



# **MENTAL HEALTH SERVICES ACT**

## **Amendment to the Prevention and Early Intervention Component of the Three- Year Program and Expenditure Plan Fiscal Year 2009-10**

### **Executive Summary**

February 17, 2010

### **Introduction**

As a result of an extensive Community Planning Process (CPP) for the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA), Sacramento County submitted Project 1 - Suicide Prevention to the Department of Mental Health (DMH) and the Mental Health Services Oversight and Accountability Commission (MHSOAC). The Project was approved on October 22, 2009. After submitting the Suicide Prevention Project, the Division continued planning for three more PEI projects. These three Projects are an Amendment to our PEI Plan.

### **Planning Process**

The following strategies were used to engage the community and elicit feedback regarding needs and priorities for PEI funding:

- PEI Cultural Competence Advisory Committee (CCAC): This committee was established in October of 2008 and meets monthly. The committee provides ethnic, cultural and linguistic perspectives to the PEI planning process and program development.
- PEI Community Orientation Meeting, October 2008: A total of 162 community members attended an overview of the MHSA PEI component, Sacramento's planning process and to learn about ways in which they could get involved.
- System Partner Input Paper, Fall 2008: Seventeen (17) system partners responded to a PEI System Partner Input Paper in which they articulated the Key Community Mental Health Needs and Priority Populations most critical to the populations they serve.
- Community Survey, Fall 2008: A total of 1700 surveys were completed by community members regarding the PEI Key Community Mental Health Needs and Priority Populations. The survey was translated into Sacramento County's five (5) threshold languages and the Division received assistance from community-based providers in distributing the surveys to various ethnic and cultural communities.
- Community Educational Forums, Fall 2008-Spring 2009: The Division conducted eight (8) Community Educational Forums to address several of the PEI Key Community Mental Health Needs (KCMHN) and Priority Populations. The goal of each forum was to educate the community on the forum topic and engage in a dialogue regarding their perspective of services needed and "natural settings" in which those services could be provided.
- Suicide Prevention Project Workgroup, Spring 2009: Community members, system partners and stakeholders, some of whom also served on the PEI CCAC, participated in this workgroup. Over the course of several weeks, the Suicide Prevention Project Workgroup consolidated local information and ranked strategies to develop the Suicide Prevention Project.
- PEI Phase II Committee Meetings, October – November 2009: The Division held six (6) Community Planning meetings in October and November to get community input on specific projects that could be developed for PEI funding. The meetings focused on the

## Executive Summary

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Priority Populations identified by the PEI Community Survey: Children and Youth in Stressed Families; Trauma Exposed; and Onset of Serious Psychiatric Illness. The meeting format was small workgroups using a consensus model and in two meetings, an electronic meeting system was utilized which allowed participants to provide input on computers. The first four meetings focused on developing strategies and the final meeting was used to present a draft plan and obtain feedback from the participants on both content and the PEI Planning Process.

The three Key Community Mental Health Needs and Priority Populations ranked highest by the community were as follows:

### KCMHN

1. At Risk Children, Youth and Young Adults
2. Psycho-Social Impact of Trauma
3. Suicide Prevention

### Priority Populations

1. Children and Youth in Stressed Families
2. Trauma-Exposed (all ages)
3. Onset of Serious Psychiatric Illness

### Request for Funding

Sacramento County is requesting funds for three PEI Projects, administrative costs, Training and Technical Assistance, and unspent PEI funds for Sacramento County's Prudent Reserve.

#### Project 2 - Strengthening Families

Sacramento County is requesting \$487,500 (\$1,650,000 annually) in PEI funding to develop a Strengthening Families Project. This project addresses children ages 0-5, latency age children between the ages of 6 and 12, a Transition Age program for youth between the ages of 13-25 and a project that addresses the entire family system. There are six (6) programs within this project:

1. Early Childhood Consultation
2. In-home Services for Foster Children
3. School-based Social Skills and Violence Prevention Program
4. Building Life Skills for Teens and TAY
5. Family Conflict Management

#### Project 3 - Integrated Health and Wellness

Sacramento County is requesting \$887,250 (\$2,125,000 annually) in PEI funding to develop an Integrated Health and Wellness Project. This project addresses several of the KCMHN and Priority Populations across all age groups including Trauma-Exposed, Onset of Psychiatric Illness, and Suicide Prevention. The project will include universal screenings and assessments for trauma, depression, and substance abuse and will provide peer support and brief treatment for those with identified needs. The services will be provided in primary care settings in order to reach more individuals in our community, particularly those from unserved and underserved populations. The programs within this project are the following:

1. Screening, Assessment, Peer Support and Treatment
2. Assessment and Treatment of Onset of Psychosis
3. Senior Navigator Program: Targeting Isolation and Depression in Older Adults

## Executive Summary

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### Project 4 - Mental Health Promotion Campaign

Sacramento County is requesting \$1,000,000 in PEI funding to develop a Mental Health Promotion Campaign Project. The goals of this project are to increase community awareness about mental health issues and reduce stigma and discrimination toward individuals and families living with mental illness. This project will include a culturally and linguistically appropriate multi-media community awareness campaign with specific efforts toward educating and engaging unserved and underserved cultural and ethnic communities. Sacramento County will work with Consumer and Family Member advocacy groups, system partners, agencies and groups that work with culturally and ethnically diverse communities, and other stakeholders who can be instrumental in increasing awareness of mental health issues and reducing stigma and discrimination in Sacramento County.

### Administrative Funds

Sacramento County is requesting \$225,000 (\$900,000 annually) to cover the costs associated with the intensive amount of administrative support required for ongoing community planning, implementation, monitoring and reporting regarding the PEI Projects and programs.

### Training and Technical Assistance

Per DMH Information Notice 08-37, Sacramento County is requesting \$405,400 in PEI Training and Technical Assistance funding for training and technical assistance needed in order to effectively deliver the services in our PEI Projects.

### PEI Prudent Reserve Request

Each County must establish a Prudent Reserve totaling 50% of its latest approved annual funding level for services. Per DMH Information Notice 09-16, PEI funds are now included in this calculation. Therefore, Sacramento County must have a minimum of \$15,461,130 in our Prudent Reserve account by July 1, 2010. Sacramento is requesting a total of \$3,119,700 in Unapproved Funds and Approved Unspent PEI funds from FY2007-08 to deposit into the Prudent Reserve.

Sacramento's Amendment to the PEI Plan was posted for a 30-day public review and comment period from December 28, 2009 to January 28, 2010.

A Public Hearing was held on January 28, 2010 at the Department of Health and Human Services Administrative Services Center, 7001-A East Parkway, Sacramento, at 6:00 PM.

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

**MENTAL HEALTH SERVICES ACT (MHSA)  
AMENDMENT TO THE PREVENTION AND EARLY INTERVENTION COMPONENT  
OF THE THREE-YEAR  
PROGRAM AND EXPENDITURE PLAN  
Fiscal Years 2007-08, 2008-09 and 2009-10**

**County Name:** Sacramento

**Date:** February 17, 2010

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

<b>County Mental Health Director</b>	<b>Project Lead</b>
Name: Mary Ann Bennett, Acting Deputy Director	Name: Michelle Callejas, MHSA Program Manager
Telephone Number: 916-875-9904	Telephone Number: 916-875-6486
Fax Number: 916-874-8249	Fax Number: 916-875-1490
E-mail: bennettm@saccounty.net	E-mail: callejasm@saccounty.net
Mailing Address: 7001-A East Parkway, Suite 300, Sacramento, CA 95823	

**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 Mary Ann Bennett  
County Mental Health Director

2-16-2010  
Date

Executed at: Sacramento, California

County: SACRAMENTO

Date: February 17, 2010

**Introduction**

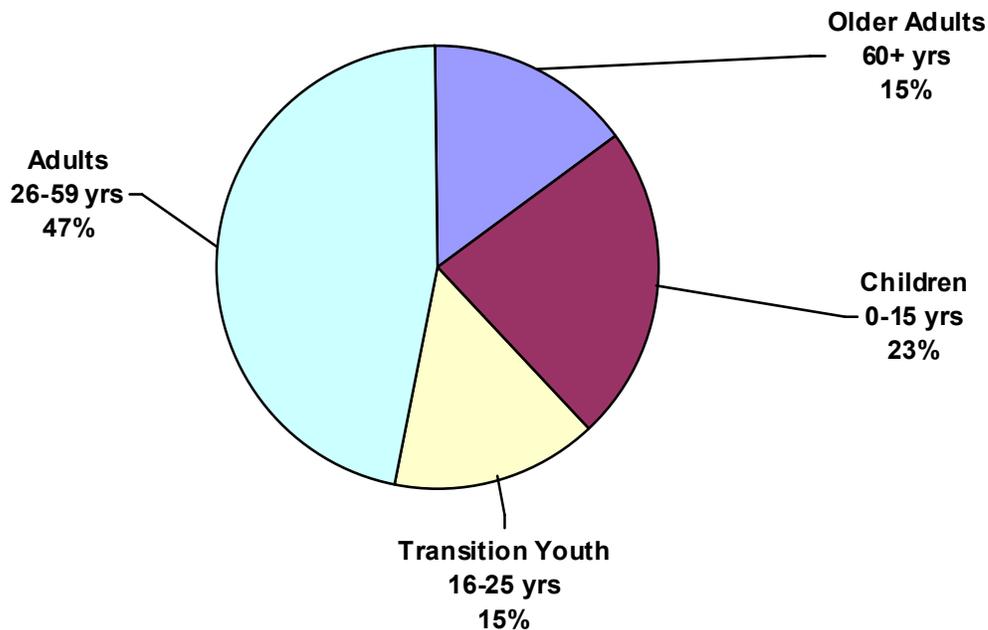
**Description**

Sacramento County is the eighth most populous county in the state, with 1,449 persons per square mile. With both urban and rural communities, the County spans 994 square miles. Geographically, the varied terrain includes both low delta lands and the foothills of the Sierra Nevada Mountain Range.

