” to support children and their families, including linking them to medical and social services, law enforcement and other community supports. When appropriate, the MDTs may call on the expertise of **WE CAN’s** Licensed Clinician or refer children and family members to Kings View or KCBH to provide comprehensive diagnostic, medication, ongoing treatment and FSP services.

¹⁹ A child will be eligible to participate in MDT meetings, even if guardians do not permit initial screening.

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

Multidisciplinary Roles and Milestones:

- A Early Childhood Prevention Services Coordinator will organize and facilitate the Children (0-10) MDT. The MDT will convene monthly. Legal guardians and/or birth parents will participate as team members during approximately forty-five minute sessions. The MDT will work with approximately 5 families per month. If issues are not resolved, the child and family may return for follow-up meetings or be referred to Kings View or the Full Service Partnerships for more comprehensive treatment. It is anticipated that approximately 50 young children and their families will be served by the MDT per year.
- Other Early Childhood MDT participants will include CPS, First 5, KCAO, UCP, Kings County Office of Education, and Kings View. The individual child care provider, teacher, school psychologist or school administrator may also be invited to attend sessions. The Prevention Services Coordinator will follow-up with families to provide advocacy and support, as needed.
- An Adolescent Prevention Services Coordinator will organize and facilitate the Children (11 -17) MDT. The MDT will convene monthly. The child (when appropriate) and the legal guardians and/or birth parents will participate as team members during approximately forty-five minute sessions. Like the Early Childhood MDT, the Youth and Adolescent MDT will serve approximately 50 children and families per year.
- Other Youth and Adolescent MDT participants will include CPS, Juvenile Probation, AOD staff, Kings View, and Kings County Office of Education. The individual school administrator or psychologist will also be invited to attend sessions. The Prevention Services Coordinator will follow up with the youth and families, and provide advocacy and support, as needed.
- The Prevention Services Coordinator will consult with the WE CAN Clinician on a weekly basis. The role of the Clinician will be to recommend additional interventions or referral to more comprehensive mental health treatment.

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

- The *In Common* Project's Recovery Services Coordinator will provide Spanish language interpretation and family advocacy, as needed.
- As part of their role in serving as a bridge between the schools and behavioral health, Prevention Services Coordinator will spend a few hours per week consulting with individual teachers and child care providers about classroom and school social, emotional and behavior-related issues. They will provide resources, inform teachers about available services, follow-up on referrals and generally serve as a liaison between the schools and behavioral health.

Early Intervention

For those children who have been identified by the MDTs as needing additional short-term support, **WE CAN** will offer several intervention strategies. The *WE-CAN VAN* is a remodeled, fully equipped recreational vehicle designed to enable PCIT and other individual therapeutic sessions. The *VAN* will travel to pre-schools, FRCs and other community settings throughout the County, prioritizing rural and isolated areas. In addition, the vehicle will travel to Hanna's House, a transitional living program for women and children, and provide a location for clinically-supervised CPS family reunification visits.

Parent-Child Interaction Therapy (PCIT) is an evidence-based treatment for conduct-disordered young children that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns.²⁰ In PCIT, parents are taught specific skills to establish a nurturing and secure relationship with their child while increasing their child's pro-social behavior and decreasing negative behavior. This treatment focuses on two basic interactions: Child Directed Interaction (CDI) is similar to play therapy in that parents engage their child in a play situation with the goal of strengthening the parent-child relationship; Parent Directed Interaction (PDI) resembles clinical behavior therapy in that parents learn to use specific behavior management techniques as they play with their child.

²⁰ <http://pcit.phhp.ufl.edu/>

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

From either the *WE-CAN VAN* or in dedicated space at community centers and schools, **WE CAN's** licensed clinician will provide PCIT and short-term, individualized and small-group therapeutic sessions for older children. In addition, the clinician will supervise skill-building groups, facilitated by the Prevention Services Coordinator. These groups may cover the following topics, or others, depending on local need: suicide prevention, LGBT issues, substance use, gangs and peer pressure, bullying, divorce, deployment, incarceration, home disruption, domestic violence and anger. Youth who have been identified through screenings and by the MDTs or other providers will be encouraged to participate. However, groups will be voluntary and open to any child with guardian consent.

Cross-the-Board Support for Early Intervention

"We need not just screening but follow-up. You are putting them in a worse situation if parents know there is a problem but they can't fix it." – Early Childhood Provider Focus Group

"We don't have PCIT in this County. Now if you could do PCIT in the Family Resource Centers, that would be great!" – Early Childhood Provider Focus Group

"We need a counselor at the schools, someone they can connect with in crisis, like a divorce or abusive father. Someone for short term, situational issues. This counselor could rotate to schools and serve as liaison between the schools and the Behavioral Health Department." – School Psychologist Focus Group

"[School-based group therapy] helps to address the bullying –the bully as well as the bullied. It addresses the low self-esteem and peer pressure, which can be connected to inability to effectively regulate thoughts and feelings. It is culturally competent. It meets kids where they are." – Community Prioritization Meeting

"We need services so that we can talk to someone when we need to; not 6 months later after all the documentation and court orders and 5150s. – TAY Focus Group

Early Intervention Roles and Milestones:

- Using first year funds, Kings County Behavioral Health will purchase a fully-equipped *WE CAN VAN*. The *WE CAN VAN* (a Winnebago Vista motor home) is designed and equipped to provide mobile PCIT.
- **WE CAN's** Licensed Clinician will be responsible for transporting the *WE CAN VAN*. During the first year, the RV will make rotations to pre-schools, service agencies such as CPS or family resource centers. Attempts will be made to serve Avenal, Armona, Kettleman City, Stratford, Lemoore and

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

Corcoran, etc. The locations will depend upon an annual MOU between Behavioral Health Department and the school district.

- The **WE CAN** Clinician will spend approximately 12 hours per week conducting PCIT sessions in the *WE CAN VAN*. It is anticipated that the clinician will serve 8 children and their families per week. Approximately 50 children and families will receive PCIT or other short-term therapies annually.
- Each Prevention Services Coordinator will spend 4 days per week providing skills-building classes to students throughout the County. It is anticipated that each Coordinator will facilitate 4 groups of approximately 6 students per 10-week session. A total of 480 youth will participate in skills-building classes during the school year.

WE CAN will offer universal, selective and intervention services to children throughout Kings County. It relies on the existing and collaborative relationships between a wide variety of providers and educators. The system is designed to meet the needs of children in their natural environments—pre-schools and child care centers. A mobile recreational vehicle will further enable Behavioral Health services in the more isolated areas of the County. While the current funding levels are not sufficient to serve all children with social, emotional and behavioral challenges in the County, the system of care is designed to target the most at-risk groups, ensure that their needs are recognized early on, and triaged to ensure services at whatever developmental stage and whatever level of support they need. PEI funding has been designated to meet the needs of those who are do not or have not yet met medical necessity. Equally critical, the State has allocated PEI funding to help identify and transition those youth who need more extensive diagnostic and treatment services. **WE CAN** is designed to ensure that children and adolescents exhibiting prodromal signs of mental illness are identified early and transitioned to Kings View, MHSA Full Service Partnerships and other extended treatments.

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served in FY 09/10 (10/11 in parenthesis)		Number of months in operation in FY 09/10
	Prevention	Early Intervention	
WE CAN Universal Screening	Individuals: Families: 38 (450)	Individuals: Families:	1
WE CAN Team-Oriented Support	Individuals: Families: 8 (100)	Individuals: Families:	1
WE CAN Early Intervention	Individuals: Families:	Individuals: 40 (480) Families: 4 (50)	1
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: Families: 46(550)	Individuals: 40 (480) Families: 4 (50)	1

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

WE CAN is designed to identify children across a full spectrum of social, emotional and behavioral needs. The project will be staffed entirely by County Behavioral Health Department employees and a contract Licensed Clinician. Staff role will be to follow up screenings with appropriate referrals to the MDTs; to interventions such as PCIT; or under certain circumstances, to Kings View Counseling Services (managed care) or Kings County Behavioral Health FSPs. Additionally, the MDTs are designed to build inter-organizational capacity to share resources and information and coordinate services between the variety of county and community-based providers who offer vital services to children and their families. By working together directly with clients, Kings County agency and CBO representatives will develop knowledge about service availability and eligibility.

6. Collaboration and System Enhancements

WE CAN leverages and builds upon existing collaborative relationships in the County. The implementation of screenings will require collaboration between Behavioral Health and First 5; the FRCs, KCAO and Head Start Pre-schools. Close ties to public schools will result in increased referrals for screenings. A measurement of successful collaboration will be the number of referrals from partner agencies following screenings.

Also, as described in Section 5 above, the MDTs rely on collaborative relationships. Such relationships will lead to system enhancements; as providers problem-solve with individual family members and youth, they will also be developing the collaborative relationships necessary to plan and implement County-wide prevention strategies in schools and community settings.

Finally, the PCIT, group skill building, and individual crisis counseling require significant collaboration between Behavioral Health Department and school systems. Such collaborations will ultimately result in the identification of at-risk children, more appropriate referrals, and increased skills on the part of teachers and administrators and behavioral health workers.

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

7. Intended Outcomes for WE CAN

Focus Area	Resources	Activities	Outputs	Outcomes	Measures	Impact
<i>List the most important things the program will accomplish</i>	<i>Describe the resources that will support the program activities</i>	<i>Describe and define the program activities</i>	<i>For each activity identify ways to demonstrate that services have been delivered</i>	<i>Identify what changes you expect each activity to effect</i>	<i>Specify the ways that these outcomes will be measured</i>	<i>Describe the impact that the community will feel in 1 – 2 years as a result of the program</i>
<p>Children with social, emotional and behavioral issues will be identified and will receive PEI services prior to entering kindergarten or prior to developing serious MH-related issues.</p> <p>At-risk children and families will receive comprehensive team-oriented support.</p> <p>Parents/guardians will learn effective strategies for dealing with challenging behaviors</p> <p>At-risk youth will gain pro-social skills which increase protective and decrease risk factors</p> <p>Children in crisis will receive one-on-one intervention</p>	<p>Three FTE KCBH staff (2 Prevention Services Coordinators and 1 Recovery Support Coordinator) and a contract licensed clinician</p> <p>Two MDTs made up of PEI Services Coordinator and partners such as Kings View, First 5, KCAO, school administrators, school psych, probation, and CPS</p> <p>Parents/Guardians and youth themselves will participate in MDTs</p> <p>A fully-equipped WE-CAN VAN for mobile therapeutic services</p>	<ol style="list-style-type: none"> Age-appropriate screenings, including ASQ-SE, DESSA, and TeenScreen Education & training to teachers and other care providers in effective referrals Monthly MDT meetings to problem-solve child specific issues and community-wide challenges Parent Child Interactive Therapy (PCIT) Skill-building groups for at-risk youth Individual short-term therapy for youth in crisis Individual teacher consultations and linkages to BH Referrals and follow up with extended MH services as appropriate 	<ol style="list-style-type: none"> # of screenings and referrals recorded; analysis of location of screenings # of trainings and # of participants at each # of individual MDT sessions and # of participants # of families receiving PCIT; duration of tx; analysis of location # of groups; # of participants, duration of tx, location # of individual sessions; duration of therapy # of consults; location of consults # of referrals to Kings View, FSPs, other services 	<ol style="list-style-type: none"> Increasing # of children with BH issues will be identified & referred to PEI programs Teachers will be more knowledgeable about child SE development Families & youth will have more support and resources Quality of parent/child relationship will improve; parenting skills will improve Participating youth will be more resilient, less anxious/depressed. School environment will improve Participating youth in crisis will show improved behaviors and emotional outcomes Teachers will have more knowledge about classroom interventions and available services More children and youth will be referred to FSPs, etc 	<ol style="list-style-type: none"> Referral log maintained by BH Teacher surveys; pre/post Parent and/or youth satisfaction surveys; provider interviews/focus groups Parent pre/post surveys Youth survey; teacher/admin interview Youth interview and/or survey Focus groups and surveys with school personnel Referral log maintained by BH 	<p>Fewer children enter kindergarten with unidentified SE issues</p> <p>Increased parent and teacher knowledge about social/emotional development; reduced stigma related to seeking support</p> <p>More resilient children & youth</p> <p>Reduced incidents of violence, drug and alcohol abuse, juvenile justice involvement</p> <p>Increased treatment for children in need of services</p> <p>Improved collaboration between agencies</p>

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

8. Coordination with Other MHSA Components

WE CAN is designed to support the transition of children with serious emotional disturbances, prodromal signs of mental illness, and co-occurring disorders to more comprehensive treatment. For those who meet eligibility requirements, children will be referred to Kings View Counseling Services and their school-based clinicians. **MHSA Full Service Partnerships** are available for those who are not eligible for Kings View services.

This project is also designed to link with **In Common**, a PEI outreach and engagement project targeting Kings County residents who have had little or no previous contact with public and community-based behavioral health services. **In Common** staff will serve as advocates and interpreters to the many Spanish-speaking parents in Kings County. Parents of children receiving PEI services will be invited to participate in the wide range of Spanish and English support groups as well. Such cross-pollination will help strengthen family systems as both children and their parents/guardians build community support networks that increase their resiliency and promote emotional wellbeing.