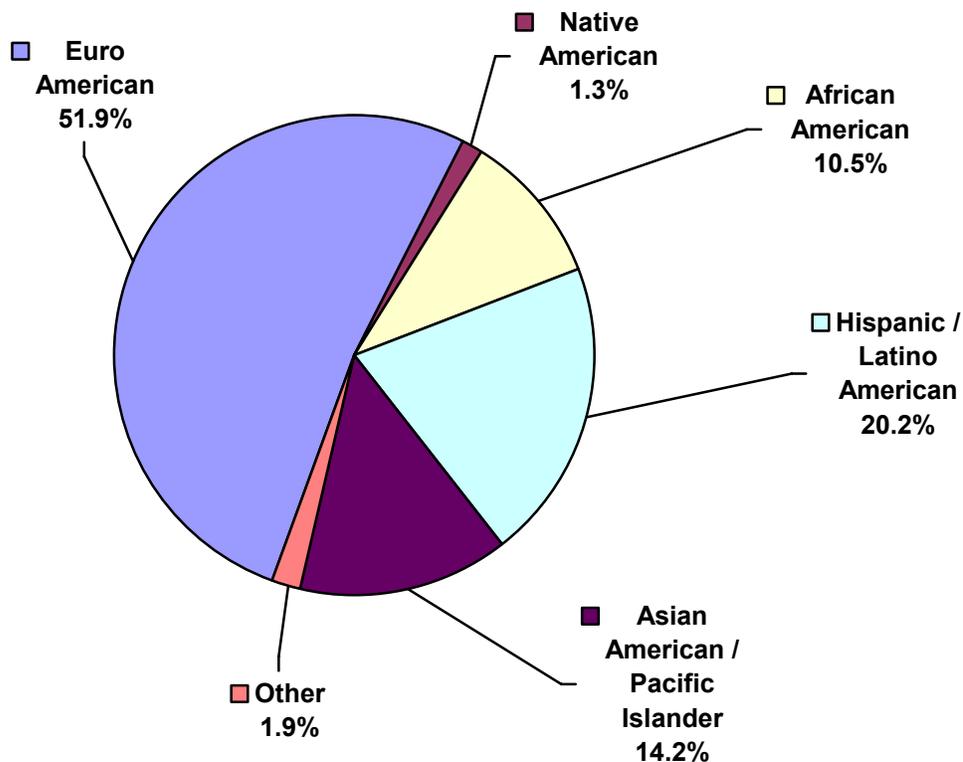
**Demographics**

About 1.4 million people reside in growing Sacramento County, and by the year 2050, the California Department of Finance estimates the population will reach nearly 2.2 million people (2009 CA Dept of Finance data). Sacramento has more people than the surrounding counties of El Dorado, Placer, Sutter, Yolo, and Yuba combined. Of the 2.3 million people who live in the six-County region, 61.9 percent live in Sacramento County. The City of Sacramento, with a population of 467,343, is the seventh largest city in California. The county is one of the most diverse areas in the state. It is home to large numbers of refugee communities, including individuals from Southeast Asia, the former Soviet, and Eastern Europe. The five most prevalent languages spoken by Sacramento's Medi-Cal population, other than English, are Spanish, Russian, Cantonese, Vietnamese and Hmong.

**Age of Population: 2004**



**Ethnic Makeup of Population: 2000 Census – 2008 Adjustment**



**Quality of Life Issues**

The county's median household income was \$56,823 (2007). More than 85,000 children, youth, and young adults under the age of 25 are living in poverty in Sacramento County (2007). An estimated 115,215 children qualify for free/reduced-priced school lunches, reflecting an increase of 17% between 2000 and 2007.

27.7% of Sacramento residents over the age of 25 years have at least a Bachelor's degree and the unemployment rate in December of 2009 (12.2%) was within 0.1% of the state average of 12.1%. (EDD Data, January 2010).

The median home price in 2008 was \$265,624. Although this is significantly lower than the state average, safe affordable housing is a primary concern in the community. According to the 2009 Point-in-Time Homeless Street Count, there are about 2,800 homeless individuals living in Sacramento County. One in five homeless individuals are part of a household with dependent children. 75% of all homeless individuals have at least one disability, such as mental illness (27%), alcohol and drug dependence (48%) or physical disabilities. 15% of all homeless individuals are veterans of the U.S. Armed Forces.

## PEI COMMUNITY PROGRAM PLANNING PROCESS

**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*

Leland Tom, Mental Health Deputy Director, had ultimate responsibility for the oversight of the PEI Planning process through March 31, 2009. In April of 2009 Mary Ann Bennett, Mental Health Deputy Director, assumed this oversight role. Michelle Callejas, MHSA Program Manager, was responsible for Community Program Planning oversight and project development. Working under the direction of the MHSA Program Manager, Kathryn Skrabo, MSW, was the PEI Coordinator and led the PEI Planning Team.

In addition to the above, the Division's Management Team, which includes consumer, adult family member, and child/youth family member representation, reviewed and approved the PEI Planning Process, stayed current on planning developments, and provided input as planning activities were conducted.

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

An MHSA PEI Planning Team was formed to assist in planning. The team included the following individuals:

- Michelle Callejas, Program Manager, MHSA
- Kathryn Skrabo, Program Planner, MHSA
- Myel Jenkins, Program Planner, MHSA
- Julie Leung, Program Planner, MHSA
- Frances Freitas, Program Planner, MHSA
- Jane Ann LeBlanc, Program Planner, MHSA
- Anne-Marie Rucker, Program Planner, MHSA
- Nancy Marshall, Program Planner, MHSA
- Robert Nelson, Program Planner, MHSA
- Dawn Williams, Program Planner, Research, Evaluation and Performance Outcomes (REPO)
- Niku Mohanty, Program Planner, REPO
- Mary Nakamura, Program Coordinator, Ethnic Services Unit
- Marilyn Hillerman, Adult Family Advocate
- Dave Schroeder, Family and Youth Advocate Coordinator
- Edwina Browning-Hayes, Family and Youth Advocate Coordinator
- Andrea Hillerman-Crook, Consumer Advocate
- Alex Rechs, Program Coordinator, Quality Management
- Jan Houle, MHSA Administrative Services Officer

**PEI COMMUNITY PROGRAM PLANNING PROCESS**

In addition, Jo Ann Johnson, Ethnic Services Manager, coordinated the development of the PEI Cultural Competency Advisory Committee (CCAC) which has provided, and will continue to provide, input throughout the planning process and program development.

Tracy Herbert, Manager of Mental Health's Research, Evaluation and Performance Outcomes Unit, developed the PEI Community Survey, coordinated the data collection from the survey, the System Partner Input Papers, the Community Educational Forums, the PEI Cultural Competency Advisory Committee feedback, and the Phase II Community Planning Meetings. Dr. Herbert also directed her staff in developing the outcomes for the various programs within Sacramento County's PEI Projects.

Finally, community volunteers and Mental Health Division staff were utilized to assist with the Community Orientation Meeting, the Community Educational Forums, and the Phase II Community Planning Meetings. Support was also provided by other stakeholders, including consumers and family members reflecting the diversity of the community, and community members that served on panels and assisted in promoting events to their communities and networks.

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

The MHSA Steering Committee, the highest recommending body on MHSA matters, has representation from all of the required partner sectors. The committee approved the initial PEI Planning Process structure and received updates on PEI community engagement activities. Some members representing partner sectors attended the PEI Regional Roundtable meeting on July 31 and August 1, 2008, which was sponsored by the California Institute of Mental Health (CiMH), the Mental Health Services Oversight and Accountability Commission and the State Department of Mental Health. In addition to Steering Committee members, other individuals reflecting the diversity of the community were invited to participate and a total of thirty-seven (37) participants attended with representation from all of our system partners. During a breakout session, Sacramento's MHSA team utilized the time to gather input regarding our local planning process. After the Roundtable, a follow-up meeting was held to further define planning and receive feedback from partners. (See Attachment A: MHSA Steering Committee Member Roster and Attachment B: PEI Regional Roundtable Attendee list)

The MHSA Program Manager attended various meetings to present information on the PEI component and to inform stakeholders about how they could become involved in the planning process. Presentations were made to the following stakeholders: Child Protective Services Executive Management Committee; Sacramento's Family Advocate Committee (FAC); the Child and Family Policy Board; the Division of Alcohol and Drug Services; Ryan White Provider's Caucus;

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Mental Health Children's Stakeholder Meeting; the Mental Health Board Older Adult Committee, and the Sacramento Health Care Improvement Project.

PEI Cultural Competency Advisory Committee

In September 2008, the PEI Planning Team began meeting weekly to plan for broad-based engagement activities with our diverse community stakeholders. The first activity planned was the PEI Cultural Competence Advisory Committee Meeting held on October 7, 2008. This meeting was convened with a large group of people representing the rich diversity of our community. The purpose of the committee was to help inform the Division regarding the diverse needs of racial, cultural and ethnic communities in Sacramento County. This committee met (and continues to meet) on a monthly basis in various locations within the county. It was recognized that the Division needed special attention to ensure that communication exchange with diverse community stakeholders occurred.

The Mental Health Plan Cultural Competence Committee has been informing the Division regarding cultural competence since the committee was formed in 1997. The PEI CCAC has been focused on the Prevention and Early Intervention component of the MHSA. The two committees will merge in February of 2010 in order to streamline participation and provide input in all mental health system efforts to reduce mental health disparities.

The PEI CCAC members also reviewed the document entitled, "Working with Diverse Racial, Cultural, Ethnic and Linguistic Communities" which was created during the Workforce Education and Training planning phase. This document summarizes the collective wisdom of thirteen key informants from diverse communities who provided feedback to supplement the information gathered from the WET Focus Groups.

In addition, the PEI CCAC members reviewed the Building Partnerships reports developed by the UC Davis Center for Reducing Health Disparities staff and provided additional feedback in order to tailor the information to our local communities.

Finally, Mental Health staff were invited to participate in the community report-back dialogues sponsored by the Center for Reducing Health Disparities that focused on Hmong, African American, and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) youth communities.

PEI Phase I Kick-Off: Community Orientation Meeting

On October 22, 2008, the Community Orientation Meeting kicked off our community PEI activities. Extensive outreach was done for the PEI Orientation Meeting beginning with an e-mail announcement and followed by a personalized letter of invitation from the Mental Health Director. This invitation went to numerous stakeholders, system partners, community agencies, principals and superintendents of school districts in Sacramento County, the Los Rios Community College District,

**PEI COMMUNITY PROGRAM PLANNING PROCESS**

CSU Sacramento, the First Five Commission, and others. The intent was to ensure that at least one representative from each agency/organization would attend and share their information with others in their organization. Along with these targeted invitations, the community was also invited to attend. Approximately 162 individuals from diverse stakeholder groups attended this event. The program included an explanation of the community planning process, an open invitation to participate in all activities at any level, distribution of the PEI community survey, an overview of the PEI component, a presentation on risk and resiliency and an overview of the Statewide Suicide Prevention Initiative. Information presented at the meeting was also recorded by a graphic artist. (See Attachment E: Community Orientation Meeting Letter of Invitation; Attachment F: Community Orientation Meeting Agenda; and Attachment G: Community Orientation Meeting Summary Graphic)

System Partner Input Paper

A System Partner Input Paper was designed to elicit input from system partners regarding the Key Community Mental Health Needs (KCMHN) and Priority Populations they see as most relevant to the populations they serve and what programs they currently have in place address mental health concerns. Sixteen partner organizations representing the following 10 service sectors and/or organizations submitted papers: School Districts (4); Criminal Justice (3); Alcohol and Drug Services (1); Public Health (1); Woman Escaping A Violent Environment (WEAVE) (1); Child Protective Services (2); Department of Human Assistance (1); Sacramento Employment and Training Agency (1); First 5 (1); and Area 4 Agency on Aging (1). In contrast to the information gathering strategy used by the previous groups, responders to the SPIP were asked to indicate (i) “the KCMHN reflected in the population you serve” and (ii) “the Priority Population that would most benefit from PEI supports and strategies.” Respondents then indicated all that applied rather than ranking in order of priority. Substantial qualitative information was also gathered in the SPIP. (See Attachment H: System Partner Letter and Attachment I: System Partner Input Paper Report Form)

PEI Community Survey

A PEI Community Survey was developed and translated into Sacramento County’s five (5) threshold languages: Spanish, Cantonese, Russian, Vietnamese and Hmong. Community members were asked to rank, in order of importance, the five KCMHN and six Priority Populations defined by DMH. Surveys were made available on-line and distributed in hard copy to community-based organizations and at various community events. Translated copies were given to members of the PEI CCAC to distribute to the cultural and ethnic communities they serve. A total of 1,795 surveys were returned, with over 1,500 individuals prioritizing either KCMHN and/or Priority Populations. Respondents represented an extremely diverse group in terms of age, ethnicity, sexual orientation, preferred language, and stakeholder group. (See Attachments J-O: PEI Surveys in English and Five (5) Threshold Languages)

**PEI COMMUNITY PROGRAM PLANNING PROCESS**Community Educational Forums

From November of 2008 to March of 2009, numerous community members partnered with mental health staff to provide eight (8) Community Educational Forums to inform stakeholders about the PEI KCMHN and Priority Populations. The goal of each forum was to educate the community about the forum topic and engage in a dialog regarding their perspective of services needed and “natural settings” in which those services could be provided. (See Attachment P: Listing of Community Educational Forums)

Approximately 473 individuals attended these forums and they represented an extremely diverse group in terms of age, ethnicity and stakeholder group. Substantial qualitative information was gathered during the forums. The Community Educational Forums were as follows:

1. Suicide Risk
2. Underserved Cultural Populations
3. Individuals Experiencing Onset of Serious Psychiatric Illness
4. Children and Youth in Stressed Families
5. Psycho-Social Impact of Trauma
6. Children and Youth at Risk of Juvenile Justice Involvement
7. Stigma and Discrimination
8. For Youth, By Youth

Significant outreach was made to recruit individuals with expertise in the various forum topics, and they provided valuable information through panel presentations. Some of the stakeholders and system partners that participated and/or provided consultation include, but are not limited to the following: The Effort (administers our local Nationally Accredited Suicide Crisis Line); Friends for Survival; The Jason Foundation; University of California, Davis (UCD) Center for Reducing Health Disparities; UCD Early Diagnosis, Assessment and Preventative Treatment Program (EDAPT); UCD Department of Psychiatry; UCD CAARE Center; Children’s Receiving Home; Wind Youth Center; Women Escaping a Violent Environment (WEAVE); Veteran’s Administration Center; Veteran’s Administration Hospital; Hmong Women’s Heritage Association; Opening Doors (provides services and supports to refugee populations); Sacramento Police Department; Sacramento City Mayor’s Office of Youth Development; Roberts Family Development Center; Sacramento County Probation; California Network of Clients; Inter-Tribal Council of California; Asian Pacific Community Counseling; La Familia Counseling Center; Youth in Focus; Muslim American Society, Social Services Foundation; Consumers and Family Members; and many others. Due to strong community participation, the Community Educational Forums were very successful. Each forum, with the exception of For Youth, By Youth, was videotaped and is available to the public. A graphic artist was utilized to capture information from the panelists and the community dialog. (See Attachments Q and R: Graphic Art from the Underserved Cultural Populations and Stigma and Discrimination Forums)

**PEI COMMUNITY PROGRAM PLANNING PROCESS**Student Mental Health and Wellness Collaborative

During the planning process, the Division of Mental Health and the Sacramento County Office of Education (SCOE) began discussions about forming a collaborative between Mental Health, SCOE, local school districts, system partners and community stakeholders. A kick-off meeting was held in February of 2009 and roughly 55 individuals attended from various stakeholder groups, including SCOE, Mental Health, all thirteen school districts, California Department of Education, Sacramento County Probation Department, Sacramento County Division of Alcohol and Drug Services, Family and Youth Advocates from Mental Health America of Northern California, and Sacramento First 5. The purpose of the meeting was to bring together education, stakeholders, mental health professionals, and other system partners to explore how schools can play a role in implementing PEI services for students between the ages of 0 and 18. The meeting was very successful and led to the establishment of the Sacramento County Student Mental Health and Wellness Collaborative. From June to December of 2009, the Collaborative held six (6) all-day planning sessions to develop local actions for the strategic directions delineated in the Student Mental Health Initiative (SMHI) paper released by the MHSOAC in September of 2007. Although access to the funding was in question at the time, the group decided to adopt the motto of “Moving Forward No Matter What” to develop a comprehensive plan that would promote emotional wellness and academic success for K-12 students and families in Sacramento County. The result was a comprehensive strategic plan entitled “*The Student Mental Health and Wellness Plan: A Framework for Change.*” Since the mechanism for accessing the funds for the SMHI is still in question, some of the strategies developed by the collaborative are reflected in the PEI Strengthening Families and Mental Health Promotion Projects. The Suicide Prevention Project will also target schools and students through the Training and Education strategies. Sacramento County will pursue SMHI funding when the guidelines are released and the mechanism for accessing funding is in place.

Suicide Prevention Project

As indicated by the PEI Survey, the community ranked Suicide Prevention as a high priority to address with PEI funding. Based on this, Sacramento moved forward with community members and developed a Suicide Prevention Project to submit to DMH, understanding there was still more community planning to do for the rest of the PEI Plan. Suicide Prevention efforts and help in a crisis also were also identified as significant needs in both the CSS and WET planning processes.

On February 19, 2009, a Suicide Prevention Community Orientation Meeting was convened. System partners, MHSA Steering Committee members, PEI Cultural Competency Advisory Committee members, Teen Suicide Prevention Taskforce members, school partners, community members, individuals that attended the Community Educational Forum on Suicide Risk, and the community at large were invited to attend. This meeting provided an opportunity to inform attendees about local and state data related to suicide. Sandra Black from the DMH Office of Suicide

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Prevention introduced The California Strategic Plan on Suicide Prevention. Our local Suicide Prevention Crisis Line / National Suicide Prevention Lifeline Provider, The Effort, reviewed local Sacramento data and informed the audience about their Crisis Line operations and services. Meeting attendees participated in assets and gaps mapping related to local suicide prevention, intervention, and post-vention services and they were invited to participate in the Suicide Prevention Project Workgroup. In addition, members of other committees, including the PEI Cultural Competence Advisory Committee and the SCOE/Mental Health participants were encouraged to participate in the Workgroup.

Using the California Strategic Plan on Suicide Prevention's strategic directions as a framework, Workgroup participants assembled on March 4, 11, 18, 2009, to develop local suicide prevention strategies. Workgroup participants linked assets and gaps, which were reframed as strategies, to one or more of the four strategic directions outlined in the Plan. Workgroup participants reviewed and clarified the strategies identified, developed additional strategies, and prioritized strategies within each strategic direction. All of these strategies combined to form Sacramento's three-year proposed Suicide Prevention Project.

The Suicide Prevention Project was strongly supported by Sacramento County's MHSA Steering Committee, Mental Health Board, community members and stakeholders. After completing the 30-day public comment period, the proposal was submitted to DMH. DMH and the MHSOAC approved the Suicide Prevention Project on October 22, 2009.

**Phase II PEI Planning**

After completing all of the activities mentioned above, data collected from the community was collated and analyzed and the data formed the framework for the second phase of PEI Planning. From October through November of 2009, a PEI Kick-Off and five (5) PEI Community Planning Meetings were held to develop actions or strategies to address the top Key Community Mental Health Needs and Priority Populations as determined by the PEI Community Survey:

**KCMHN**

1. At Risk Children, Youth and Young Adults
2. Psycho-Social Impact of Trauma
3. Suicide Prevention

**Priority Populations**

1. Children and Youth in Stressed Families
2. Trauma-Exposed (all ages)
3. Onset of Serious Psychiatric Illness

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Information derived from the first phase of planning was brought forward into the second phase. Below is a brief summary of what took place during each Community Planning meeting.