9. Additional Comments (optional)

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

COUNTY: Kings

Date: March 2010

PEI Project Name: IN COMMON

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

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

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

The PEI Community Survey (see results on page 27) provided evidence early in the Planning Process that Kings County stakeholders recognize the need to more deeply extend services to individuals and communities that have traditionally been under- or inappropriately-served. In addition, the survey suggested that the *mitigation of stigma associated with seeking services* and *the elimination of discrimination against persons with SMI* are key community mental health needs. The ***In Common*** Project responds to these challenge by building bridges and increasing access to those residents who have had little or no previous contact with behavioral health services.

Both qualitative inquiry and quantitative data were used to identify specific populations that are currently or have historically been underserved in Kings County.

Spanish-speaking and Latino community members: Stakeholder participation in the PEI Community Planning Process corroborated and expanded upon what the above data tells us. A PEI Planning Focus Group brought together 16 Spanish-speaking/Latino participants, all women, most of whom were mothers, to discuss prevention-related needs and opportunities. Service providers from First 5 and Migrant Head Start outreached for the focus group and provided input from their perspectives. Participants described their experience seeking and receiving services through the schools. One participant described attempts to get help for her daughter that were met by school administrators with a lack of concern and follow-through. Due to what she and others in the group perceived as cultural insensitivity, the administrator simply described her concerns as normal teenage behavior. The participants in the group felt that providers do not always take Latino concerns and traditional values seriously. These experiences, according to the participants, resulted in distrust and an ongoing need for culturally competent services.

One of the barriers to serving Kings County's increasing proportion of Spanish-speaking residents has to do with the shortage of bilingual staff and need for language interpreters. Another service barrier has to do with rural isolation and a shortage of transportation options. A disproportion number of Latino

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

residents live in rural agricultural towns such as Avenal and Kettleman City, and in urban areas outside Hanford city limits.

The group unanimously agreed that one of the biggest needs they had was for Spanish language support groups. They said that while there were Spanish parenting classes in the County, there were no “*grupos de apoyo*” or support groups that were not geared toward parent/child relations. In addition, at least in Armona where the focus group was held, there was no community center to provide a space for such groups or to provide other social and wellness-oriented activities; the local FRC was closed due to budget cuts.

The lack of social infrastructure has a disproportionate impact on Latino men. Women socially engage with one another as parents in children’s schools, but according to the focus group participants who not coincidentally were all women, men have nowhere safe and healthy to

go to talk with their peers. Similarly, older Latinos are disproportionately isolated and in need of social engagement.

Service Utilization, Age and Gender

According to service utilization rates 2004/5, the proportion of males receiving services declined as their age increased. Seventy percent of clients age 0-15 were male, while only 30% age 60+ were male. Conversely, the proportion of females receiving services steadily increased as they aged. Overall 70% of males with SMI are not receiving services.

Kings County Native American Penetration Rates:

Calculations based on US Census 2000 population estimates show that in 2004/04, 59% of Native Americans with SMI were not receiving services. Given that the Native population between 2000 and 2008 increased from 1638 to 3298, penetration rates are likely to be significantly lower than estimates suggest.

Tachi Yokut and other Native community members: A Native American PEI focus group at the Santa Rosa Rancheria²¹ revealed the development of positive collaborations between tribal administration, Native American providers and the Behavioral Health Department. Participants explained that a Behavioral Health Clinician had recently begun outreach and weekly visits to the Rancheria, and they were encouraging their clients to attend informational meetings about available

²¹ attended by youth and early education service providers; tribal police and administrators; Tribal Spirit AOD providers; Indian Health Services; and career development/TANF specialists

Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)

services and supports.

Nonetheless, there is a long history of distrust and stigma associated with seeking mental health services in Kings County. One focus group participant stated, *“People don’t want to go [to Behavioral Health or Kings View Counseling Services] because they say ‘I’m not crazy.’ And when you talk about ‘the County’, the tribe hasn’t had a good history with Kings. We usually hear only from the Sheriff’s Department or CPS.”* **In Common** will build upon recent efforts to transform historically strained relations by prioritizing outreach and advocacy, both on the Rancheria and off.

Other Underserved Populations and Subpopulations: Community stakeholders described several other socio-economic and environmental issues that impact the County’s ability to enter into traditionally underserved, unserved and historically inappropriately served communities in Kings County. These issues deserve to be highlighted because the key objective of **In Common** will be to reach those who have had little or no previous contact with mental health services.

- GLBT community members are relatively isolated and stigmatized in Kings County; there are few “out” service providers.
- The current growth in poverty and homelessness, including homeless women and families, increases isolation and presents barriers to seeking and following-through with services.
- Rural communities are underserved due to social isolation and a lack of transportation alternatives. These communities tend to be poorer and Hispanic. Current economic conditions, including agricultural hardship, have had a tremendous impact on outlying communities.
- Anecdotal evidence suggests that there are a high number of families who have moved to Hanford to have contact with incarcerated loved ones. These families experienced displacement and are likely to feel distrust in “the system.”
- There are increasing pockets of ethnic populations in Kings County. *“We are no longer just a Mexican American and white community,”* explained one stakeholder; *“We have African American, Hmong, Central Americans and Punjabi here.”*

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

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

Kings County's *In Common* Project

In Common is a prevention-related outreach and engagement project targeting Kings County residents who have had little or no previous contact with public and community-based behavioral health services. The project has three primary objectives:

- 1) Reduce stigma associated with seeking behavioral health services;
- 2) Increase access by building bridges between behavioral health services and unserved, underserved and inappropriately served communities; and
- 3) Generate individual & community resiliency through community-based support groups that engender optimism and hope and build social, emotional and life skills.

***In Common* Bridge Building**

In Common will include two interrelated project components. The first component will be an Outreach, Education and Bridge Building Program, using best practices associated with community health workers (in Spanish, *Promotores de Salud*). Bilingual (Spanish/English) ***In Common*** community bridge builders will work exclusively in community settings, and serve as a link between potential consumers and family members who traditionally lack access to mental health care and the county behavioral health care system. Based on existing literature about the impact of community health worker programs and input from the Kings PEI Community Planning Process, the ***In Common*** staff will be expected to deeply understand the issues most impacting the communities they serve and the traditional resiliency factors within these communities. Specific targets will include the more isolated Spanish-speaking communities and the Santa Rosa Rancheria and surroundings.

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

While the *In Common* bridge builders will help connect community members to services and supports by educating and reducing stigma and advocating and providing moral and logistical support for entry into

Community Members Identify Criteria for Bridge Builders

“The person can’t seem like someone coming from the County; they can’t say they are coming from the mental health department. They have to be totally bilingual and culturally appropriate. It’s not about their education level. It’s about whether they have the heart.” – Spanish Speaking Focus Group

“To be successful, you need someone who is Native, or at least has a passion, for working with Native communities. You need someone who the community can trust, where there isn’t constant turnover.” – Native American Focus Group (Santa Rosa Rancheria)

“People sometimes trust someone from off the reservation. If we could have a wellness advocate, that would work, maybe then the tribe could pick them up and bring them on board.” – Native American Focus Group (Santa Rosa Rancheria)

the system, they will do so by promoting the unique cultural strengths and assets—such as cultural identity, spiritual coping, traditional health practices—that traditionally have helped communities cope with stress.²² Being uniquely positioned in community settings, their role will also be to influence and transform behavioral health services by educating providers about health needs and perceptions of services.

A recent study by the Annie E. Casey Foundation and University of Arizona of 400 community health workers around the country identified the following core roles.²³ These activities will serve as the basis for the *In Common* Bridge Building Program:

- Bridging Cultural mediation between communities and the [behavioral] health care system;
- Providing culturally appropriate and accessible [behavioral] health education and information, often by using popular education methods;
- Assuring that people get the services they need;
- Providing informal counseling and social support;
- Advocating for individuals and communities within the health and social service systems;
- Providing direct services (such as basic first aid) and administering health screening tests²⁴; and
- Building individual and community capacity.

²² Walters KL, Simoni JM. (2002). [Reconceptualizing native women’s health: An “indigenous” stress-coping model](#). *Am J Public Health* 92, 520-524.

²³ Wiggins N, Borbon A. 1998. Core roles and competencies of community health advisors (Chapter 3). *The National Community Health Advisor Study: Weaving the Future*. Tucson, Arizona: University of Arizona Press (410-223-2890).

²⁴ In this case, administering mental health screenings described in the **WE CAN** project.

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

In Common Bridge Building leverages relationships forged between Behavioral Health and CBOs through the CSS and PEI planning processes. Family Resource Centers, located in outlying and unincorporated areas, including those funded by First 5, will provide a home base for ***In Common*** bridge builders. They will also be able to provide resources throughout the County at KCAO-run Head Start, Early Head Start and Migrant Head Start Childcare Centers. Other locations for providing community education, advocacy and informal counseling may include health clinics, public schools, the Santa Rosa Rancheria administration building, the Senior Access for Engagement (SAFE) Program in Armona, Veterans Services Office and local faith-based organizations. The bridge builders will also be tasked with providing home visits and visits to farm worker encampments, when appropriate.

Bridge builder Roles and Milestones:

- The ***In Common*** Bridge Building Team will be comprised of a Recovery Support Coordinator and a Community Specialist. The bilingual Community Specialist will primarily be responsible for outreach about available services and supports, eligibility, the nature of mental health, early signs and symptoms, etc. The Community Specialist will develop one-on-one contacts with community providers and make group presentations to community members. Outreach will be conducted at primary care clinics, social service agencies, food distribution sites, churches and other faith based institutions, emergency service agencies, prisons (family members), the Santa Rosa Rancheria, senior and other community centers, schools and even grocery stores and transit hubs, locations where low-income, underserved community members frequently go. One of the Community Specialist's main objectives will be to refer interested individuals to ***In Common*** support groups and/or advocacy and case management provided by the ***In Common*** Recovery Support Coordinator. It is anticipated that the Community Specialist will make 1,000 outreach contacts annually.

- The ***In Common*** Bilingual Recovery Support Coordinator will primarily be responsible for case management, advocacy, interpretation and linking individuals to available behavioral health services. For example, s/he may accompany a Spanish-speaking senior citizen to an appointment at Kings View or provide interpretation for parents at a ***WE CAN*** MDT meeting. The Recovery Support

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

Coordinator may visit the homes of isolated individuals to let them know about support groups. S/he will outreach directly to families of persons with SMI to help them navigate the system and connect to support networks. It is anticipated that the Recovery Support Coordinator will provide one on one case management and advocacy to approximately 10 individuals per week. Approximately 130 individuals with little or no previous contact with behavioral health services will receive intensive PEI Bridge Building services annually.

In Common Support Groups

As part of KCBH’s commitment to extending preventative services into the community, **In Common** will organize and staff social and emotional skills-building and support groups. These groups will be developed as an extension of our Bridge Building into underserved communities. For example, during one focus group, Spanish-speaking stakeholders articulated a profound desire to participate in a Spanish-only support group, of which few or none currently exist in the County. Native stakeholders at the Santa Rosa Rancheria expressed a great deal of interest in attending a vicarious trauma support group for service providers. The formation of groups will respond to local interests as they arise in order to open doors to those who have had little or no previous contact with wellness-oriented mental health services.

During the PEI planning process, stakeholders expressed deep interest in creating safe and supportive

environments for all residents to share resources and information about wellness and recovery; to develop self-care and social and relationship skills; and to promote advocacy and mutual aid and short-

Community Support for Support Groups

“Sometimes we want to blame our problems on our kids. But the problem may be with us, the parents, and what we are going through. A sense of depression and feeling alone, that we are transferring to our kids our sense of depression and feeling alone.”
– Spanish Speaking Focus Group

“When we make a group just for men, then the men go. They won’t say they are sad and lonely, even though they may not have seen their family in many years. They will say they want to go to a group to learn to play the guitar, though.” –Spanish Speaking Focus Group

“We have an issue with grief and trauma here. Especially amongst tribal support people like us. We deal with a lot of stress every day. For example, the tribal police deal with a lot of deaths and violence.” –Native American Focus Group (Santa Rosa Rancheria)

“Treat the family as well as the person with mental illness; they don’t live in a vacuum. Families armed with information can support the treatment.” –Family Member Focus Group

Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)

term recovery from trauma and crisis. Based on existing interest, the *In Common* Prevention Coordinator will organize and facilitate (or coordinate facilitation of) the following groups:

- *Grupo de apoyo*: A Spanish women's group
- *Grupo de apoyo*: A Spanish men's group
- Parents of teens (English and Spanish)
- Parents of children with special needs (English and Spanish)
- Fathers' group
- LGBT support
- Vicarious trauma for providers
- PTSD and trauma group
- Elder provider support and social group
- Grief and transition for older adults
- Support for families of persons with SMI
- Relationship and marriage skills
- Families of incarcerated individuals
- Families of deployed individuals

Groups will be held in natural settings and advertised in appropriate locations and via relationships with schools, senior centers, faith-based organizations, social service agencies, clinics and hospitals, libraries and fraternal organizations.

As an example, a support group for families of persons with SMI was formed less than one year ago. *In Common* will be charged with expanding outreach and formalizing its structure, and evaluating participant satisfaction. Participants have noted that they would like to build the capacity of the group to be able to educate families on their loved-ones' diagnosis and treatment, mechanisms to cope with the stress of being a caregiver and how to navigate the behavioral health system. Other group activities might include NAMI trainings and the development of a family speakers' bureau.