Phase II Kick-Off: The MHS Manager provided an orientation to PEI and reviewed the first phase of planning. 107 community members and stakeholders attended the Kick-Off meeting. The REPO Manager presented and discussed data that determined the KCMHN and Priority Populations that would be the focus of the next several meetings. (Attachments: S: Phase II Kick-Off Meeting Agenda; T: PEI Overview; U: Data Identifying Sacramento's Key Community Mental Health Needs and Priority Populations, V: PEI Data Summary; W: PEI Planning Phase II)

Meeting 1: The MHS Manager briefly reviewed the planning process and focus of next several Community Planning meetings. It was emphasized that the planning was not about funding a particular agency, entity or project, but rather, to focus on strategies related to the KCMHN and Priority Populations that would best serve our community as a whole. The PEI Planning Principles and the Consensus Workshop Method that would be used in the planning process were also discussed. (See Attachment X: PEI Planning Principles) Despite a severe storm taking place at the time of the meetings, 67 community members attended and participated in a visioning exercise about what our community would look like if prevention and early intervention services were implemented successfully. (See Attachment Y: Visioning Exercise)

Meeting 2: The focus of the second meeting was the Priority Population of Children and Youth in Stressed Families. Stressors identified by the community during different phases of the planning were presented to those in attendance. Additional stressors were identified by stakeholders after which the meeting facilitators utilized an Electronic Meeting Method to have the participants rate the importance of each stressor. The top rated stressors with regard to Children and Youth in Stressed Families were: Onset of Psychiatric Illness; Child Abuse and Neglect; Domestic Violence; Homelessness; Substance Abuse; Family Abandonment; Family members with mental illness; and School Bullying. (Because Onset of Psychiatric Illness was the third community ranked Priority Population, participants were instructed to rate it the highest score possible.) (See Attachment Z: Rating of the Stressors)

The large group of 84 participants was broken out into six (6) small workgroups and staff members utilized the Consensus Workshop Method to assist participants in identifying actions that would best address the top rated stressors. Each group further categorized their actions into broader strategies. At the larger group level, all the strategies from each small group were put into similar categories to develop overall Strategic Directions to address Children and Youth in Stressed Families. (See Attachment AA: Overall Stressors Strategies)

Meeting 3: Meeting 3 focused on the second-ranked Priority Population, Trauma-Exposed. There was a brief presentation on types of trauma that were identified by

**PEI COMMUNITY PROGRAM PLANNING PROCESS**

the community during prior planning processes and at the Community Educational Forum on Trauma. The 94 community members in attendance agreed to move forward with the understanding that trauma affects individuals differently. Therefore, instead of focusing on what types of trauma to address, the community focused on strategies that would address the impact of trauma regardless of the specific trauma experienced. The Consensus Workshop method was utilized again to help participants reach consensus on strategies that could help address the impact of trauma on individuals in our community. As in the previous meeting, individual group strategies were placed into similar categories to develop overall Strategic Directions. (See Attachment BB: Overall Trauma Strategies)

Meeting 4: The Strategic Directions developed by community members in Meetings 2 and 3 were presented to the 96 individuals who attended Meeting 4. There were too many strategic directions to address with the limited amount of PEI funding available, so participants were asked to utilize the Electronic Meeting method to rate the effectiveness of each Strategic Direction. The results were projected for participants to see and there was very little statistical difference between the various strategies. A community member suggested all participants rank, rather than rate, the top three Strategic Directions they believed to be most effective in order to further narrow the options. Participants completed ranking, and in analyzing the rating versus the ranking, there was strong consistency in the top priorities for the community. (See Attachment CC: Top Ranked and Rated Strategies.)

Between Meetings 4 and 5: Mental Health staff placed every strategy and action developed by participants in the Community Meetings onto sticky walls in a conference room. Staff worked over 20 hours to try to consolidate the strategies and activities as there were many overlaps, duplications and ideas that could be combined. Staff members were diligent in honoring the spirit and intent of each strategy. The combined strategies were put into a draft proposal to be presented back to participants at the last Community Planning meeting. (See Attachment DD: PEI Draft Proposed Projects)

Meeting 5: The proposed draft plan was presented to 61 community members at the last Community Planning meeting. The large group was broken out into six (6) smaller groups to obtain feedback on both the draft plan and the overall PEI Planning Process. Some of the feedback provided was used in the draft PEI Project Proposals that was developed for the MHSA Steering Committee. Other feedback will be used for the Request for Proposal (RFP) process and for future MHSA and other Mental Health planning processes.

#### MHSA Steering Committee

The PEI Proposed Projects were presented to the MHSA Steering Committee on December 17, 2009. (See Attachment EE: PEI Proposed Projects) There was robust discussion by the members and public comments were also made. The Steering Committee voted unanimously in support of Mental Health staff developing the

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proposed project further with the understanding that time would be allowed for further feedback during the 30-day public comment period.

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

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

The County engaged with various cultural groups during the Community Services and Supports (CSS) and the Workforce, Education and Training (WET) planning processes. To continue building relationships, community leaders and other members from underserved ethnic communities were invited to a lunch meeting in October of 2008 to discuss how the work accomplished in WET could “bridge” or carry over to PEI.

The PEI Cultural Competence Advisory Committee (CCAC) was formed as a direct result of the Bridge meeting. The PEI CCAC provides input into the PEI Planning Process and on programs developed out of the planning process. Members were asked to participate in the Community Educational Forums and/or recommend potential presenters or panelists in order to address cultural issues related to the various forum topics. Along with taking the PEI surveys into their communities, they also assisted in promoting the Community Educational Forums by distributing flyers. One of the PEI CCAC meetings was dedicated to the issue of suicide. Responses to questions about suicide were collected and input was sent to the Suicide Prevention Workgroup. In addition, several members of the PEI CCAC participated on the workgroup.

As mentioned previously, eight (8) Community Educational Forums were held throughout the County. There were two goals for each forum: 1) to briefly educate the community about PEI, the Key Community Mental Health Needs and Priority Populations, and 2) to engage the community in a dialogue about specific needs related to each topic and natural settings in which PEI services and activities could be provided in order to reach more members of the community. In planning each Forum, a minimum of at least one cultural perspective was showcased. Forum Two: “Underserved Cultural Populations: Disparities in Accessing Services” had specific information on cultural and refugee issues. Other cultural perspectives were covered in different forums and included the following: LBGTQ issues; Russian and other refugee acculturation issues; depression and the elderly; foster youth; Native American historical trauma; and client and family member perspectives and concerns.

Working with the Center for Reducing Health Disparities (CRHD), Division staff members were invited to attend community report-back meetings from focus groups conducted by CRHD in the prior year. The meetings focused on issues identified as important by the Hmong, African American and Lesbian, Gay, Bisexual, Transgender

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and Questioning (LGBTQ) youth communities. Suicide, anxiety, depression, and isolation were some of the major concerns voiced from participants in each of these meetings.

The first Community Educational Forum focused on Suicide Risk. The agenda included local data from The Effort, a nationally accredited Suicide Crisis Line located in Sacramento. Dr. Tanya Fancher, a University of California, Davis Researcher who studies depression in the Southeast Asian Population, spoke on suicide risk in the Asian elderly population. Judith LaDeaux, Student Affairs Coordinator of Native American Studies at the University of California, spoke about suicide in the Native American community. This forum generated great interest in the topic of suicide prevention and the importance of developing culturally and linguistically appropriate services and outreach activities.

In the Phase II Community Planning meetings, outreach was conducted through e-mail blasts but more importantly, through our CCAC members. Interpreters were available for several of the meetings in order to translate for Spanish and Hmong speaking community members. There were about fifteen (15) Hmong speaking and five (5) Spanish speaking individuals. With the use of the interpreters, they were able to participate in both the Electronic Meeting and Consensus Workshop processes.

- 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 PEI Survey was translated into Sacramento County's five (5) threshold languages and distributed at specific agencies that serve our diverse communities. Agency partners helped to outreach the surveys and members of the PEI CCAC assisted in outreach to their communities. Panelists and presenters were recruited at the PEI CCAC committee to do presentations at the eight Community Educational Forums.

The PEI survey was distributed at the 28<sup>th</sup> Annual Mental Health and Aging Conference on October 23, 2008, where there were over 200 individuals in attendance. An MHSA staff member attended the monthly Older Adult Committee meeting to solicit input and report on MHSA and PEI events and activities.

The Community Educational Forums were held at different geographic locations that had access to public transportation. Flyers promoting the Community Educational Forums indicated that interpretation services would be provided upon request. Forums were rotated from evening to afternoon to accommodate a variety of schedules. Promotion of the Community Educational Forums was extensive and included sending out flyers to the MHSA email distribution list of over 1300. Flyers were also sent to system partners and providers to distribute and post. Finally, flyers were available at various events and meetings.

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In addition to engaging diverse cultural and ethnic groups, adults, older adults, consumers and family members, Sacramento County continued its engagement efforts and partnerships with transition age youth. MHSA supported eight (8) individuals to attend the “Serving Youth with Emotional Disturbance and Transition-Aged Youth Being Served in or At-risk for the Juvenile Justice System” conference held January 15<sup>th</sup> and 16<sup>th</sup>, 2009. Transition age youth from Mental Health America conducted a panel presentation as did staff from the Mental Health’s Child and Family Services Unit.

The For Youth by Youth Community Educational Forum was planned by a team of young people. An active outreach campaign to form a committee was conducted from November 2008 to January 2009. Outreach began with phone calls to local community-based organizations working with youth, including agencies serving those from unserved and underserved communities. All phone calls were followed up with informational emails. MHSA staff also presented information directly to youth by making presentations at various agency sites.

At our Phase II Community Planning meetings, there was strong representation by TAY who actively participated in the process. One of the young adults also volunteered to operate one of the computers and facilitated the discussion during of the Electronic Meeting processes.

In order to reach more culturally and ethnically diverse community members, the PEI CCAC meetings have been held in various locations and hosted by partnering organizations. Some of the venues and hosts include:

- Oak Park Community Center
- The Gardens Family Care Community Center
- Roberts Family Development Center
- Asian Pacific Community Counseling
- Hmong Women’s Heritage Association
- Romanian Business Center
- Bethany Presbyterian Church
- Slavic Assistance Center – Cottage Way Christian Church

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

The MHSA Program Manager was invited to do a half-day presentation at the Consumer Speaks Conference on October 27, 2008. The first part included an overview of PEI, including a discussion about the Key Community Mental Health Needs and Priority Populations. The second part of the afternoon was used to have a general discussion and elicit feedback about PEI from the consumer’s perspective. (See Attachment FF: Consumer Speaks Conference Flyer)

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The MHSA Steering Committee is comprised of 50% consumers and family members, with two of them being Transition Age Youth. Committee members are invited and included in all PEI activities, as well as being apprised of developments through the regular bi-monthly Steering Committee meetings.

The PEI Planning Committee included a Consumer Advocate, an Adult Family Advocate and a Family and Youth Advocate Coordinator. A PEI presentation was also made to the Family Advocate Committee (FAC) meeting.

Community Educational Forum Eight was For Youth by Youth. This Forum was planned and presented by a large group of transition age youth. Committee members included young people who self-identified as consumers and family members.

The Division's long-standing collaborative relationship with Mental Health America of Northern California has been instrumental in promoting PEI planning activities. Staff members from MHA of Northern California have been involved in Community Educational Forums, served on the PEI Planning Committee, and helped arrange for volunteers to assist with the logistics of various events. Panel members for the Community Educational Forums included family advocates, representatives from the California Network of Mental Health Clients, the United Advocates for Children and Families, and other adult consumers as panelists.

Family and youth advocates were also invited to participate in the Student Mental Health and Wellness Collaborative and provided input specifically related to school-based services and how the schools could effectively engage more parents/caregivers and families.

**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:*

i) *Individuals with serious mental illness and/or serious emotional disturbance and/or their families*

Consumers and family member involvement is a core value in the implementation and oversight of Sacramento County's Mental Health Plan. Consumers and family members comprise 50% of the MHSA Steering committee and also participate in Task Forces and Ad Hoc Committees. They participated in all PEI community engagement and planning activities and will also participate in implementation.

PEI was part of the Consumer Speaks Conference held October 27, 2008. After a PEI overview/training, a dialogue was facilitated with the audience to

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provide feedback on Key Community Mental Health Needs and Priority Populations. Surveys were distributed at the Consumer Self-Help Center and other consumer-focused organizations.

MHSA developed a contract with MHA of Northern California to video-tape each of the Community Educational Forums. A crew of consumers and family members, trained by the local public access cable network, film and produce a program called "Mental Health Matters" that has been nationally recognized and airs on public access television. Four to six consumers from the Mental Health Matters film crew videotaped seven (7) of the Community Educational Forums. Several of the forums have been aired on public access television and they are available to the public at no cost.

Youth consumers were active in planning the For Youth by Youth Community Educational Forum. This forum was designed and facilitated by 28 diverse transition aged youth in the community who have some level of involvement in the mental health system and/or who had a special interest in mental health issues.

- ii) *Providers of mental health and/or related services such as physical health care and/or social services*

A Program Manager from Public Health's Promotion and Education Unit attended the PEI Roundtable as part of the Planning Team and provided input on the planning process.

The Primary Health Interim Director, Deputy Director of Child Protective Services, Division Manager of Alcohol and Drugs Services, Deputy Director of Adult Protective Services, and Deputy Director of the Department of Human Assistance are members of the MHSA Steering Committee. In addition, representatives from three (3) community agencies that provide services to children, youth, adults and older adults are on the Steering Committee.

All of the mental health contract agencies in the County, as well as hospitals, primary care clinics, and Public Health were invited to the PEI Community Orientation meeting on October 22, 2008.

To address veterans' issues, Janet Lial, Suicide Prevention Coordinator at the Veterans' Administration Hospital, presented at the Community Educational Forum on Suicide Risk and Mike Miracle, Director, Veteran's Center presented on Trauma in the Military at the Community Educational Forum entitled The Psycho-social Impact of Trauma.

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Alondra Thompson, a licensed therapist in private practice, presented on post-partum depression at the Community Education Forum about Individuals Experiencing Onset of Serious Psychiatric Illness.

At the Community Educational Forums, the following doctors from the UC Davis Health Care system, served as panel members:

- Dr. Tanya Fancher – Suicide in the Elderly Population
- Dr. Cameron Carter – Youth and Early Adulthood Onset of Mental Illness
- Dr. Ladson Hinton – Elderly Depression

iii) *Educators and/or representatives of education*

The Superintendent of the Sacramento County Office of Education (SCOE) is a member of the MHSA Steering Committee. SCOE and two (2) representatives from the Los Rios Community College District attended the CiMH PEI Roundtable as part of the Sacramento Team.

Local schools were major participants in the Teen Suicide Task Report developed in 2006 and provided input into the Suicide Prevention Project Workgroup.

SCOE has a state contract with the California Department of Education to develop tools for counties across the state to use to support local PEI education efforts. The SCOE and Division of Mental Health partnership summary document was developed by SCOE to be distributed statewide as an example of how education and mental health can work together collaboratively to better serve children, youth and families in our community. (See Attachment GG: Collaborative Partnerships in Sacramento County)

As described in Section 1c of this Form, there has been an ongoing collaborative between Mental Health, SCOE, local school districts, family advocates, youth and many other stakeholders. This collaborative will continue to implement the strategies delineated in the Student Mental Health and Wellness Plan.

iv) *Representatives of law enforcement*

Representatives from Probation, Sacramento County Sheriffs Department and the Juvenile Court are on the MHSA Steering Committee, the highest recommending body for MHSA activities in Sacramento County.

One of the Community Educational Forums focused on Youth at Risk of Juvenile Justice. The Chief of Probation and the Sacramento City Youth Gang and Violence Prevention Coordinator were two of the panelists, in addition to

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several gang prevention specialists, one with the Sacramento Police Department and another with the Mayor's Office of Youth Development.

The Probation Department and the Criminal Justice Cabinet also submitted System Partner Input Papers as part of the PEI Planning Process. The Probation Department sent a representative to participate in the Mental Health and SCOE Collaborative meeting in February of 2009.

- v) *Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families*

At the Community Educational Forum entitled Stigma and Discrimination, Delphine Brody, representing the California Network of Mental Health Clients, presented the client perspective and Vickie Mendoza from the United Advocates for Children, Youth and Families presented the youth family perspective. Marilyn Hillerman, representing NAMI, presented the adult family perspective and Laurel Mildred, the former Executive Director for the California Network of Mental Health Clients and current Principal of Mildred Consulting and Advocacy represented an overall perspective on mental illness, prevention, stigma and discrimination.

Jesus Sanchez from Youth in Focus spoke on the stigma associated with being lesbian, bisexual, gay, transgender or questioning. Kenn Logan, a youth advocate with Mental Health America, and Lou Williamson, MA, an adult consumer, provided their perspectives as panelists on the Individuals Experiencing the Onset of Serious Psychiatric Illnesses Community Education Forum.

MHSA works very collaboratively with consumers and family members employed by Mental Health America (MHA) to promote PEI planning activities. Staff members from MHA have been involved in community Educational Forums and serve on the PEI Planning Committee and MHSA Steering Committee.

During Phase II, Sacramento County's Mental Health Director spoke with mental health staff, mental health providers, Mental Health America of Northern California, and the MHSA Steering Committee requesting that they strongly encourage consumers and family members to participate in the planning process. Several consumers, family members, and Youth Advocates that have not participated in prior MHSA activities attended and participated in the Community Planning meetings.

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

Experiences from the CSS and WET planning process provided the community with a familiarity with the MHSA participatory process.

Mental Health recruited thirty-seven individuals (including staff and community stakeholders) to attend the PEI Regional Roundtable meeting on July 31 and August 1, 2008, which was sponsored by the California Institute of Mental Health (CiMH), the Mental Health Services Oversight and Accountability Commission and the State Department of Mental Health. During a breakout session, Sacramento's MHSA team utilized the time to explain our local planning process and gather input about how it could be strengthened. After the Roundtable, a follow-up meeting was held to further define planning and receive feedback from stakeholders and partners.

MHSA sponsored representatives from Education, Probation, Alcohol and Drug Services, Child Protective Services, Family Advocates and Youth Advocates to attend the 2009 California Mental Health Advocates for Children and Youth Conference (CMHACY) which focused on Prevention and Early Intervention. Those who attended were able to bring back information to help inform our PEI Planning Process.

The Community Orientation Meeting and each of the eight Community Educational Forums included an overview of PEI and opportunities for community members to get involved in the planning process. The PEI planning process was also presented to the PEI Cultural Competence Advisory Committee and they were encouraged to outreach to their respective communities to recruit individuals to participate.

At the MHSA Steering Committee, training on the PEI component was provided to members. Additionally, the PEI Planning Process was reviewed and discussed with the Steering Committee and the Division's Management Team. At each MHSA event, laminated posters listing the MHSA five (5) essential elements are posted and we continually train to these elements.

For the Suicide Prevention Project Workgroup, the first overview meeting provided an orientation to PEI and at each subsequent workgroup meeting, PEI principles and values and the five essential elements were part of each discussion.

During Phase II PEI Planning, the community received an overview of the PEI Component and the planning process up to that point. Data collection and results were discussed and explanations were provided about how Sacramento's KCMHN and Priority Populations were selected.

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**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.*

During the CSS process, there was a sense that the County engaged in, but did not sustain, meaningful relationships with diverse communities. Specific feedback was that Mental Health solicited their input only to meet Mental Health's needs but a lot of the feedback was disregarded. Because of this feedback, strong efforts were made, and continue to be made, to outreach and engage with our unserved and underserved communities with an emphasis on building and maintaining relationships. Careful thought went into the PEI CCAC meeting held on Oct 7, 2008, to make sure feelings of inclusion and respect were experienced by participants.

We continue to work on improving communication and inclusion. There is an MHSA distribution list of over 1300 and all activities, meetings and issues of importance are sent to those on the list. For certain events and planning meetings, personal phone calls were also made to ensure participation and clarify information. Periodic updates are also sent via email.

When planning various community events, we take into account the times and locations to meet the needs of community members. We also make an effort to seek specific input from our system partners and stakeholders in order to nurture relationships.

During the CSS process, 143 program proposals were submitted for consideration but only five (5) were approved due to the limited amount of funding available. This resulted in a high level of frustration in the community and many stakeholders chose not to continue participating. In moving forward with PEI, we have been clearer about the limited resources available and made a concerted effort to manage expectations. During the Phase II Community Planning meetings, we emphasized that the planning was not about funding specific organizations or programs but tried to keep the focus on overall strategies to address community needs regarding the PEI Priority Populations. We also utilized a Consensus Workshop Method to reach decisions rather than having individual voting.

In learning from CSS, we strengthened our communication efforts with the community. We made sure that all information generated during Phase II Community Planning meetings were posted to our website in a timely manner. We also brought back information from previous meetings so the participants could provide input to make sure we captured their feedback accurately.

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- 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.*

In addition to sending out flyers, posting events on the MHSA web page and sending out e-mail announcements to our distribution list, we engaged our other system partners to assist us in promoting PEI events through their networks. Outreach efforts were measured to be successful based on the number of individuals that attended our PEI activities. We asked everyone that attended to sign in and were able to identify what kind of demographic breakdown we had. Evaluations were completed at each of the Community Educational Forums and the input was very favorable.

At the end of the Suicide Prevention Project Workgroup, the committee evaluated the planning process. The feedback was positive and included the following:

- Appreciated having data to respond to rather than having to create something from scratch;
- Liked the brief format of having longer meetings for a fixed amount of time;
- Members felt their opinions were heard;
- One member from the PEI CCAC appreciated that the feedback from the PEI CCAC was actually incorporated into the Suicide Prevention Project – good example of follow-through and inclusion.