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

The proposed Elder Provider Support Group acknowledges the stress and physical toll associated with seniors caring for grandchildren and/or spouses. Many older adults also suffer from longstanding stigma that prevents them from reaching out for help. The Elder Provider Support Group will provide not only emotional and social support to elder caregivers, but as an incentive and as recognition of the stress and fatigue they face, participants in the group will have access to an MHSa **prevention-oriented respite fund**.

By combining outreach to underserved communities and accessible, pro-social support networks, ***In Common*** aims to reduce communitywide stigma associated with seeking behavioral health services; increase individual and community wellbeing; and prevent trauma and stress from causing harm to the individual, their loved ones and the larger community. Each group will be uniquely tailored to the target population; facilitated in locations where people naturally go; and flexibly respond to existing needs and interests. ***In Common*** staff will coordinate and facilitate these groups on a weekly basis or more frequently, or identify peer facilitators more appropriately suited for facilitation.

Support Group coordinator roles and Milestones:

- With coordination assistance from the bilingual ***In Common*** Community Specialist, the Prevention Services Coordinator will facilitate approximately 8 support groups a week. Some groups will be ongoing, while others will be temporal--between 6 to 8 weeks in duration.
- It is anticipated that each group will include between 6 – 12 individuals, for a total of approximately 250 individuals served annually.

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served in FY 09/10 (10/11 in parenthesis)		Number of months in operation in FY 09/10
	Prevention	Early Intervention	
Bridge Building Advocacy and Case Management	Individuals: 94 (1130) Families:	Individuals: Families:	1
In Common Support Groups	Individuals: 20 (250) Families:	Individuals: Families:	1
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 114 (1380) Families:	Individuals: Families:	

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

Like *WE CAN*, the *In Common* project will be operated by Kings County Behavioral Health Department. In Kings, clinical services are predominantly provided by Kings View Counseling Services, a longstanding community-based organization and the contracted entity for the County’s Mental Health Plan. The Behavioral Health Department is a relatively new entity, and since MHSA, has adopted the transformative role of extending culturally competent services into community settings. Clinical services, for example, are offered on-site at the Santa Rosa Rancheria, and the two FSP clinicians are bilingual and predominantly serve the Spanish-speaking population.

In Common is intended to extend the reach of services provided by KCBH as well those provided by other local behavioral health organizations. Bridge builders will educate representatives of community based organizations about available services and supports and reciprocate by educating behavioral health providers about such organizations. The bridge builders will also maintain contact with community members to ensure follow-through with referrals. To secure linkages, the bridge builders

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

may accompany individuals identified as needing services to appointments as an advocate and interpreter.

6. Collaboration and System Enhancements

Stakeholders during the PEI Planning Process insisted that cultural competency be embedded in all behavioral health projects and services. The role of the bridge builders will not only be to educate community members and organizations about mental health, but through their role as intermediaries, they will also serve the vital role of educating behavioral health providers about the unique resiliency factors of traditional cultures and the socio-economic needs of underserved community members. Such reciprocal learning helps systems expand their reach by developing mutual trust and respect.

**Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)**

7. Intended Outcomes for *In Common*

Focus Area	Resources	Activities	Outputs	Outcomes	Measures	Impact
<i>List the most important things the program will accomplish</i>	<i>Describe the resources that will support the program activities</i>	<i>Describe and define the program activities</i>	<i>For each activity identify ways to demonstrate that services have been delivered</i>	<i>Identify what changes you expect each activity to effect</i>	<i>Specify the ways that these outcomes will be measured</i>	<i>Describe the impact that the community will feel in 1 – 2 years as a result of the program</i>
<p>Reduce stigma associated with seeking behavioral health services</p> <p>Increase access to services by building bridges between behavioral health services and unserved, underserved and historically inappropriately served communities</p> <p>Generate individual and community resiliency through community-based support groups that engender optimism and hope and build social, emotional and life skills</p>	<p>A full time Community Specialist to conduct outreach</p> <p>A full time Recovery Support Coordinator to advocate and link people to services</p> <p>A full-time Prevention Services Coordinator to facilitate support groups</p> <p>A new In Common vehicle for field visits</p>	<p>1. Culturally and linguistically appropriate outreach</p> <p>2. Community and home based one-on-one engagement</p> <p>3. Case management, advocacy and interpretation linking individuals to initial BH services</p> <p>4. Referrals to support groups and more intensive services as needed</p> <p>5. Coordination and facilitation of support groups</p> <p>6. Senior caregiver respite</p>	<p>1. # of outreach contacts and event location</p> <p>2. # of community and home visitations, # of contacts made, location of event</p> <p>3. # of consults, # of case management hours, case management notes, # of translation and interpretation sessions, duration of assistance</p> <p>4. # of referrals to support groups, Kings View, FSPs, other services, # of successful referrals</p> <p>5. # of support groups, # of attendees, location</p> <p>6. # of users, # of respite hours per user</p> <p>7. Note: demographics for all activities will be collected</p>	<p>1. Providers in underserved communities will have an increased knowledge of services and comfort providing referrals</p> <p>2. An increased number of community members will have knowledge of available services and supports</p> <p>3. At-risk Individuals from underserved communities will have more knowledge of services and less stigma associated with mental health</p> <p>4. More individuals will participate in support groups, the number and diversity of support networks will increase</p> <p>5. There will be an increased number of referrals to BH services</p> <p>6. Individuals participating in groups will feel supported, empowered and emotionally healthy</p> <p>7. Seniors will experience less stress associated with care giving</p>	<p>1. County-wide provider survey, and an outreach log maintained by Community Specialist</p> <p>2 & 3. Confidential Pre/Post survey regarding perceptions of mental health</p> <p>4. Referral log maintained by BH</p> <p>5. Pre/Post surveys and focus groups</p> <p>6. Client satisfaction survey</p>	<p>Penetration rates for previously underserved communities will increase</p> <p>Increased community knowledge about mental health, and willingness to seek support</p> <p>More resilient communities and individuals</p> <p>Reduce incidence of violence, drug and alcohol abuse and suicide</p> <p>Behavioral health providers will have increased knowledge of underserved communities and develop culturally appropriate service mechanisms</p>

Kings County Behavioral Health Department
Instructions for Preparing the PEI Project Summary (Form No. 3)

8. Coordination with Other MHSA Components

In Common staff will work closely with **WE CAN** staff to incorporate cultural competency into youth-related prevention activities. For example, as *In Common* bridge builders identify monolingual parents whose children have behavioral issues, they may accompany them to a screening appointment as an interpreter and advocate. Similarly, they may accompany parents to a MDT meeting and follow up to ensure continuity of services. Because FSP clinicians in Kings County are bilingual, bridge builders will be more easily able to connect those to whom they outreach to more extensive CSS services.

Several of the support groups are geared towards family members of those receiving MHSA and other mental health services. By supporting families to better support their loved ones, this PEI program will help support the recovery of persons with SMI and SED.

9. 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: **KINGS** Date: 3/8/10

PEI Project Name: **WE-CAN**

Provider Name (if known):

Intended Provider Category:

Proposed Total Number of Individuals to be served: FY 09-10 180 FY 10-11 1080

Total Number of Individuals currently being served: FY 09-10 0 FY 10-11 0

Total Number of Individuals to be served through PEI Expansion: FY 09-10 180 FY 10-11 1080

Months of Operation: FY 09-10 2 FY 10-11 12

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 09-10	FY 10-11	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	\$0	\$0	\$0
Prevention Co-ordinator 2.0 FTEs	\$16,110	\$96,659	\$112,769
Recovery Support Co-ord 1.0 FTE	\$6,119	\$36,712	\$42,831
	\$0	\$0	\$0
b. Benefits and Taxes @ % 40.164%	\$8,928	\$53,567	\$62,495
c. Total Personnel Expenditures	\$31,156	\$186,938	\$218,094
2. Operating Expenditures			
a. Facility Cost	\$5,314	\$31,885	\$37,199
b. Other Operating Expenses	\$10,234	\$61,401	\$71,635
c. Total Operating Expenses	\$15,548	\$93,286	\$108,834
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Licensed Clinical Worker	\$25,000	\$150,000	\$175,000
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
a. Total Subcontracts	\$25,000	\$150,000	\$175,000
4. Total Proposed PEI Project Budget	\$71,704	\$430,224	\$501,928
B. Revenues (list/itemize by fund source)			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$71,704	\$430,224	\$501,928
6. Total One-Time Costs	\$182,302		\$182,302

Budget Narrative: WE CAN

The budget submitted for review includes a 2 month portion of the 2009/10 fiscal year as well as a request for funding for the 2010/11 fiscal year. All costs are prorated for two months for the 2009/10 fiscal year unless otherwise noted.

Personnel Expenditures

Program expenditures for the **WE CAN** program are based on the fully loaded staffing costs associated with the newly-proposed Kings County Behavioral Health positions, per current county contract agreements. The program anticipates utilizing the services of three full time staff, including two Prevention Services Coordinators and one Recovery Support Coordinator, as described in the PEI project description. Benefits are calculated at 40.16% of current salary and include associated health, medical, unemployment, pension, and related and applicable state and county employment taxes and contributions.

Operating Expenditures

Operating expenditures include all start-up and ongoing operational costs including facility costs for offices for program staff and leased equipment including telephones, computers, copy machines and other equipment necessary for general office functioning. Additionally, operating expenditures include all the costs associated with implementing evidence based screenings (e.g. ASQ SE start up kits cost \$194.95). Monthly rent is anticipated at \$2,657 in accordance with the average per foot cost of approximately 1,000 square feet of office space in the area. Other ongoing operating costs that are anticipated include costs associated with owning and operating the **WE CAN VAN**. Annual vehicle expenses include storage, insurance, fuel, and maintenance costs. The insurance policy will also require a special rider to allow various KCBH employees to drive the van. Annual costs for the vehicle are anticipated to be approximately \$40,000 given the nature of the vehicle, which will not be fuel efficient, and that it is intended to be used for regular and ongoing trips to remote county

regions. Note: costs associated with training staff in screenings and evidence based practices are included in the PEI Training and Technical Assistance budget).

Subcontracts/Professional Services

WE CAN will work with a licensed clinician to provide PCIT and individual counseling sessions for program participants. The annual anticipated cost of the clinician is anticipated to be \$150,000 in accordance with the contract clinicians currently working with KCBH.

Revenues

No revenues are anticipated through this project.

One Time Costs

A one-time cost of \$182,302 is currently budget for the purchase and customization of the **WE CAN** van.

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

County Name: KINGS Date: 3/8/10

PEI Project Name: **IN-COMMON**

Provider Name (if known):

Intended Provider Category:

County Agency

Proposed Total Number of Individuals to be served: FY 09-10 114 FY 10-11 1380

Total Number of Individuals currently being served: FY 09-10 0 FY 10-11 0

Total Number of Individuals to be served through PEI Expansion: FY 09-10 114 FY 10-11 1380

Months of Operation: FY 09-10 2 FY 10-11 12

Proposed Expenses and Revenues			Total Program/PEI Project Budget		
			FY 09-10	FY 10-11	Total
A. Expenditure					
1. Personnel (list classifications and FTEs)					
Salaries, Wages			\$0	\$0	\$0
a.	Prevention Co-ordinator	1.0 FTE	\$7,847	\$47,081	\$54,928
	Recovery Support Co-ord	1.0 FTE	\$6,119	\$36,712	\$42,831
	Community Specialist	1.0 FTE	\$5,375	\$32,250	\$37,625
	Benefits and Taxes @	% 46.0777%	\$8,912	\$53,470	\$62,382
b.	Total Personnel Expenditures		\$28,252	\$169,513	\$197,765
c. 2. Operating Expenditures					
	Facility Cost		\$4,819	\$28,913	\$33,731
a.	Other Operating Expenses		\$9,280	\$55,677	\$64,957
b.	Total Operating Expenses		\$14,098	\$84,590	\$98,688
c.					

3. Subcontracts/Professional Services (list/itemize all subcontracts)				
		\$0	\$0	\$0
		\$0	\$0	\$0
		\$0	\$0	\$0
a. Total Subcontracts			\$0	\$0
4. Total Proposed PEI Project Budget		\$42,350	\$254,103	\$296,453
B. Revenues (list/itemize by fund source)				0
		\$0	\$0	\$0
		\$0	\$0	\$0
			\$0	\$0
1. Total Revenue	\$0	\$0	\$0	\$0
5. Total Funding Requested for PEI Project		\$42,350	\$254,103	\$296,453
6. Total One-Time Costs		\$35,953		\$35,953

Budget Narrative: *In Common*

The budget submitted for review includes a 2 month portion of the 2009/10 fiscal year as well as a request for funding for the 2010/11 fiscal year. All costs are prorated for two months for the 2009/10 fiscal year unless otherwise noted.

Personnel Expenditures

Program expenditures for the ***In Common*** program are based on the fully loaded staffing costs associated with the newly-proposed Kings County Behavioral Health positions, per current county contract agreements. The program anticipates utilizing the services of three full time staff including one Prevention Services Coordinator, one Recovery Support Coordinator and one Community Specialist, as described in the PEI project description. Benefits are calculated at 46.08% of current salary and include associated health, medical, unemployment, pension, and related and applicable state and county employment taxes and contributions.