The initial outreach for the For Youth, By Youth Community Educational Forum began in November 2008 and continued up to date of the Forum, March 6, 2009. Electronic methods were a primary source of outreach – the flyer was emailed out to many distribution lists and posted through electronic newsletters. The For Youth, By Youth committee also took responsibility for promoting the Forum by taking flyers to their high schools and local community based agencies, such as Asian Pacific Community Counseling, La Familia and Hmong Women’s Heritage Association.

The For Youth, By Youth planning committee completed a survey on the planning process. The committee members were surveyed to assess how they felt about the experience of leadership and planning and it was very favorable.

Evaluation surveys were collected at each of the Phase II Community Planning Committee Meetings and during the last Community Meeting verbal input about the participation process was solicited. Overall, the feedback was favorable. Some examples include:

Question: What did you like about the PEI Planning Process?

- Well organized, a lot of work went into process behind the scenes
- Like having longer meetings rather than more meetings
- The continuation of the information (from Phase I)

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- Gave the chance for individual voices to be heard/opportunity for everyone to be heard
- Clear effort to get a broad group of stakeholders
- Consensus building process
- Electronic data, instant results
- Inclusive – including non-English speaking
- Ability for equal participation by all
- User-friendly handouts
- Well-facilitated by staff
- Respect for diversity

Question: How could we have improved the PEI Planning Process?

- Make sure stakeholders get to the meeting or have other focus groups in the LGBTQ community and other stakeholder communities (elders, consumers, different languages, specific age groups, etc.)
- Allow opportunity to give/provide input on the plan if you missed a specific meeting or were late to a meeting
- Outreach to schools and churches to get participants
- Present existing prevention and early intervention resources at the beginning of the process
- Outreach more to consumers, family members, seniors, TAY, cultural groups and professional organizations
- Offer play care
- Provide MHSA phone number and names on handouts
- Have multiple meetings at different times
- Provide information on website and inform people that the information is posted.
- Have important outcomes translated

Outreach during the PEI Planning Process, particularly during Phase II, led to the involvement of individuals and stakeholders that had not participated in prior MHSA planning activities. There were many consumers, family members and youth, including those from diverse communities, that participated in the Community Planning Meetings who stated they had not previously been involved. Service providers assisted significantly in spreading the word about how to participate, as did the PEI CCAC, MHSA Steering Committee members, and Mental Health staff members.

The feedback received from the community to strengthen and ensure inclusion will be considered in future planning processes.

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Enclosure 3

Form No. 2

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

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

January 28, 2010  
6:00 p.m. – 9:00 p.m.  
DHHS-DBHS Administrative Services Center  
7001-A East Parkway  
Conference Room 1  
Sacramento, CA 95823

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

The Division of Mental Health posted the Plan Amendment to the PEI Component Three-Year Program and Expenditure Plan from December 28, 2009 to January 28, 2010.

An announcement was placed in the Sacramento Bee newspaper indicating the link to the posting and the date of the Public Hearing. An e-mail indicating the link to the posting and date of the Public Hearing was sent to all of our Child and Adult contract providers, our local libraries, and over 1300 individuals on our MHSA e-mail distribution list. The Executive Summary was translated into Sacramento County's five (5) threshold languages and also posted for review. Mental Health staff worked with agencies that serve various cultural and ethnic groups in circulating the translated versions and obtaining feedback from the communities they serve. Efforts were also made to advertise the posting using ethnic media including the following:

- Crossings TV (KBTV): targets Hmong, Vietnamese and Cantonese speaking community members via television and on Crossings' website
- KFSG 1690 Radio: radio announcements regarding PEI in Russian
- El Hispano: a free weekly newspaper ran Spanish versions of the public notice

The MHSA Program Manager presented this proposed Plan Amendment to the following stakeholder groups:

- Mental Health Board, January 6, 2010
- MHSA Steering Committee, January 21, 2010
- PEI Cultural Competency Advisory Committee, January 26, 2010
- Public Hearing, January 28, 2010

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

Throughout the 30-day posting period, including the Public Hearing, community members and stakeholders provided both written and verbal feedback on the proposed Plan Amendment. There were many comments received that spoke to the overall Plan Amendment or to the Planning Process, while some comments were about specific projects and programs. Comments were submitted by community members and stakeholders, the MHSA Steering Committee, the PEI CCAC, and Education.

Below is a summary of comments received and a response from the Division of Mental Health.

#### **General Comments – Overall Plan**

- The planning process was very organized and efficient
- The proposed plan is a true representation of community input and priorities
- The plan is inclusive and well-integrated
- Appreciation for the number of times the plan references language and culture
- Good job addressing all age groups and including a multi-cultural perspective, addressing co-occurring disorders, including families and focusing on violence prevention
- The programs have good outcomes that can be evaluated
- Need to ensure the inclusion of Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex (LGBTQI) when referencing culture
- LGBTQI individuals exist in all communities and should be served by all of the PEI programs
- It is important to reiterate that MHSA is supposed to lead to “system transformation”
- Need to ensure that all the PEI Projects contribute to transforming the mental health system as required by the MHSA
- All programs should be consumer and family-member driven
- Family members and consumers should be employed as staff not just volunteers
- Advocacy efforts should be supported by including a family partner/advocate and peer/advocate staff position in every funded program
- We need to acknowledge the impact of alcohol and drug use/abuse and provide good training regarding addressing substance abuse issues within the context of these programs
- Training is critical to PEI and efforts should focus on training school personnel
- In order to reduce stigma and discrimination, we need to provide training and education to teachers and community members about mental health issues

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There were many comments submitted regarding the overall plan by our partners in Education:

- Schools are an effective way to reach large numbers of children and families – there are over 240,000 children and youth in Sacramento County schools
- Suggestion to incorporate components from the Student Mental Health and Wellness Plan (SMHWP) into Projects 2 and 3
- Schools should be used as the natural setting for more of the programs in the PEI Plan Amendment
- Expand the role of proposed mental health personnel to include provision of training, technical assistance and coordination for school personnel to implement prevention and early intervention activities.
- Twelve of the fourteen strategies presented in the SMHWP could be easily addressed in the PEI Plan, including social skills, violence prevention, general prevention/awareness instruction, screening and assessment, parent education, and communication/marketing.
- To extend the reach of Mental Health staff and their PEI activities, include broad-based teacher/school staff training to recognize mental health issues, make appropriate referrals, and create supportive school environments.
- Include activities that address the entire county and target populations through strategic use of the countywide school system.
- Providing services in the schools is an effective way to leverage services – you can reach more children, youth and families with limited funding and you can achieve the intended goal of the MHSA, which is system transformation.
- The schools remain committed to the work of MHSA until system transformation is achieved

**Project 2: Strengthening Families****General Comments:**

- Need to specify in the narrative that adults and older adults may be served in all of the Strengthening Families Programs.
- Suggestions were made to incorporate SMHWP activities into Projects 2 and 3 by developing a training model that provides training of trainers and school-based practitioners to implement the programs and activities.
- Do not forget “homelessness” in program implementation as it was rated by the community as a top stressor for Children and Youth in Stressed Families
- To ensure success of any school-based programs, parents from diverse communities should be used as “cultural brokers” by the schools

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### Program 1: Early Childhood Consultation:

- Instead of using mental health clinicians, use traditional helpers to outreach to ethnic communities to provide child development information to families
- Education suggested expanding childcare settings to include their large number of preschool programs and to work with their early childhood staff, as they are often the very first resource a family has beyond the family constellation.
- Suggestion to include the role of clinicians to include training and professional development to staff to identify mental health issues earlier

### Program 2: In-Home Support Services to Foster Children

- Use a team approach rather than a Developmental Specialist
- The concept of a Developmental Specialist was unclear
- This program should also be used to encourage foster parents to enroll children in Pre-K and Kindergarten programs

### Program 3: School-based Social Skills & Violence Prevention

- Several positive comments were made about the program targeting both children and parents; good job including parents/caregivers in the School-based Social Skills and Violence Prevention Program – need to ensure that parents and caregivers are given the same information the children and youth are given
- Concern expressed about how ethnic and cultural groups will be identified and what kind of emphasis there will be on serving these groups
- Question was raised about how we will ensure families are included in both programs.
- There was a recommendation that a committee with diverse representation (beyond psychiatrists) be established to implement school-based projects.
- Several individuals spoke about schools “not being a welcoming” location for services and believed this program should not be implemented just by the schools.
- One community member noted that putting all the money in the schools won’t reach the kids most at risk – they are not typically in school and you won’t reach their parents either.
- The CCAC also issued statements about the schools not being the only location for this program. There was concern about schools not being welcoming to culturally and ethnically diverse families and there was also concern about the willingness of schools to partner with Community Based Organizations – some are willing and some are not, mostly due to the administration of the particular school.
- Some individuals advocated that at least some of the services in this program be offered after school and at locations other than schools due to the concerns mentioned above and because not all children and youth are in schools to receive these services.
- Community partnerships should be included in this program to ensure diversity.

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- Social skills and violence need to be taught and understood within the context of culture.
- There was a recommendation to use non-professionals to do community engagement
- LBGTQ needs to be included in the violence prevention component and should be school-wide.
- LBGTQ concern regarding need for parental permission if subject matter is taught in health classes

**Program 4: Building Life Skills for Teens and TAY:**

- A question was posed as to how innovative this program is when it expands on an existing program
- Concern expressed that the program only focuses on teens and TAY and leaves out the family

**Program 5: Family Conflict Management:**

- This program addresses an important community need however, prescribing the approach may not be best.
- There was a suggestion that innovative and culturally competent approaches from grass roots organizations may work best
- It is imperative to take culture into account when addressing family conflict

**Project 3: Integrated Health and Wellness**

Suggestions made to incorporate SMHWP activities into Projects 2 and 3 by developing a training model that provides training of trainers and school-based practitioners to implement the programs and activities.

**Program 1: Screening, Assessment, Peer Support and Treatment:**

- There were several comments received that were strongly supportive of using primary care as a natural setting in order to reach more people, especially from diverse communities
- Several comments suggested adding the schools as a second natural setting for the Screening & Assessment, Peer support and Treatment Program
- Training and technical assistance should be provided for school personnel to do depression and suicide screenings.
- One comment suggested that the Peer Support and Treatment services be in a separate location to reach underserved and unserved groups where they are not likely to see people they know.
- Suggestion to use terms such as “community gathering” rather than support groups
- In supporting siting this program in primary care settings, it was noted that Sacramento County Adult Mental Health and Older Adult Mental Health Services do not have any prevention or early intervention programs and most

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mental health care is provided in primary care settings. Due to stigma, many individuals do not feel comfortable presenting to specialty mental health providers. Also, many primary care settings lack behavioral health expertise, staffing and/or relationships with specialty mental health yet serve an ethnically diverse population with co-morbid medical and behavioral health conditions.