Operating Expenditures

Operating expenditures include all start-up and ongoing operational costs including facility costs for offices for program staff and leased equipment including telephones, computers, copy machines and other equipment necessary for general office functioning. Monthly rent is anticipated at \$2,410 in accordance with the average per foot cost of approximately 900 square feet of office space in the area. Other ongoing operating costs that are anticipated include costs associated with owning and operating the ***In Common*** car. Annual vehicle expenses include storage, insurance, fuel, and maintenance costs. The insurance policy will also require a special rider to allow various KCBH employees to drive the vehicle. Annual costs for the vehicle are anticipated to be approximately \$30,000 annually given the nature and that it is intended to be used for regular and ongoing trips to remote county regions. Another operating expenditure includes approximately \$2,400 in respite stipends for senior caregivers who attend support groups.

Subcontracts/Professional Services

No subcontractors or professional services are anticipated to be utilized on this project.

Revenues

No revenues are anticipated through this project.

One Time Costs

A one time cost of \$35,000 is currently budget for the purchase of the ***In Common*** vehicle. An additional sum of \$10,953 is also anticipated for the printing and production of various communication materials for the ***In Common*** project.

County: KINGS

Date: 3/26/2010

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	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2009-10	Budgeted Expenditure FY 2010-11	Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Program Manager	0.2	0.2	\$2,233	\$13,399	\$15,632
b. PEI Support Staff	1	1	\$3,680	\$22,079	\$25,759
c. Other Personnel (list all classifications)					\$0
_____					\$0
_____					\$0
_____					\$0
d. Employee Benefits @ % 57.62%			\$3,407	\$20,443	\$23,850
e. Total Personnel Expenditures			\$9,320	\$55,921	\$65,241
2. Operating Expenditures					
a. Facility Costs			\$1,590	\$9,538	\$11,128
b. Other Operating Expenditures			\$7,541	\$45,247	\$52,788
c. Total Operating Expenditures			\$9,131	\$54,785	\$63,916
3. County Allocated Administration					
a. Total County Administration Cost			\$2,354	\$14,121	\$16,475

4. Total PEI Funding Request for County Administration Budget					\$20,805	\$124,828	\$145,632
B. Revenue							
1 Total Revenue					\$0	\$0	\$0
C. Total Funding Requirements					\$20,805	\$124,828	\$145,632
D. One-Time Funds					\$103,651	\$0	\$103,651

Budget Narrative: PEI Administration

The budget submitted for review includes a portion of the 2009/10 fiscal year as well as a request for funding for the 2010/11 fiscal year. All costs are prorated for two months for the 2009/10 fiscal year unless otherwise noted.

Personnel Expenditures

PEI Administration expenditures are based on fully loaded staffing costs associated with administering the ***In Common*** and ***WE CAN*** projects. Administration will require a .2 FTE PEI Program Manager and FTE Support Staff. The Program Manger will be responsible for supervising all PEI staff and ensuring program quality assurance. The Support position will assist project staff in all activities, including setting up meetings and outreach visits, producing materials, contract compliance, data entry, scheduling and follow-up with family and school districts. Benefits are calculated at 57.62% of current salary and include associated health, medical, unemployment, pension, and related and applicable state and county employment taxes and contributions.

Operating and Administration Costs

Operating expenditures include all start-up and ongoing operational costs including facility costs for offices for administration staff and leased equipment including telephones, computers, copy machines and other equipment necessary for general office functioning. Monthly is anticipated at \$795.

Revenues

No revenue is anticipated.

One Time Costs

One time expenses are \$103,651 for a social marketing campaign to inform the community about the new PEI projects. Costs include printed outreach materials, public service announcements for local TV, newspapers, radio and billboards.

PREVENTION AND EARLY INTERVENTION BUDGET SUMMARY

Form No. 6

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

County:	KINGS
Date:	03/10/2010

#	List each PEI Project	Fiscal Year			Funds Requested by Age Group			
		FY 09/10	FY 10/11	Total	*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
1	WE-CAN	\$71,704	\$430,224	\$501,928	\$376,446	\$125,482	\$0	\$0
2	IN-COMMON	\$42,350	\$254,103	\$296,453		\$74,113	\$148,227	\$74,113
				\$0				
				\$0				
				\$0				
				\$0				
				\$0				
	One-time funds	\$321,906		\$321,906				
	Administration	\$20,805	\$124,827	\$145,632				
	Total PEI Funds Requested:	\$456,765	\$809,154	\$1,265,919	\$376,446	\$199,595	\$148,227	\$74,113

LOCAL EVALUATION OF A PEI PROJECT

Enclosure 3

Form No. 7

County: Kings

Date: 4/1/2010

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

PEI Project Name: WE CAN

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

WE CAN (Wellness & Empowerment Children and Adolescent Network).

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

The two projects proposed in this PEI plan are intended to work in concert with one another. ***In Common*** will lay the foundation for **WE CAN's** prevention-related activities by reducing stigma associated with seeking behavioral health services and by building bridges with unserved, underserved, and historically inappropriately served communities. **WE CAN** will provide community based screening, prevention, and early intervention services for children and youth who would not otherwise receive behavioral health-related services until after a crisis occurs. Of the two projects proposed, **WE CAN** is anticipated to have a more direct impact on individuals, as opposed to communities. In addition, by comparing **WE CAN** service and outcome data between the general population *and* specific underserved communities, we will also be able to assess the *indirect* outcome of the ***In Common*** project. Evaluation feedback on the **WE CAN** activities will be critical in helping KCBH assess program success and to provide guidance to support continuous program improvement.

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

A detailed logic model is included under Section 7: *Intended Outcomes of the WE CAN PEI Project Description*.

LOCAL EVALUATION OF A PEI PROJECT**Form No. 7**

Kings County Behavioral Health has developed eight critical person/family-level and program/system-level outcomes:

Person/family-level outcomes

1. Increasing # of children with BH issues will be identified & referred to PEI programs
2. Families & youth will feel supported and have access to a greater number of resources
3. Quality of parent/child relationship will improve; parenting skills will improve
4. Participating youth will be more resilient and less anxious and depressed.
5. Participating youth in crisis will show improved behaviors and emotional outcomes

Program/system-level outcomes

6. Teachers will have more knowledge about classroom interventions and available services. The school social environments will improve.
7. Child care providers, teachers and school administrators will be more knowledgeable about child social-emotional development
8. More children and youth with SMI will be referred to Full Service Partnerships, Kings View Counseling and other community-based treatment.

LOCAL EVALUATION OF A PEI PROJECT

Form No. 7

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

PERSONS TO RECEIVE INTERVENTION

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS							
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/ DISCRIMINATION	
<u>ETHNICITY/ CULTURE</u>								
African American			36					
Asian Pacific Islander			18					
Latino			432					
Native American			108					
Caucasian			468					
Other (Indicate if possible)			18					
<u>AGE GROUPS</u>								
Children & Youth (0-17)			1080					
Transition Age Youth (16-25)								
Adult (18-59)								
Older Adult (>60)								
TOTAL			1080					
Total PEI project estimated <i>unduplicated</i> count of individuals to be served							1080	

LOCAL EVALUATION OF A PEI PROJECT

Form No. 7

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

The **WE CAN** evaluation will utilize a mixed methods approach relying on both qualitative data (interviews and focus groups) and quantitative data (service record logs and parent/youth surveys).

The following provides an overview of the four anticipated data sources:

- Evaluators will conduct interviews with preschool teachers and school administrators on an annual basis. In particular, preschool interviewees will be asked to assess processes, outcomes and satisfaction with screenings, PCIT and other one-on-one interventions. School administrators and psychologists will be asked to comment on the extent to which the skills-building groups are transforming the attitudes and behaviors of participant youth and the school environment in general. The evaluator will also interview partner providers who participate in MDT meetings to help assess processes and perceived impact.
- The evaluators will survey youth, their guardians and teachers prior to and following participation in the school-based skill-building groups. The surveys will help assess the impact of participation on youth behaviors and sense of wellbeing. In addition, the evaluator will conduct youth focus groups with several skill-building groups during the last session. During the focus group, the WE CAN clinician will serve as a clinician witness, but the Prevention Services Coordinator normally in attendance with the group will be absent to ensure that the youth are able to speak freely about their experiences in the skill-building group sessions, and to reflect on the impact their participation has had in their daily lives. Passive consent forms will be included in the parent information packet developed for inclusion in the skill building classes.
- Parents/guardians who receive PCIT services (and parents/guardians and youth over the age of 11 who participate in MDT meetings) will be asked to complete confidential surveys upon completion of services. Surveys will ask about cultural competency (e.g. “Do you feel like the therapist /team respected and understood your culture?”) and about other indicators regarding client satisfaction, impact and program fidelity. For example, in assessing fidelity to

LOCAL EVALUATION OF A PEI PROJECT**Form No. 7**

the MDT model, the survey will ask about whether the parent/child was asked who else should be part of the team and if those individuals are now participating on the team.

- On an annual basis, the evaluators will review client records and referral and service logs to assess extent of outreach into underserved communities, follow-up with referrals, retention levels and fidelity to intervention models. **WE CAN** is concerned with program retention and hopes to see 80% of the individuals and families that begin services with us stay through the recommended service period. The evaluation will cross-tabulate retention rates and client satisfaction by various characteristics including type of service, age, geographic location, and race/ethnicity to determine program impact on various age groups, cultures and communities.
- The evaluator will prepare an annual report based on findings from qualitative and quantitative measurements. Particular attention will be paid to identifying program strengths, challenges and lessons learned, and extent of fidelity to evidence-based practices. The WE CAN logic model, on page 39, will serve as a basic evaluation guide for measuring project outcomes.

5. How will data be collected and analyzed?

The **WE CAN** evaluation will rely on program staff to facilitate data collection activities. The evaluation design and the development of the survey, interviews, and discussion group tools will be conducted by an outside evaluator. All analysis will be conducted by the outside evaluation firm in harmony with KCBH. Analysis will be conducted in accordance with general practices of reviewing qualitative data including reporting on key themes that emerge and highlighting special comments or sentiments that are illustrative of the strengths and challenges of the program. Quantitative data analysis, including survey results, will be analyzed using basic statistical analysis to cross tabulate findings by important independent variables such as participant demographics, school or home community, and services received.

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

LOCAL EVALUATION OF A PEI PROJECT

Form No. 7

WE CAN is intended to link with **In Common**, a PEI outreach and engagement project targeting Kings County residents who have had little or no previous contact with public and community-based behavioral health services. To the extent necessary the **WE CAN** program will draw upon the expertise of the **In Common** staff who serve as advocates and interpreters to the many Spanish-speaking parents in Kings County. The **In Common** Community Specialist will be asked to review the parent and youth survey tools for cultural appropriateness. These tools will be translated into Spanish.

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

The formative evaluation described here will be conducted in partnership with KCBH and is intended to provide ongoing input and advice towards strengthening the program model. The program evaluation team will work closely with the PEI Program manager to ensure that program compliance and fidelity standards are followed. In particular the PEI program manager will be responsible for ensuring that:

- scheduled activities are happening with the frequency and regularity anticipated in this plan;
- program staff are meeting with an appropriate number of people each month; and
- program staff are appropriately trained and have protocols for the program models and activities described in this plan (for example multi-disciplinary team and parent child interactive therapy).

These activities will be recorded in daily or weekly activity logs that will be signed off by the PEI Program manager, and reviewed by the evaluation team annually. The evaluation team will compare records of service delivery with the literature describing the best practices or fidelity standards for the applicable model and include a summary analysis in the annual evaluation report.

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

The intention of the evaluation is to inform ongoing program improvement and findings will be readily shared back to program staff for their own assessment and analysis. The final report will be

LOCAL EVALUATION OF A PEI PROJECT

Form No. 7

made public and available for download on the KCBH website. Evaluation findings will also be summarized in a presentation to program staff and key stakeholders in a half day retreat designed to help program staff and stakeholders reflect on the accomplishments of the **WE CAN** program. The final report for the fiscal year ending June 30 will be distributed in October and the community presentation will be held in November. These activities are intended to launch the community program planning process to inform the Annual Update.

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Appendices

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Appendices

Appendix

- A. Kings County MHSa Newsletter
- B. PEI Vision Statement
- C. Sample Meeting Announcement
- D. Key Informant Interview Protocol
- E. Focus Group Protocol
- F. Stakeholder Demographics Form
- G. PEI Mental Health Needs and Priority Populations Survey
- H. Kings County Qualitative Needs Assessment
- I. MHSa Community Input Forms: PEI Priorities
- J. Potential PEI Project and Evidence-Based Practice Handout
- K. Tally of Results from the PEI and Innovation Priorities Meeting

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN
Appendices

Appendix A: Kings County MHSA Newsletter



MHSA Update

The passage of the Mental Health Services Act (MHSA) on November 2, 2004, has afforded Kings County Behavioral Health an opportunity to transform its mental health system of care. The goals of MHSA are to:

- ✓ Reduce the long-term, adverse impact of untreated mental illness on individuals, families, and state and local budgets.
- ✓ Expand innovative service programs for children, adults and seniors.
- ✓ Reduce the stigma associated with being diagnosed with a mental illness.

Between 2007 and 2008, Kings County Behavioral Health engaged community members in a comprehensive series of community activities to develop:

- ✓ Mental Health Services and supports.
- ✓ Mental health workforce training and education strategies.

Beginning this November 2009, Kings

County Behavioral Health will launch the community planning process for the MHSA Prevention and Early Intervention (PEI) and the Innovation (INN) components. Upon completion of these planning processes, the State will award Kings County over \$2 million.

Innovation

The MHSA Innovation component funds novel, creative and ingenious mental health practices that contribute to learning. Innovation programs cannot replicate programs in other counties. Innovation programs should be designed to:

- ✓ Promote interagency collaboration,
- ✓ Increase access to services, particularly for underserved groups and/or
- ✓ Increase the quality of existing services.

As strategies funded by MHSA under this component are innovative in nature, not all will succeed. Counties are encouraged to take a risk!

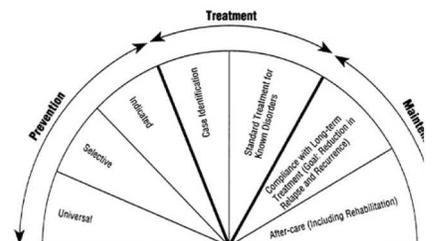
Prevention and Early Intervention

The PEI component provides funding for programs that engage persons prior to the development of serious mental illness or emotional disturbances. The intention is to alleviate the need for additional mental health treatment, and to transition those with ongoing needs to more comprehensive mental health services.

Prevention strategies help reduce stigma and target community members who are experiencing challenging life circumstances and who may be “at risk” of developing behavioral health issues. Prevention strategies are meant to reduce risk factors, increase coping mechanisms and promote community wellness.

Early Intervention strategies are targeted toward individuals experiencing the early stages of mental illness and for whom short-term; relatively low-intensity services are appropriate.

Additionally, Early Intervention programs aid in the transition to more extensive behavioral health services to help prevent issues from getting worse.





**Behavioral Health
Department**
450 Kings County Dr., Suite
104
Hanford, CA 93230

Phone:
(559) 582-3211 ext. 2376

E-Mail:
Peter.Munoz@co.kings.ca.us

Kings County
Behavioral Health
450 Kings County Dr., Suite 104
Hanford, CA 93230

Your Participation is Critical!

Kings County Behavioral Health is seeking input from community members in crafting its Prevention and Early Intervention and Innovation Plans.

All members of the public are invited to participate in this process. In particular we are seeking individuals who are:

- ✓ Consumers or family members of mental health service consumers
- ✓ Family members of young children with special needs
- ✓ Teens and young adults
- ✓ Representatives from underserved cultural populations
- ✓ Recent immigrants
- ✓ GLBT community members
- ✓ Older adults

We are also seeking input from professionals who may be involved in prevention and early intervention activities. In particular we are seeking:

- ✓ Educators
- ✓ Health care providers
- ✓ Law enforcement/probation/emergency service providers
- ✓ Mental health providers
- ✓ Clergy
- ✓ Others caring for underserved and vulnerable populations

Your input is critical to creating programs that meet the needs of Kings County's diverse residents.

Please contact Kings County Behavioral Health if you are interested in attending a **focus group** or a **community meeting** in the coming months.

In addition, Kings County will be convening an **MHSA Planning Council** to help guide the process. The first planning council meeting for this phase of MHSA planning will be on November 23, 2009, from 12pm to 2pm at the Administration Multipurpose Room. If you are interested in attending, please contact Peter Munoz, at 582-3211 ext. 2441, peter.munoz@co.kings.ca.us



**RECIPIENT NAME
STREET ADDRESS
ADDRESS 2
CITY, ST ZIP CODE**

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Appendices

Appendix B: PEI Vision Statement

Our Vision for Prevention & Early Intervention

In Kings County Prevention and Early Intervention Programs...

... Will be inclusive and accessible to all residents.

*... They will include outreach for the eradication of social
stigmas associated with mental illness.*

... They will focus on wellness, recovery and resiliency.

... We will educate

- * police and other community agencies,*
- * doctors and other healthcare professionals,*
- * teachers and school administrators, and*
- * parents and family members*

to recognize early signs and symptoms of mental illness.

*... All providers will view the client and family
holistically, empowering each member to seek and
receive appropriate mental health services.*

*This statement is the result of a collective exercise by Kings County
MHSA Planning Council in November 2009. Prepared
By Resource Development Associates, in conjunction with
Kings County Behavioral Health*



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Appendices

Appendix C: Sample Meeting Announcement

Mental Health Services Act (MHSA) “Transforming Mental Health Services”

Please Join Kings County Behavioral Health Department
for a Community-wide meeting on:

February 19, 2010
9 AM – 4 PM

Location:
680 North Campus Drive, Suite S
Hanford, CA 93230

Prevention and Early Intervention (PEI)

The PEI component of MHSA provides funding to help individuals prior to the onset of serious mental illness or serious emotional disturbance when short-term, relatively low-intensity services are appropriate. During the first part of the meeting we will be prioritizing the strategies identified previously in the planning process.

Innovation

The Innovation component of MHSA provides funding for new, novel, and creative strategies for addressing the mental health needs of each county. During the second part of the meeting we will be developing & prioritizing innovative projects based on the unique needs of Kings County residents.

RSVP is appreciated, but not required. If you have any questions or require special accommodations to attend, please contact:

Peter Muñoz
(559)582-3211 Ext. 2441
(559)589-6916 Fax
peter.munoz@co.kings.ca.us

**LUNCH
PROVIDED!**



**YOUR INPUT
IS NEEDED!**

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Appendices

Appendix D: Key Informant Interview Protocol

**Kings County Behavioral Health Department
MHSA Prevention and Early Intervention & Innovation Planning Process**

Interviewee name:

Organization (if applicable):

Address:

Date:

Interviewer:

(Note to interviewer: At the conclusion of this interview, please draft a narrative with interview highlights pertaining to identified needs, leverageable resources and strategy ideas. Please include the narrative at the end of this form.)

Interview Overview Script

"The purpose of our conversation today is to help inform the Kings County's Mental Health Services Act (MHSA) Planning Process. Following this planning process, the State of California will award Kings County approximately \$700,000 per year to develop and expand prevention and early intervention programs and a total of \$600,000 for new and innovative mental health initiatives. In these interviews, we are asking key County stakeholders to help us identify key mental health needs, and strategies to address these needs.

This current process builds on earlier community planning processes that helped Kings County develop and expand mental health services and supports for persons with serious mental illness and emotional disturbances.

The Prevention and Early Intervention component of the Mental Health Service Act is designed to fund programs for the general population and at-risk individuals BEFORE they experience the onset of mental illness. Prevention programs help promote wellness, reduce risk factors and build resiliency. Early interventions are designed treat individuals following the initial onset of mental illness for a short period of time, in order to prevent problems from getting worse. Intervention services are designed to help individuals avoid the need for more extensive services and to help transition those with need to appropriate ongoing services and supports.

The Innovation component of the Mental Health Service Act provides funding for novel, creative and ingenious mental; health practices. The strategies generated by Kings County stakeholders cannot replicate programs in other jurisdictions throughout California. The purpose of innovation is to promote learning, and by nature, not all Innovative strategies will succeed.

1. *Do you have any questions about what is intended by prevention or early intervention or by innovation?*

Disclaimer

The contents of this interview will be kept confidential, meaning your name will not be attached to anything you say; however we would like to present a list of names in the plan of those who we have interviewed.

2. *Do you consent to have your name shared in the public document? Yes No (circle one)*

Interview Questions

3. *Can you briefly tell me about the services and supports that you (your agency) provide to Kings County residents?*
4. *Did you participate in the community services and supports planning process for MHSA? If yes, was there anything that you remember coming out of the CSS planning process that is relevant to the prevention and early intervention plan?*
5. *What existing prevention and early intervention activities are you aware of in Kings County?*
6. *Are there significant gaps in current prevention-related activities? Specifically for:*
 - a. *Young children and families*
 - b. *Transitional Age Youth (probe: at risk of school failure or juvenile justice involvement)*
 - c. *Adults*
 - d. *Older Adults*
 - e. *Underserved population groups (probe: race or ethnicity, language, economic, parolees, veterans, LGBT, geographically isolated (where?))*
 - f. *Specific at-risk populations not covered above: (trauma exposed; foster children; stressed families; children at risk of school failure; children at risk of juvenile justice involvement, suicide risk)*
7. *Do you have any data on the needs or gaps that you identified?*
8. *What do you think should be done to address these gaps? (This is where they will discuss possible strategies. For each idea, probe for: target population? evidence-based practices (if they are sophisticated)? Where services are to be provided (schools, homes, BH department, CBO.)?*

Innovation

Now, switching gears, let's talk about the Innovation component. For this component, we are not only concerned with prevention and early intervention strategies, but we are looking for new and innovative ideas for services that promote mental health wellness, resiliency and recovery for the general population; for individuals at-risk of mental illness or emotional disturbance; or for persons with serious mental illness. Innovative strategies promote learning. The strategies that we select will be evaluated, and if they are successful, they will add to the growing body of knowledge and understanding of what contributes to community wellness.

The MHSA guidelines specify that Innovation programs should be used for at least one of the following purposes:

- increase access to underserved groups

- increase the quality of services, including better outcomes
- promote interagency collaboration
- increase access to services

I'm going to ask you to think for a moment "outside the box" about each of these objectives.

9. *Do you have any ideas for innovative strategies that might help underserved groups access mental health services? (probe: if we were to fund this program, what would you hope to learn?)*
10. *Do you have any ideas for innovative strategies that might increase the quality of existing services and promote better outcomes? (probe: if we were to fund this program, what would you hope to learn?)*
11. *Do you have any ideas for innovative strategies that would promote interagency collaboration or communications? (probe: if we were to fund this program, what would you hope to learn?)*
12. *Do you have any ideas for innovative strategies that would increase access to services for those most in need? (probe: if we were to fund this program, what would you hope to learn?)*
13. *Do you have any other ideas for innovative strategies that might address the unique needs or take advantage of the unique strengths of this community? (probe: if we were to fund this program, what would you hope to learn?)*

General Question

14. *Are there any questions that we did not ask or any other ideas that you have that would help guide this planning process?*

Demographics

Per the state guidelines for planning purposes it is important for us to compile demographics on the people that have participated in the planning process. These demographics will be kept confidential and only used to report on total numbers included in the planning effort.

Decline to answer demographic questions

Do you identify yourself as a consumer or a family member of a consumer of mental health services?

- Consumer
- Family Member
- Both
- Neither

Please indicate your age range:

- 18-25
- 26-59
- 60 and older

Do you consider yourself to be:

- Male
- Female
- Transgender

What is your race ethnicity? Do you consider yourself:

- White/Caucasian
- Black/African American
- Hispanic/Latino
- Southeast Asian
- Other Asian or Pacific Islander
- American Indian/Native American/First Nations (including Hawaiian and Alaskan Native)
- Mixed Race: _____
- Other: _____

Any comments?

Do you have any other comments or concerns?

Is there anything you would like to tell me about this interview process?

Thank you for your time today. Your input has been very valuable. Following this discovery phase we will be inviting all stakeholders to participate in strategy prioritization community meetings. These meetings will likely be held in January. Is it ok for us to contact you to invite you to participate in these meetings? Great! Thank you for your participation. I look forward to meeting you in person.

Interview Narrative Here

MHSA Community Input Form

PEI Mental Health Needs and Priority Populations

Please take the time to fill out this survey sheet and submit it to RDA or Peter Muñoz at the end of this meeting. Thank you!

Background Information:

Prevention and Early Intervention is intended to:

- Engage persons prior to development of serious mental illness or emotional disturbance.
- Alleviate the need for additional mental health treatment.
- Transition those with identifiable need to extended mental health treatment.

Prevention and Early Intervention Definitions:

- **Prevention** occurs prior to a diagnosis of mental illness.
 - Universal targets the general population
 - Selective targets groups whose risk of developing mental illness is higher than average
- **Early Intervention** is directed toward individuals and families for whom a short-duration, low-intensity intervention is appropriate to improve a mental health problem or concern very early in its manifestation
 - Reducing need for more intensive services
 - Preventing mental health problem from getting worse

Please mark the two Key Community Mental Health Needs* you feel are most relevant to Amador County:

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

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Appendices

Appendix E: Focus Group Protocol

**Mental Health Department
MHSA Prevention and Early Intervention Planning Process**

Focus Group Facilitator Form

Focus Group Summary

Facilitator Name:

Hosting Organization (if applicable):

Key Contact:

Total Number of Participants:

Overview of Prevention and Early Intervention

Please review the following key points with the providers you are meeting with.

- Do introductions and go over focus group guidelines
- This is a planning process to help figure out how to spend PEI and Innovation money in Kings County.
- Mental health prevention and early intervention is an opportunity to help **children and transitional age youth who are at risk of developing emotional disturbance or mental illness** develop pro-social and coping skills, avoid risky behaviors and connect with critical supports.
- Introductions, name and occupation, ice-breaker “If you could invent one thing that would improve peoples’ lives, what would it be?”

Focus Group Questions

Please ask the group members the following questions:

- What PEI programs are there in Kings County, and how successful are they at reaching children and TAYs at risk of developing emotional disturbance or mental illness?
- Where do families go for help?
- What challenges or stressors do Kings County children and TAYs face? (for example; child abuse/neglect, intergenerational drug use; financial instability.) Data sources?
- Who in Kings County is most at risk?
- What types of PEI programs would help children and youth? Consider **universal** strategies, **selective** strategies for specific at risk populations, or **targeted interventions** to help youth that may be experiencing signs and symptoms of severe emotional disturbance or mental illness.