- Because the Priority Population to be served in this program is trauma- exposed, a suggestion was made to fund clinicians that have language capacity to serve the different refugee populations as well as have awareness of intergenerational issues.
- A community member encouraged us to remember the young people who have witnessed violence in the community or have been a part of a street gang and suffer from PTSD.
- The LBGQTQ population suffers from the trauma of bullying and needs to be considered. LGBTQ also suffer from other types of trauma which should be addressed in this program.
- There was a comment that consumers can benefit greatly from trauma-informed services and there should be more emphasis on Peer support for trauma survivors.
- There was concern that Children and Youth in Stressed families was not marked in the box on Form 3, 1& 2.
- There was interest in using schools to increase awareness and deliver services by providing training and Technical Assistance to school personnel to assist with screening and/or assessments.
- A school liaison for homeless children and families noted that most of her families do not go to primary care settings for services – they typically go to emergency rooms when they need treatment; it would be more effective to reach this population in school settings.
- Another community member noted the importance of having strong linkages between schools and primary care settings

Program 2: Assessment and Treatment of Onset of Psychosis:

- There were many comments received both verbally and in writing that supported this program
- A couple of comments noted the value of this type of program but questioned the cost per client and the small number of children and youth that would be served
- There was a suggestion to provide these kinds of services in school settings.
- One comment encouraged the Division to ensure this program is easily accessible
- There was public testimony and written responses submitted in support of this program specifically identifying the EDAPT (a program administered by UC Davis that provides assessment and early treatment of psychosis) for consideration
- It was noted that EDIPP/EDAPT is a school-based program. They have done extensive outreach and training in the schools and currently partner with two districts. There is a standard of practice which includes schools.

## PEI COMMUNITY PROGRAM PLANNING PROCESS

### Program 3: Senior Navigator Program: Target Isolation and Depression in Older Adults

- There were a few comments submitted supporting services for older adults
- There were a couple of comments concerned that the program is expensive and will not serve that many people

### Project 4: Mental Health Promotion Campaign

- Mental Health promotion messages should emphasize that mental health consumers touch all systems.
- There was a suggestion that consumers needed to be made aware of this project of the PEI Plan and to be ready to go so things can be put in place as soon as we get DMH and MHSOAC approval.
- A couple of comments were received from school personnel suggesting that the dollars in this program should be reduced and shifted to Projects 2 and 3 or to jump start the SMHWP.
- Schools were also suggested as a natural setting for mental health promotion and reduction of stigma.
- Utilize existing communication systems within education to reach families, making the communication/marketing campaign more cost-effective. The communication/marketing strategies of Project 4 are described in the SMHW plan.

### Division Response

#### General Comments – Overall Plan

The Division of Mental Health would first like to acknowledge and thank all the community members, stakeholders and system partners that participated in the various PEI Community Planning activities. Given the overall decline in local services and funding, it was impressive to see the community come together and focus on the collective needs and priorities for the community, rather than specific programs and projects. While there may be differing opinions about program implementation and specific program logistics, the process yielded a PEI Plan that is inclusive, comprehensive, and based on community input and consensus.

The Division understands that in accepting MHSA funding, we are also accepting the responsibility to transform our overall system of care. Mental Health is committed to ensuring the funding utilized for all MHSA components is used with integrity and in pursuit of this system transformation that includes improved services and outcomes for children, youth, adults, older adults and families living in our community. Critical to this transformation is the integration of the five essential elements into all projects and programs. This includes culturally competent, client and family-driven services and the employment of consumers and family members. The overall plan includes roughly twelve (12) paid positions for consumers, youth

**PEI COMMUNITY PROGRAM PLANNING PROCESS**

advocates and family members and many of the programs will provide stipends for consumers, youth and family members. With the leveraging of resources still to be determined, the Division will explore additional ways to include more employment opportunities throughout implementation.

Regarding the comments made about LGBTQI individuals, Mental Health will ensure that PEI programs appropriately and effectively serve these communities. Sexual orientation and gender identity are included in the Division's operational definition of "culture", which is "the integrated pattern of human behavior that includes thought communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs (Cross et al, 1989). A particular individual's cultural identity may involve the following parameters among others: ethnicity, race, language, age, country of origin, acculturation, gender, socioeconomic class, disabilities, religious/spiritual beliefs, sexual orientation, and gender identity."

The Division has provided, and will continue to provide, trainings and technical assistance on cultural competence for county and contracted providers. Over the past three years, Mental Health has conducted eight (8) cohorts (thirty-two (32) hours per cohort) of training utilizing the California Brief Multicultural Competence Scale modules. Mental Health plans to continue to conduct the training on a quarterly basis with the goal of having all service provider staff supervisors and administrators receive the training. To date, over two hundred fifty (250) individuals have been trained. As with all mental health services, we will continue to make certain that services are culturally and linguistically responsive to our diverse communities and will draw from the collective expertise of our merged PEI CCAC and Mental Health Plan Cultural Competence Committees. During the CSS process, a tool was developed to assist MHSA CSS Programs in their development of culturally and linguistically competent services. The Cultural Competence/Ethnic Services Unit will continue to implement this tool and provide assistance to all MHSA programs, including PEI.

The Division acknowledges the dynamic interplay between substance abuse and mental illness and understands the importance of prevention efforts and training aimed at both issues. The significant amount of comments directed toward the need for training to support PEI and expand community capacity to deliver PEI services is recognized and echoed by the Division. Sacramento County is requesting Training and Technical Assistance funds to be used for PEI and will take into account community input to help guide the selection of trainings. Training associated with this particular funding will be complemented by the training and education in the Suicide Prevention Project and the Mental Health Promotion Campaign. Targets will include providers, the schools, other system partners, gatekeepers and the community at large. Training and educational strategies will include the use of consumers, family members, system partners, advocates, cultural brokers, and others

**PEI COMMUNITY PROGRAM PLANNING PROCESS**

to improve the effectiveness of services and to reduce stigma and discrimination toward those living with mental illness.

Education has been a significant partner in the overall PEI Planning Process. As indicated previously, the Division of Mental Health, the Sacramento County Office of Education (SCOE), the thirteen (13) public school districts, and numerous stakeholders, including mental health service providers, youth and adult community members, Probation, Child Protective Services, Alcohol and Drug Services, and others convened over a 10-month period of time and developed a countywide plan for promoting student emotional wellness and academic success. The product of this planning process, the Sacramento County Student Mental Health and Wellness Plan (SMHWP), was intended to serve as a foundation for the County Plan for the Student Mental Health Initiative and the PEI Plan. The plan contains goals, objectives and strategies for integrating prevention and early intervention efforts into the schools, acknowledging schools as natural settings.

The Student Mental Health and Wellness Collaborative was one of several efforts undertaken as part of the extensive planning process required by the MHSA. As with other MHSA funding, the Division worked with multi-cultural consumers and family members, system partners, and other community members and stakeholders on deciding how to allocate a small amount of money across all age groups in natural community settings based on input provided during the planning process. While the schools were identified as a natural setting for reaching children, youth and families, other natural settings for PEI services were also identified by the community, including primary care settings, in-home services and community-based organizations, including those that focus on cultural and ethnic communities, that individuals and families go to for services other than mental health.

There are several strategies within the SMHWP that have been integrated into some of the PEI Projects and Programs including the Suicide Prevention Project, the Mental Health Promotion Campaign, the School-based Social Skills and Violence Prevention Program, and the Building Life Skills for Teens and TAY program.

While there are many other strategies in the SMHWP that fit with PEI, the PEI Guidelines require that funding be dedicated to serving adults and older adults as well. A minimum of 51% of PEI funding must go to ages 0 – 25. The Sacramento community supported dedicating 55% to ages 0 – 25; 20% to Adults ages 26 to 59; and 25% to Older Adults ages 60 and older. The Division worked diligently to ensure that these percentages were met in the entire PEI Plan.

The Division also understands that the schools reach over 240,000 children and youth in Sacramento and believes the SMHWP can have a significant impact on our community. Additionally, there was significant community support to increase the capacity to provide prevention services in school settings. Therefore, the Division will continue to collaborate with SCOE and submit a proposal to the MHSA

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Steering Committee requesting that a portion of one-time PEI funding be directed toward implementing the SMHWP while also continuing to pursue the Statewide Student Mental Health Initiative funding.

Assuming community support, the Division will submit a PEI Plan Update as soon as possible requesting PEI funding to implement specific SMHWP strategies and activities. Given the input from our ethnic and cultural communities, efforts will include approaches to strengthening relationships with schools and children, youth and families from diverse communities.

**Project 2: Strengthening Families**

The narrative was revised to reflect that adults and older adults in the lives of children and youth receiving services from this project will also receive services as appropriate. The Division appreciates the reminder to include homeless children and youth as targets for PEI services. Homelessness was a stressor rated highly by the community as significant to the Priority Population of Children and Youth in Stressed Families, and this will be taken into consideration as Requests for Proposals (RFPs) for PEI Programs are developed. As indicated in the response above, training will target schools and specific strategies in the SMHWP will be considered for future funding.

**Program 1: Early Childhood Consultation**

The Mental Health Clinician plays an important role on the multidisciplinary team within the Early Childhood Consultation Program and he/she will provide training to staff to identify mental health issues. It is important that the person who assumes this position has experience and training in issues related to the 0 to 5 age group. This requirement does not preclude the use of traditional helpers to outreach to ethnic communities to provide child development information to families. This suggestion was supported in several meetings with the PEI CCAC and will be considered as part of this program and/or the Mental Health Promotion Campaign. Regarding the suggestion to include preschool programs and early childhood staff, existing services currently target federally funded preschools. The Early Childhood Consultation will be able to expand the number of locations and staff served.

**Program 2: In-Home Support Services to Foster Children**

The program narrative was expanded to include clarification of a Developmental Specialist. While the position described is a Mental Health Clinician, the critical function of this position to have a solid understanding of child development issues and developmental milestones, the ability to assess situations and environments, and to provide guidance when there are concerns about the physical or emotional development of a young child. The Developmental Specialist will not work in isolation; rather, he/she will be part of a team providing supports for children ages 0 to 5 and Foster Families with whom they reside. The team can certainly encourage and help link foster parents with Pre-K and Kindergarten programs. The Division

**PEI COMMUNITY PROGRAM PLANNING PROCESS**

will collaborate with Child Protective Services to explore leveraging opportunities and coordinate service delivery.