Innovation Questions:

- In regards to innovation, what do you think Kings County could do to increase the effectiveness of mental health services and supports for persons with mental illness?

- Is there a need to improve communication and collaboration between agencies and organizations that provide services to persons with mental illness? How come? What should be done?

- What is one thing that Kings County could do to increase access to Mental Health Services for persons with SED/SMI? What about increasing access to services for people from underserved or inappropriately served groups?

- Go Around: What is one question about mental health in Kings County you wish you knew the answer to?

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Appendices

Appendix F: Stakeholder Demographics Form

**Kings County Behavioral Health Department
MHSa Planning Process**

Stakeholder Group Demographics

Per State guidelines, we must report the following demographic information on planning participants. This information will be kept confidential and used for reporting purposes only. You may decline to answer these questions.

I decline to answer demographic questions

Do you identify yourself as a consumer or a family member of a consumer of mental health services?

- Consumer
- Family member of a consumer
- Both a consumer and a family member of a consumer
- No, I do not identify as a consumer or a family member of a consumer

Please indicate your age range:

- 18-25
- 26-59
- 60 and older

Please indicate your gender:

- Male
- Female
- Transgender

What is your race ethnicity?

- White/Caucasian
- Black/African American
- Hispanic/Latino
- Southeast Asian
- Other Asian or Pacific Islander
- American Indian/Native American/First Nations (including Hawaiian and Alaskan Native)
- Mixed Race: _____
- Other: _____

Please return both pages to a Resource Development Associates staff member upon concluding the meeting. The demographic information is confidential. Your name WILL NOT be connected to your response.

If you have any questions or would like to talk to someone at the Behavioral Health Department regarding this process please contact Peter Muñoz at (559)582-3211 Ext. 2441

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Appendices

Appendix G: PEI Mental Health Needs and Priority Populations Survey

MHSA Community Input Form

PEI Mental Health Needs and Priority Populations

Please take the time to fill out this survey sheet and submit it to RDA or Peter Muñoz at the end of this meeting. Thank you!

Background Information:

Prevention and Early Intervention is intended to:

- Engage persons prior to development of serious mental illness or emotional disturbance.
- Alleviate the need for additional mental health treatment.
- Transition those with identifiable need to extended mental health treatment.

Prevention and Early Intervention Definitions:

- **Prevention** occurs prior to a diagnosis of mental illness.
 - Universal targets the general population
 - Selective targets groups whose risk of developing mental illness is higher than average
- **Early Intervention** is directed toward individuals and families for whom a short-duration, low-intensity intervention is appropriate to improve a mental health problem or concern very early in its manifestation
 - Reducing need for more intensive services
 - Preventing mental health problem from getting worse

Please mark the two Key Community Mental Health Needs* you feel are most relevant to Amador County:

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

Please mark the three PEI Priority Populations* you think are most in need of PEI services in Amador County:

- Underserved Cultural Populations** (PEI projects address those who are unlikely to seek help from any traditional mental health services 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 PEI programs and interventions)
- Individuals Experiencing Onset of Serious Psychiatric Illness** (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 services.)
- Children/Youth in Stressed Families** (Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of caregiving adults (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.
- Trauma Exposed** (Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health services.)
- Children/Youth at Risk for School Failure** (Due to unaddressed emotional and behavioral problems)
- Children/Youth at Risk of or Experiencing Juvenile Justice Involvement** (Those with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through Community Services and Supports)
- Other** _____

(Optional) Please use this space to provide any comments about why you selected these key community mental health needs or priority populations.

* Please note; these Key Mental Health Needs and Priority Populations were identified in the MHSA PEI guidelines prepared by California Department of Mental Health, the OAC and its PEI Committee

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Appendices

Appendix H: Kings County Qualitative Needs Assessment PPT

MHSA Planning Council

January 19, 2010



Kings County Behavioral Health
Prevention and Early Intervention
&
Innovation
Mental Health Services Act

Prepared by Resource Development Associates, Inc

Agenda

- Introductions
- Where are we in planning process?
- PEI and Innovation guidelines recap
- Discovery Phase Report Back
 - Challenges
 - Opportunities
 - Initial Strategies
- Comments and Additions
- Next Steps

April 10

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2

Introductions

- Name?
- Affiliation?

- Who is your local hero? Why?



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3

Where are we in the planning process?

- ✓ **MHSA Guidelines & Introduction**—Planning Council #1
- ✓ **Preliminary information gathering**
 - ✓ Key informant interviews
 - ✓ Focus groups
- **Report back**—Planning Council #2
- **Strategy Development**—Strategy Roundtables
- **Community Prioritization**—Community Meetings
- **Quantitative Needs, Budgets & Feasibility Analysis**—RDA
- **Strategy Recommendations**—Planning Council #3
- **Plan Drafting**—RDA
- **Plan Approval**—Planning Council #4
- **BOS Approval and Submission to State**

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4

Stakeholder Participation

- 18 key informant interviews
- 11 Focus Groups
 - Family Member Support
 - Older Adult
 - Public Education
 - Providers, Children 0-5
 - Oak Wellness Center Consumers
 - Emergency Services/5150 Group
 - Child Welfare Services
 - BH and Kings View Staff
 - Transitional Age Youth
 - Tribal TANF
 - Monolingual Spanish (Scheduled)

163 Participants
to Date!

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5

PEI: Definitions

- **Prevention occurs prior to a diagnosis of mental illness.**
 - **Universal targets the general population**
 - Selective targets groups whose risk of developing mental illness is higher than average
- **Early Intervention is directed toward individuals and families for whom a short-duration, low-intensity intervention is appropriate to improve a mental health problem or concern very early in its manifestation**
 - Reducing need for more intensive services
 - Preventing mental health problem from getting worse
 - Transitioning those with identifiable need to more extensive services

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6

MHSA Innovation

Purpose

- Funds novel, creative & ingenious mental health practices
- Cannot replicate programs in other jurisdictions
- Must be aligned with MHSA principles
- Must contribute to learning
- By nature, not all innovative strategies will succeed



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7

Challenges, Opportunities & Initial Strategies

Establishing a Nexus

What we heard.....

Young Children & Their Families

Challenges

- Families are stressed due to high rates of poverty, unemployment, isolation & housing insecurity. Made worse by diminished services due to recent budget cuts.
- Young children are traumatized by exposure to substance use, violence, abuse & parental abandonment.
- Many parents don't recognize or ignore developmental needs of young children, and lack skills for dealing with behavioral problems & other parenting challenges.
- Child care providers & teachers have insufficient training & time to deal with children with socio/emotional & behavior problems; many children are disciplined rather than treated.

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10

Challenges:

- Once children with BH needs are identified, teachers, parents & even BH providers are unclear about available services & eligibility requirements.
- Existing BH caseloads are very high; often restricted to those who meet medical necessity.
- Shortage of bilingual, culturally competent providers prevent parents from accessing appropriate services.
- Other barriers include stigma, lack of childcare & limited transportation; many never even receive an initial assessment.
- Confusion about HIPAA & privacy regulations limits information-sharing between partner agencies.

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11

Opportunities

- Family Resource Centers (FRCs) provide one-stop services to families at a variety of locations in Kings County
- First 5 funds FRCs, training to childcare providers, supports transition to kindergarten
- Kings County Action Organization runs Head Starts and crisis & abuse support
- Kings View offers individuals & family therapy at their main clinic, two satellite clinics Lemoore and Avinal, 4 FRCs; and at 36 schools

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12

Opportunities

- *Ages and Stages* screening provided at Hanford & Lemoore FRCs
- United Cerebral Palsy has an infant & child development program for children 0-3. Runs *Parent and Me* classes & *Devereux Early Childhood Assessment (DECA)*.
- MHSAs Children's *Full Service Partnership Program* serves children with serious emotional disturbance

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13

Initial Strategy Ideas

- **Public Awareness & Education**
 - Develop father-involvement campaign
 - Provide incentives to child care providers who make successful referrals
- **Screening & Assessment**
 - Intensive outreach, parent education and screenings at food banks, social service agencies & health clinics
 - Expand *Ages and Stages* screening
 - Home visiting for young and at-risk parents
 - Increase funding for DECA, to help teachers and parents identify protective and risk factors, and implement strength-based strategies

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14

Initial Strategy Ideas

- **Short-term Interventions**
 - Parent Child Interactive Therapy
 - Cognitive Behavioral Therapies such as *Coping Cat*, which targets children with anxiety, and *Real Life heroes*, which treats juvenile PTSD and trauma.
- **Systems Change & Innovation**
 - Expand eligibility for short-term/crisis counseling for young children & families
 - Develop school-based behavior management programs and/or multidisciplinary teams
 - Implement a children's system of care
 - Child Welfare/MH Liaison to provide on-site assessments

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15



What we heard.....

Transitional Aged Youth

Challenges

- 25% of serious mental illnesses emerge by age 14; 75% emerge before the age of 25. TAYs are most at risk.
- Many youth are exposed to violence, abuse, bullying, drugs and gangs.
- Many lack parental guidance or mentorship, which impacts their ability assess their own needs & make healthy choices; affects their self esteem,
- Lack of guidance limits the identification of emerging mental health issues.
- Limited coordination between military & civilian services means that children of military families are at risk of school failure.

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17

Challenges

- Kings County has exceptionally high rates of teen pregnancy. Young parents need extensive supportive services to ensure intergenerational wellness.
- Youth aging out of foster and group homes experience displacement, anxiety, isolation and financial insecurity.
- For juvenile offenders, lack of age-appropriate wellness programs in Kings County make completing terms of probation difficult.
- Shortage of support services for youth transitioning from incarceration results in high rates of recidivism.

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18

Opportunities

- Full Service Partnerships provide comprehensive services for TAYs with Severe Emotional Disturbances
- Independent Living Program (ILP) promotes self-sufficiency through life skills training; funds transitional housing for those aged out of foster care
- Summer Camp Program offers BH programming for youth
- Friday Night Live encourages healthy relationships with caring adults through youth & leadership development programmin

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19

Opportunities

- *Why Try?* interactive curriculum which helps youth overcome their challenges and improve outcomes in the areas of truancy, behavior, and academics.
- After School Enrichment programs in some elementary schools
- Teen Centers at Lemoore, Hanford & Corcoran offer engaging, supervised social activities for teens
- Planned Parenthood provides confidential pregnancy tests & birth control
- Champions Recovery Alternatives provides intensive outpatient treatment to adolescents and young adults

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20

Initial Strategy Ideas

- **Public Awareness & Education**
 - Bilingual outreach campaign
 - Peer-based mentoring programs in schools
 - Pro-social teen after school program
- **Screening & Assessment**
 - On-site BH professional to conduct assessments at CPS
 - Mental Health screenings "Teen Screen" in High Schools

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21

Initial Strategy Ideas

- **Short-term Interventions**
 - Healthy communication training for parents & youth
 - Functional Family Therapy for high-risk youth
 - "Transition to independence" Program to help empower at-risk youth
 - Promote and expand mentoring through Boys & Girls Clubs, Big Brother, PAL
 - Teen parenting program
 - Expand Summer Camp Program
 - Safe places for TAYs in crisis modeled after the *EOC Sanctuaries* in Fresno

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22

Initial Strategy Ideas

- **Systems Change and Innovation**
 - Develop school-based, multidisciplinary teams to work with TAY and their families providing assessment, behavior management, performance expectations (Dialectic Behavioral Training)
 - Implement a system of care across age groups
 - Expand Boys Ranch to include those not yet incarcerated
 - Expand equine assisted growth and learning program for youth with behavior issues

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23



Adults & General Population

Challenge

- Poverty & homelessness increasing throughout the County. Housing & financial insecurity has substantial impact on MH.
- Substance abuse; anger & relationship challenges; PTSD and trauma are major issues for Kings County adults
- Caseloads are very high. Priority is for the SMI with few resources available for persons without diagnosis
- People experiencing initial onset of mental illness are sent out of County
- Insufficient training for 1st responders & law enforcement result in arrest instead of treatment.

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25

Challenge

- There is a general shortage of providers with backgrounds that reflect Kings County diverse population, particularly Spanish-speaking providers
- Community members & providers lack knowledge of available services
- Transportation from outlying communities to Hanford is one of the biggest barriers
- Communications between agencies, budget cuts and complex eligibility requirements results in delays of treatment.

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26

Opportunities

- Oak Wellness Center has informed and committed peer volunteers
- Partnership for Prevention promotes collaboration between agencies.
- Kings View provides individual & group therapy, case management, crisis intervention, substance abuse and dual-diagnosis treatment & psychiatry at Hanford & satellite locations.
- Kings CONNECTION & 211 United Way Resource Phone Line
- Annual homeless services event provides flu & tetanus shots, dental care, haircuts, free bicycles & dog food.

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27

Initial Strategies

- **Public Awareness & Education**
 - Mental Health Fairs providing information, referrals, screenings, etc.
 - Increase collaboration with public health and other partner agencies
- **Screening & Assessment**
 - Equip doctors with BH screening tool to do voluntary universal assessments

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28

Initial Strategies

- **Short-term Interventions**
 - Stress management, couples counseling and conflict resolution program for adults
 - Provide additional services for those impacted by economic downturn—the homeless, recently unemployed; and foreclosed
- **Systems Change & Innovation**
 - Provide free and accessible transportation from FRCs to Hanford Kings View
 - Ensure that all programs have a cultural competency component

 What we heard.....

Older Adults

April 10

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29

Challenge

- Seniors living alone or in remote, isolated areas are at-risk of depression & suicide. Majority of senior resources are centrally located in Hanford and Lemoore
- Monolingual seniors are even less likely to seek services; few bilingual & bicultural geriatric MH providers
- Insufficiently trained family caregivers may not recognize early signs or appropriately respond to MH needs of seniors.
- In-home assessments & services have been drastically reduced as a result of recent budget cuts.

April 10 Resource Development Associates 31

Challenge

- Seniors treated & released following crisis do not always follow-up on referrals & are not seen again until another crisis occurs.
- Delays due to insufficient interagency communication about referrals results in some seniors falling through the cracks.
- Co-occurring dementia and mental illness requires unique services and interagency communication.
- Lack of communications between psychiatrists & primary care providers result in inappropriate or over-medication

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Opportunities

- Behavioral Health SAFE outreach teams provide clinical & case management services to vulnerable seniors.
- Senior Centers provide daily meals and social activities
- Preventive Health Care for Adults (PHCA) conducts comprehensive health screenings that include MH questions
- Kings County Commission on Aging offers advocacy, I&R, support services and Adult Day-Care, and collaborates with KCAO on Generations Program.
- In Home Services & Supports (IHSS) offers in home services for the elderly and disabled.
- Government Center Complex offers multiple senior services in close proximity, reducing the need for extensive use of transit.

April 10 Resource Development Associates 33

Initial Strategies

- Public Awareness & Education**
 - Increase wellness activities such as exercise, brain fitness & dances at faith-based, cultural and senior centers.
- Screening & Assessment**
 - Implement PEARLS depression screening & short-term home-based counseling sessions or other home visiting program

April 10 Resource Development Associates 34

Initial Strategies

- Short-term Interventions**
 - Fund older adult caregiver counseling & support program
 - Short-term Cognitive Behavior Therapy for later life depression
 - Provide wrap-around services to older adults following crisis
- Systems Change & Innovation**
 - Develop integrated primary health care and MH service program that includes cross-training, increased communications and referrals & voluntary screening.
 - Develop strategy to support Medi-Cal billing for seniors at Kings View

April 10 Resource Development Associates 35

Other Challenges? Other Strategies?

Contact Jennifer Susskind
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Appendices

Appendix I: MHSA Community Input Forms: PEI Priorities

MHSA Community Input Forms

PEI Priorities

Strategy Breakout by Age Group (Please check appropriate box):

- Children & Families
- School Age Children & Transition Age Youth
- Adults
- Older Adults

List your top two strategies here:

1) _____

2) _____

Strategy 1

Please explain why you selected this strategy?

What needs does this strategy help address?

Are there any existing resources that can be leveraged to help build this strategy?

Is there anything else you would like us to consider about this strategy?

Strategy 2

Please explain why you selected this strategy?

What needs does this strategy help address?

Are there any existing resources that can be leveraged to help build this strategy?

Is there anything else you would like us to consider about this strategy?

Other Considerations

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Appendices

Appendix J: Potential PEI Project and Evidence-Based Practice Handout

Potential Project & Evidence Based Practices
 Target Population: Young Children & Families

Universal/ Selective/ Targeted?	Project Description	Evidence-based Practice or Other Resource	Cost (\$-\$\$\$)
Project 1: Mental Health Screening for Young Children 0-5			
Universal	A behavioral health professional to conduct outreach and education and coordinate social and emotional screenings in preschools (<i>which schools?</i>) and pediatricians' offices and provide appropriate referrals to children and families needing services. Outreach is targeted to areas with a high concentration of low income residents and culturally underserved populations. Potential areas include Corcoran, Avenal, Stratford, and Hanford.	Ages and Stages including Social and Emotional; Devereux Early Childhood Assessment (DECA); Brief Infant-Toddler Social Emotional Assessment (BIT SEA); Early Screening Project (ESP); Social Skills Rating System (SSRS); Preschool and Kindergarten Behavior Scale (PKBS); Primary Project	\$\$
Project 2: Father Involvement Campaign			
Universal	A strength-based educational campaign that builds on the positive impact father involvement has in healthy child development, and de-stigmatizes fathers as caregivers. This program provides outreach to fathers, reinforces relationships through shared activities, and increases parent knowledge and involvement in mental health services. This program addresses the needs detailed in First 5's Planning Grant Report for Lemoore.	Papás: Supporting Fatherhood Involvement; Male and Father Involvement Initiative (National Head Start Program)	\$
Project 3: Mental Health Liaison for CPS			
Selective	Mental Health professional to provide consultation to Child Protective Services, to promote integration of services, and conduct screening, assessments and referrals.		\$\$
Project 4: Multi-Disciplinary Teams for Very Young Children and their Families: Preschool Model			
Targeted	A collaborative team made up of an Advocate and parents or caregivers and other key stakeholders such as child care providers, First 5, KCAO or UCP staff, therapists and CPS staff to support families and children 0-5. Target populations will include families that have experienced domestic violence and other traumas and parents with SMI or SED or co-occurring substance abuse disorders. The role of the Advocate will be to identify at-risk families, provide initial assessment, parenting recommendations and, when appropriate, convene the Multidisciplinary Team.	Children in Need of Support (CHINS)	\$\$\$
Project 5: Multi-Disciplinary Teams for School-Age Children & their Families: Elementary School Model			
Targeted	A collaborative team made up of an Advocate and parents or caregivers and other key stakeholders such as school administrators, teachers, therapists and CPS staff to support elementary school age children with behavioral and emotional needs and their families. Teams would provide comprehensive service coordination and help transition children to more intensive intervention as needed. The role of the Advocate will be to identify at-risk families and children with behavioral, social and/or emotional needs, provide initial assessment and, when appropriate, convene the Multidisciplinary Team.	Children in Need of Support (CHINS)	\$\$\$
Project 6: Parent-Child Behavior Services: Early Intervention			
Targeted	Parent-Child Interaction Therapy (PCIT) is an empirically-supported treatment for conduct-disordered young children that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. In PCIT, parents are taught specific skills to establish a nurturing and secure relationship with their child while increasing their child's prosocial behavior and decreasing negative behavior.	Other EBPs include: Triple-P – Positive Parenting Program; Adolescent Transitions Program (ATP)/Strengthening Families; Ready for Success Project; DARE to be You (DTBY); Parenting Wisely; Home Instruction Program for Preschool Youngsters (HIPPPY); Parents and Teachers as Allies; Nurturing Parenting Program; Make Parenting a Pleasure; Playgroup Victoria	\$\$\$

Potential Project & Evidence Based Practices

Target Population: TAY and Older School Aged Youth

Universal/ Selective/ Targeted?	Project Description	Evidence-based Practice or Other Resource	Cost (\$-\$\$\$)
Project 1: Expand Character Counts			
Universal	School-based education and behavior management framework in which a Character Coach/teacher leads activities that reinforce good decision making, based on six "pillars" or core values including: trustworthiness, respect, responsibility, fairness, caring and citizenship. Administered either as part of the school-day or in an after school setting, this program can be divided into 6-8 week classroom curriculum blocks for skills building, service learning, and life skills.	Character Counts	\$
Project 2: Pro-Social Enrichment Activities			
Universal	School or community-based enrichment activities offered at non-traditional times and in non-traditional ways. (e.g. before/after school, evenings, summer). Includes social and emotional skills building, academic or vocational support, leadership, peer relationships, bullying prevention, peer counseling, mentoring, anger management, coping skills, resiliency, and creativity, community service. <i>(where is this program most needed? What time frame?)</i>	Afterschool Programming; After School Education and Safety (ASES); Ropes Courses	\$\$-\$\$\$
Project 3: Parents of Teens Support Groups at Schools			
Selective	Peer-based support groups for parents who are dealing with teenagers with anger, aggression, depression and other social or emotional issues. Increases community knowledge of mental health, and connects parents to resources. <i>(What is the best time?)</i>	Talking Parents/Healthy Teens; Parents Anonymous Program; NAMI resources	\$
Project 4: Expand "Play to Your Strengths" Summer Camp			
Selective	This strategy provides funding for Kings View Summer Program for TAYs, and extends the eligibility to any youth interested in intensive wellness and prevention-related pro-social activities such as peer mentorship and counseling, enrichment activities such as arts and team-oriented sports, community service, social skills development.		

Project 5: School-Based Group Therapy			
Selective	Therapeutic groups at schools for at-risk youth who do not necessarily meet medical necessity. Groups target needs of each participating middle or high school. Teaches youth to express themselves in an emotional language, teaches coping skills and anger management, and provides support for parenting teens and youth. Groups may address suicide prevention, bullying, race, identity, disability, dealing with peer pressure, substance abuse, GLBTQ issues.		\$
Project 6: Multi-Disciplinary Teams for Older School-Age Children: Middle & High School Model			
Targeted	School-based collaborative teams comprised of a Student Advocate, parents or caregivers, Preventionist/Therapist, school psychologist, teachers, juvenile justice, and other key stakeholders. Teams provide support to youth at-risk of school failure, substance abuse, juvenile justice involvement, suicide, and those suffering from low self-esteem, depression, physical impairment, exposure to drug use, abuse and bullying. Student Advocate work with individual students to address issues and convene multidisciplinary teams as needed. Teams provide comprehensive service coordination and help transition children to more intensive intervention as needed. Advocate may also lead therapeutic groups at school,	Children in Need of Support (CHINS); Nevada County: "Early Intervention Team;" Student Assistance Programs (SAP); Steps to Respect, Cognitive Behavior Intervention for Trauma in Schools (CBITS), Coping and Support Training (CAST), Olweus Bullying Prevention Program; Promoting Alternative Thinking (PATH);	\$\$\$
Project 7: Short-Term School-Based Therapy			
Targeted	School-based mental health professional conducts limited, one-on-one interventions focused on developing coping strategies and a building resiliency in youth with established mental health issues or conduct disorders.	Dialectical Behavior Therapy (DBT); Aggression Replacement Training (ART); Functional Family Therapy (FFT)	\$\$-\$\$\$
Project 8: Transitioning from Juvenile Justice Settings			
Targeted	Case Management, advocacy and support for youth transitioning from Juvenile Justice Settings. Case Managers and youth develop a service plan for meeting all court and probation requirements, and accessing mental health services. May include theater-based program that teach youth to express themselves emotionally while participating in a positive, structured activity and becoming involved in the community.	San Francisco's La Cultura Cura Program run by La Raza: http://www.ifrsf.org/english/programs_LaCulturaCura.html	\$\$-\$\$\$

Potential Project & Evidence Based Practices

Target Population: Adults & All Ages

Universal/ Selective/ Targeted?	Project Description	Evidence-based Practice or Other Resource	Cost (\$-\$\$\$)
Project 1: Anti-Stigma Campaign			
Universal	<p>Build on existing public education campaign aimed at reducing stigma, increasing community awareness of services and changing attitudes towards mental health.</p> <p>May include public service announcements on local TV and radio stations, consumer and family presentations to schools, faith congregations, business leaders and elected officials, and the distribution of informational fliers to various community locations.</p>	Eliminating Barriers Initiative (EBI); Bridges to wellness; NAMI Anti-Stigma Campaign	\$
Project 2: Community Mental Health Liaison			
Universal	<p>A mental health liaison to connect community service providers, primary care, the faith community, first responders, housing, and other key stakeholders to resources and information on mental health issues. The Liaison will conduct outreach, coordinate voluntary mental health screenings, build community capacity to respond to individuals experiencing first break or in crisis, and promote the integration of services for those needing ongoing treatment.</p>	Mental Health Consultation in Primary Care; Integrated Primary Care and Mental Health	\$\$\$

Project 3: Paraprofessional Bridge Program			
Selective	A paraprofessional from an underserved cultural background to conduct outreach and referrals to underserved groups such as Spanish speakers, Native communities, families of incarcerated adults. The paraprofessional will share knowledge of important mental health issues, assists with system navigation, and connect neighbors to medical or mental health services.	Promotores De Salud; Gathering of Native Americans (GONA)	\$-\$\$
Project 4: Expansion of Services for Latino and Spanish Speaking Population			
Selective	Establishment of a multi-service center that provides group counseling, support groups, parenting classes, social activities, family support, and other culturally relevant services to Spanish speaking population	Could share existing location in Armona where Senior SAFE services are provided	\$\$\$
Project 5: Support for Families			
Targeted	Trained and stipended family volunteers to educate families on their loved-ones' diagnosis and treatment, how to cope with the stress of being a caregiver, and how to navigate the behavioral health system. May include additional family support in group settings.	NAMI Family to Family; NAMI Support Group model; Existing family support group	\$
Project 6: Suicide Prevention & Trauma Response Task Force			
Targeted	A taskforce comprised of representatives from mental health, AAA, public health, and schools will work to raise community awareness of suicide as a preventable community health issue. They will provide risk awareness training for primary care providers, schools, faith communities, connect survivors and family members to support services and create educational materials.		\$\$

Project 7: The Prevention and Recovery of Early Psychosis (PREP) Program

<p>Targeted</p>	<p>A new psychosis prevention and early intervention program designed to dramatically improve outcomes for schizophrenia, severe bipolar, and related SMIs. Incorporates evidence-based early diagnosis (including assessment of psychosis risk up to two years before full psychosis develops), treatment, and cognitive rehabilitation services. Includes: 1) community education designed to educate social service agencies, schools, parents, primary care providers and mental health professionals about the early signs of psychosis; 2) intensive diagnostic approach; 3) medication management; 4) psychosocial treatment including Cognitive Behavioral Therapy and Vocational Support; and 5) Cognitive rehabilitation designed to rehabilitate cognitive deficits caused by schizophrenia. Funds would be used for additional psychiatric, therapeutic and outreach staffing and training.</p>	<p>PREP</p>	<p>\$\$\$</p>
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Potential Project & Evidence Based Practices
Target Population: Older Adults

Universal/ Selective/ Targeted?	Project Description	Evidence Based Practice or other Resource	Cost (\$-\$\$\$)
Project 1: Mental Health Screening for Older Adults			
Universal	Meals on Wheels and other paraprofessional personnel who regularly check in on home-bound and isolated seniors are trained by mental health workers to conduct mental health screening and provide referrals. Following this outreach and screening, trained peer counselors or mental health professionals will provide brief individual or group counseling, teach coping skills and help older adults maintain quality of life and independence.	PHQ-9; Cornell Scale for Depression in Dementia; Geriatric Depression Scale; Prevention of Suicide in Primary Care Elderly Collaborative Trial (PROSPECT); Home Delivered Meals Prevention and Screening	\$\$
Project 2: Support and Respite for Older Adult Caregivers			
Selective	A counseling and support intervention for spouse caregivers and/or grandparents as parents that is intended to improve the well-being of caregivers and help them to mobilize their social support network and better adapt to their role. Also establishes a small fund for respite care.	New York University Caregiver Intervention; The Grandparent Project	\$\$
Project 3: Roots and Shoots Cross-Generational Mentoring			
Selective	A program that links older adult volunteers with children and/or TAYs to provide pro-social activities, one-on-one tutoring, vocational training and guidance. May be offered with at a youth center or other community location. Would require a program coordinator, a safe environment, and outreach. Intervention is designed to improve outcomes for seniors as well as youth. Helps to reduce stigma.	Rites of Passage, Across Ages, Foster Grandparent Program	\$\$
Project 4: Healthy Lifestyle Alternatives and Elder Support Network			
Selective	Pro-social and alternative wellness-oriented activities in a non-stigmatizing community setting. Includes activities such as Wii, computer and Internet classes, social networking opportunities. Helps to identify seniors with substance and gambling addictions, those experiencing abuse, neglect, severe depression, suicide ideation, loss of loved ones or loss of physical or cognitive functionings. Connects seniors to support services, including mental health services.		\$\$
Project 5: Grief and transition support			
Targeted	Provide limited, intervention-oriented counseling sessions focused on developing coping strategies and a personal mental health plan (such as WRAP). Can be delivered in senior centers and other locations in the community.		\$\$

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Appendices

Appendix K: Tally of Results from the PEI and Innovation Priorities Meeting

Results from the PEI and Innovation Community Prioritization Meeting 2/19/2010

PEI

Young Children & Families

- 1. Mental Health Screening for Young Children 0-5 5**

A behavioral health professional to conduct outreach and education, to coordinate social and emotional screenings in preschools and pediatricians' offices, and to provide appropriate referrals to children and families needing services. Outreach is targeted to areas with a high concentration of low income residents and culturally underserved populations. Potential areas include Corcoran, Avenal, Stratford, and Hanford.

Participant comments:

 - *MH screening is vital prior to entering school or becoming clients of programs such as CVRC or CPS.*
 - *Screening provide “more bang for your buck” and provides early intervention that addresses an identified need.*
 - *Early identification would prepare school systems and community service providers for trends. It would prepare parents and provide early interventions (cost effective), early engagement and education plus the long-term benefit of a reduction in stigma attached to BH.*

- 2. Multi-Disciplinary Teams for School-Age Children 5**

A collaborative team made up of an Advocate and parents or caregivers and other key stakeholders such as school administrators, teachers, therapists and CPS staff to support elementary school age children with behavioral and emotional needs and their families. Teams would provide comprehensive service coordination and help transition children to more intensive intervention as needed. The role of the Advocate will be to identify at-risk families and children with behavioral, social and/or emotional needs, provide initial assessment and, when appropriate, convene the Multidisciplinary Team.

Participant comments:

 - *This strategy targets all children early (k-3); early intervention is critical to achieving better outcomes.*
 - *Builds better systems by leveraging existing resources and avoiding duplication of efforts. Provides services where the kids already are. There is a parental comfort level with school system; they are a trusted source for information.*

- *You have a longer period of time for observation, and a captive audience for intervention.*

3. Multi-Disciplinary Teams for Very Young Children 4

A collaborative team made up of an Advocate and parents or caregivers and other key stakeholders such as child care providers, First 5, KCAO or UCP staff, therapists and CPS staff to support families and children 0-5. Target populations will include families that have experienced domestic violence and other traumas and parents with SMI or SED or co-occurring substance abuse disorders. The role of the Advocate will be to identify at-risk families, provide initial assessment, parenting recommendations and, when appropriate, convene the Multidisciplinary Team.

Participant comments:

- *Historically, we know what importance CHINS played in the lives of children and families in the past and what a tremendous loss this was when that grant ended.*
- *There is no start up require; it is, cost-effective to leverage what is already in place to some degree.*
- *This project is a continuum of Mental Health Screenings for 0-5. It supports families and children as they approach school-age; provides early diagnosis of possible mental illness; and picks up where screening leaves off.*
- *This strategy identifies opportunities for strong prevention and intervention. It brings community resources together to solve problems. It also creates a safety net and brings back a system of care model/wrap-around concept*

4. Parent-Child Behavior Services: Early Intervention 2

5. Mental Health Liaison for CPS 2

6. Father Involvement Campaign 0

Teens & TAY**1. School-Based Group Therapy****7**

Therapeutic groups at schools for at-risk youth who do not necessarily meet medical necessity. Groups target needs of each participating middle or high school. Teaches youth to express themselves in an emotional language, teaches coping skills and anger management, and provides support for parenting teens and youth. Groups may address suicide prevention, bullying, race, identity, disability, dealing with peer pressure, substance abuse, GLBTQ issues.

Participant comments:

- *If you target school-based groups you can address the issue immediately. You take away the stigma of going to mental health for therapy.*
- *This project helps to address the bullying—the bully as well as the bullied—addressing the low self-esteem and peer pressure which can be connected to inability to effectively regulate thoughts and feelings. It is culturally competent. It meets kids where they are.*
- *That's where the kids go, there is limited existing funding, and it targets high-risk behavior.*

2. Multi-Disciplinary Teams for Older School-Age Children**4**

School-based collaborative teams comprised of a Student Advocate, parents or caregivers, Preventionist/Therapist, school psychologist, teachers, juvenile justice, and other key stakeholders. Teams provide support to youth at-risk of school failure, substance abuse, juvenile justice involvement, suicide, and those suffering from low self-esteem, depression, and physical impairment, exposure to drug use, abuse and bullying. Student Advocate works with individual students to address issues and convene multidisciplinary teams as needed. Teams provide comprehensive service coordination and help transition children to more intensive intervention as needed. Advocate may also lead therapeutic groups at school.

Participant comments:

- *Serves the most students in a large system.*
- *Provides school-based group involvement, a team approach, and includes many entities (school, parents, justice).*

3. Transitioning from Juvenile Justice Settings**3**

Case Management, advocacy and support for youth transitioning from Juvenile Justice Settings. Case Managers and youth develop a service plan for meeting all court and probation requirements, and accessing mental health services. May include theater-based program that teach youth to express themselves

emotionally while participating in a positive, structured activity and becoming involved in the community.

Participant comments:

- *It's the most underserved population who has one of the most significant impacts on the community at large. Not addressing this will impact generations to come.*
- *This strategy provides prevention of further involvement in County justice system, cost savings, and has an innovative approach. The creative expression in youth may provide success experience, include optional nature component.*

Other comments:

- *There are gaps for youth; those youth involved in activities are more likely to be mentally adjusted.*

4. Expand Character Counts	2
5. Pro-social Enrichment Activities	2
6. Expand Play to Your Strengths Summer Camp	1
7. Parents of Teens Support Group	0

Adults & All Ages**1. Paraprofessional Bridge Program****4**

A paraprofessional from an underserved cultural background to conduct outreach and referrals to underserved groups such as Spanish speakers, Native communities, families of incarcerated adults. The paraprofessional will share knowledge of important mental health issues, assists with system navigation, and connect neighbors to medical or mental health services.

Participant comments:

- *The reality is that our County has been historically underserving this population. It has an advantage in that it is outreach.*
- *Promotores help reduce stigma of mental health; makes mental health therapy relative-easier to relate; culturally responsive, home-based. Hits population of incarcerated adults/families that usually do not get help.*
- *We chose this project because it is more culturally diverse, not just specific to one minority.*

2. Support for Families**3**

Trained and stipended family volunteers to educate families on their loved-ones' diagnosis and treatment, how to cope with the stress of being a caregiver, and how to navigate the behavioral health system. May include additional family support in group settings.

Participant comments:

- *The exponential effect of dealing with a family member with mental health issues is significant and should be addressed. This is a proven effective model.*
- *Families are the most damaged by day to day stress because they are vulnerable. Often times they are overwhelmed. NAMI has been successful.*
- *It's a support group developing empathy. This project addresses the issue of stigma and also addresses caregiver stressors. It aids with navigation through behavioral health systems.*

3. PREP Program**3**

A new psychosis prevention and early intervention program designed to dramatically improve outcomes for schizophrenia, severe bipolar, and related SMIs. Incorporates evidence-based early diagnosis (including assessment of psychosis risk up to two years before full psychosis develops), treatment, and cognitive rehabilitation services. Includes: 1) community education designed to educate social service agencies, schools, parents, primary care providers and mental health professionals about the early signs of psychosis; 2) intensive diagnostic approach; 3) medication management;

4) psychosocial treatment including Cognitive Behavioral Therapy and Vocational Support; and 5) Cognitive rehabilitation designed to rehabilitate cognitive deficits caused by schizophrenia. Funds would be used for additional psychiatric, therapeutic and outreach staffing and training.

Participant comments:

- *This project provides early intervention, intense response to severe diagnosis, evidence-based treatment, and a multi-disciplinary approach through community and schools.*
- *It is the most comprehensive option, but not all may be do-able. There is a need to include paraprofessionals. Early intervention at first break is most successful.*
- *There would be a reduction in 51/50s, and long-term placements, which is a huge cost saving to the County. This strategy also minimizes the repeated criminalization of mental illness. It reduces the emotional impact on families.*

7. Suicide Prevention Task Force

3

Taskforce includes a coroner, mental health providers, AAA, public health, and schools. The taskforce will work to raise community awareness of signs of suicide, provide critical incident debriefing, provide risk awareness training for primary care providers, schools, faith communities, businesses and at other community locations, connect survivors and family members to support services and create annual educational briefs communicating yearly suicide statistics for the County.

Participant Comments

- *A suicide prevention and trauma response task force doesn't exist in this County. MH staff drop and go to respond w/o any additional resources to support suicide prevention and trauma.*

8. Community Mental Health Liaison

1

9. Expansion of Services for Latino & Spanish Speaking Community

1

Older Adults**1. Support and Respite for Older Adult Caregivers****7**

A counseling and support intervention for spouse caregivers and/or grandparents as parents that is intended to improve the well-being of caregivers and help them to mobilize their social support network and better adapt to their role. Also establishes a small fund for respite care.

Participant comments:

- *There is a Lack of resources for this service/population, and a growing need.*
- *This strategy provides support to humanize mental health issues such as depression, and hospitalization.*
- *Provides a release to providers by promoting support specifically to their area of concern. Prevents burnout and caregiver decomposition, it also prevents elder abuse.*
- *It helps older caregiver as well as the child/children.*
- *Helps address caregivers' emotional needs, physical health, keeps care receiver from institutional situations, helps with financial concerns, and relief from guilt.*

2. Mental Health Screening for Older Adults**6**

Meals on Wheels and other paraprofessional personnel who regularly check in on home-bound and isolated seniors are trained by mental health workers to conduct mental health screening and provide referrals. Following this outreach and screening, trained peer counselors or mental health professionals will provide brief individual or group counseling, teach coping skills and help older adults maintain quality of life and independence.

Participant comments:

- *Currently there is no mechanism for screening and identifying older adults, they don't intersect with other systems and we don't know who they are.*
- *Access- meeting seniors where they are (rural or urban, reaches those homebound and isolated. Address transportation, peer relations and socialization. Supports independence, and provides early intervention.*
- *Reaches isolated seniors, non-ambulatory seniors, creates links using seniors' natural contacts*

3. Healthy Lifestyle Alternatives and Elder Support Network**4**

Pro-social and alternative wellness-oriented activities in a non-stigmatizing community setting. Includes activities such as Wii, computer and Internet classes, social networking opportunities. Helps to identify seniors with substance and gambling addictions, those experiencing abuse, neglect, severe

depression, suicide ideation, loss of loved ones or loss of physical or cognitive functioning. Connects seniors to support services, including mental health services.

Participant comments:

- *Open to all, normalized behavior, promotes activities which prevent depression/dementia, and can address almost all other issues. Provides more socialization in a non-threatening environment.*
- *This strategy addresses a variety of issues, establishes connections and support service (linkages), and includes a physical component.*

4. Roots and Shoots Cross Generational Mentoring	1
5. Grief and Transition Support	1