**Program 3: School-based Social Skills and Violence Prevention**

There were numerous significant comments made that can be incorporated into the competitive bid process to strengthen this program. Specifically, the RFP can include questions that require the applicant to demonstrate how they will ensure inclusion of parents and caregivers, particularly from diverse communities; how applicants will provide culturally and linguistically responsive services, including to LGBTQI youth; how consumers, family members, and/or non-professionals can be utilized to do community outreach.

In response to the concerns expressed by community members about locating these programs only at the schools, the Division will consider only schools eager to deliver these services on their campuses and willing to work collaboratively to ensure they are successful. Schools in at-risk communities will be targeted and applicants will have to address the issues mentioned above in their responses. Consideration will also be given to having some services provided after school to reach more children, youth and families. The Division will work with SCOE and/or local school districts to leverage resources and serve as many students as possible.

The recommendation to establish a committee with diverse representation to implement school-based programs is important. The Student Mental Health and Wellness Collaborative Leadership Team is an existing body that can be considered for expansion and the PEI CCAC, the Cultural Competency Committee, and the MHSA Steering Committee will also be consulted for ideas.

**Program 4: Building Life Skills for Teens and TAY**

A question was posed as to whether this program will be innovative since it is looking to expand existing services. While the goal is to leverage existing successful services, those services can be innovative as long as the outcomes for the program are achieved. TAY in Sacramento County continue to be an unserved and underserved age group with long term consequences and poor outcomes for those with unmet needs. It is imperative to provide effective services that address emotional and developmental issues and assist youth in successfully transitioning to adulthood.

**Program 5: Family Conflict Management**

This program was developed in response to the community rating Domestic Violence as an important stressor to address with PEI funding. While a model has been defined in the program narrative, the Division is open to other approaches that achieve the intended outcomes and applicants will have the opportunity to address this when responding to the RFP. Applicants will also be required to specify how they will address cultural issues in providing services within this program.

**PEI COMMUNITY PROGRAM PLANNING PROCESS****Project 3: Integrated Health and Wellness**

This Project was developed in response to community consensus regarding the top ranked strategic direction for addressing the Priority Population of Trauma-Exposed (across all ages.)

**Program 1: Screening, Assessment, Peer Support and Treatment**

The decision to use primary care settings for this program was based on community input identifying primary care as a key location to reach large numbers of community members that wouldn't normally seek out mental health services. Primary Care was also suggested as a way to reach older adults and individuals of all age groups from diverse racial and ethnic communities. This natural setting is also in alignment with the emerging practice of integrating behavioral health with primary health to provide more holistic treatment and support for co-occurring mental and physical health issues and substance use disorders.

The Division recognizes that schools are also a natural setting in which to provide screenings and assessments; however, due to funding limitations and ensuring dollars are allocated across all age groups, the Division does not support expanding this particular program into the schools. This program is designed to provide services for adults and older adults as well as some children and youth. The proposal to use one-time dollars to jump-start the SMHWP activities will be vetted with the Steering Committee and community. These dollars can potentially be used to provide screenings and assessments for depression, suicide and other issues in school settings. The schools will also be a target for training and education in Sacramento County's Suicide Prevention Project, Mental Health Promotion Campaign and Training and Technical Assistance.

Peers will play a significant role in the Screening, Assessment, Peer Support and Treatment Program as well as in the Senior Navigator Program. The Division agrees with the comment that consumers can benefit from trauma-informed services and that peers can be an important support in the recovery process. Some of the training that will take place for this Project is Cognitive Behavioral Therapy (CBT) and Trauma-Focused CBT. Peers providing services in this program will also receive the training. Additionally, other types of training that are needed to provide effective services and meet the needs of our diverse communities will be considered. The Division will work with community members, subject matter experts and the PEI CCAC and Cultural Competency Committee to help inform the selection of particular trainings.

It is understood that there are many types of trauma experienced by members of our community, including trauma experienced by LGBTQI individuals, veterans, refugees, victims of crime, historical or intergenerational trauma, and others. This program will not differentiate between types of trauma; rather, it will focus on addressing the impact of trauma on the individuals requesting services.

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The Division is open to having the Support Groups be referred to as “Community Gatherings” or other terms that may be less stigmatizing to those seeking services. The use of culturally sensitive and non-stigmatizing language has been the subject of many discussions both in the PEI CCAC and the Student Mental Health and Wellness Collaborative meetings as appropriate language can play a significant role in reaching more people and helping to reduce disparities.

**Program 2: Assessment and Treatment of Onset of Psychosis:**

This program was developed based on community input that ranked Onset of Psychosis as the most important population to address the PEI Priority Population of Individuals Experiencing Onset of Serious Psychiatric Illness. While the cost per client is high, there were many discussions about the debilitating effects of psychosis and that investing earlier, even if it is expensive, will result in longer-term cost savings both in terms of human suffering and impact on other service delivery systems.

While recognizing the success of the EDAPT program and the lives that have been significantly impacted by their services, this program will go through a competitive bid process. The RFP will address the issues of accessibility to service, culturally competent services, and partnerships with local schools.

**Program 3: Senior Navigator Program**

While the costs may seem high for this program, the Division will work diligently with other system partners and agencies to leverage resources. If there is a program design that can reach older adults and achieve the intended outcomes of the program, it would be in the community’s best interest to implement that program. The RFP will yield more information about what resources will be leveraged that can lead to more individuals being served.

**Project 4: Mental Health Promotion Campaign**

All of the comments received will be incorporated into the Mental Health Promotion Campaign. Many of the strategies were taken directly from the SMHWP activities and mental health promotion and education will take place both in the schools and in the community. As with all MHSA activities and planning processes, information will be posted on our website and at provider locations to inform the community, including consumers, family members, system partners and other stakeholders, about opportunities get involved in these efforts. Consumers and family members will be recruited to participate in the Speaker’s Bureau and stipends will be provided to those who participate. The Mental Health Promotion Campaign will be critical to educating our community about mental illness and wellness, and ultimately, in reducing stigma and discrimination toward those living with mental illness.

## PEI COMMUNITY PROGRAM PLANNING PROCESS

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

Approximately 3,473 individuals participated in the PEI Community Planning Process over the last several years. Below is a breakdown of PEI Events, Stakeholder Representation, and Agency Participation.

Event	# of Participants	
Surveys	1700	
System Partner Input Papers	17	
PEI Phase I Kick Off 10-22-08	163	Volunteer hours = 20
Community Educational Forum 1	50	<ul style="list-style-type: none"> <li>• Total number of participants for all forums = 480</li> <li>• Total number of volunteer hours for forums = 547.5</li> <li>• Youth attended 8 planning meetings for a total of 349.5 hours (included in above total)</li> </ul>
Community Educational Forum 2	66	
Community Educational Forum 3	76	
Community Educational Forum 4	46	
Community Educational Forum 5	42	
Community Educational Forum 6	70	
Community Educational Forum 7	45	
Community Educational Forum 8	85	
Phase II Kick Off 10-01-09	104	
Phase II Community Planning Meetings	406	
Suicide Prevention Workgroup	110	
Mental Health Board	11	
Steering Committee	28	
SCOE	121	
PEI Cultural Competence Advisory Committee	247	
Collaborative Partners in Sacramento	48	
Regional Roundtable	38	
<b>TOTAL</b>	<b>3473</b>	

Stakeholder Representation	
Consumers - TAY	African American
Consumers - Adult	Asian Pacific Islander
Consumers - Older Adult	Caucasian
Family Members of Child	Chinese
Family Members of Adult	Filipino
Family Members of Older Adult	Guamanian
Advocates - Youth/Adult/Older Adult	Hmong
Youth	Italian American
NAMI Representation	Japanese

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Veterans	Latino (Hispanic)
Mental Health Association	Mien
Service Providers - Children	Multi-ethnic
Service Provider - Adult	Native American
Service Providers - Older Adult	Polish
Law Enforcement	Romanian
Adult Protective Services	Russian
Child Protective Services	LGBTQ
Education Reps - all levels	Ethnic Service Providers
Dept of Human Assistance	Faith-Based Providers
Alcohol & Drug Services	Social Service Providers
Health	Interested Community Members
Juvenile Court Probation	Physical Health Providers
Mental Health Board Members	

<b>Specific Agencies (samples)</b>	
Healthy Start	MAPP Inc
UC Davis Center for Reducing Health Disparities	Sacramento Native American Health Center
Friends of Survivors	Washoe Tribe of NV/CA
Hmong Women's Heritage Assoc	SAFE
Slavic Assistance Center	Area 4 on Aging
Opening Doors	SCOE
Southeast Asian Resource	UCD
La Familia	Youth in Focus
Assisted Access Specialist	SETA
Sac Lao Family	United Iu-Mien Community
Turning Point Community Programs	APCC
First 5	UCD EDAPT Clinic
WEAVE	Heritage Oaks Hospital
Big Brothers, Big Sisters	Children's Receiving Home
Healthy Family Project	Sacramento Children's Home
Birth & Beyond	VAMC Sacramento
Black Infant Health	Lilliput Children's Services
Child Action, Inc	Chaplaincy
Senior Peer Counseling	Veteran's Administration
Sacramento Steps Forward	EMQ
Sacramento City Mayor's Office of Youth Development	

PEI PROJECT SUMMARY

Form No. 3

County: Sacramento

PEI Project Name: Strengthening Families

Date: February 17, 2010

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

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

## PEI PROJECT SUMMARY

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

The Sacramento County Division of Mental Health, Phase I Community Planning Process involved a series of activities and events designed to solicit input from stakeholders in order to identify PEI Key Community Needs and Priority Populations. For more detail on this process, please see Enclosure 3, Form 2.

The quantitative and qualitative data gathered from the PEI community stakeholder process was integrated and analyzed by the Research, Evaluation and Performance Outcomes (REPO) Unit in the Mental Health Division. The Key Community Mental Health Needs for Sacramento County were determined to be: 1) At Risk Children, Youth, and Young Adults; 2) Psycho-Social Impact of Trauma; and 3) Suicide Risk. The Priority Populations were: 1) Children and Youth in Stressed Families; 2) Individuals Experiencing Onset of Serious Mental Illness; and 3) Individuals Exposed to Trauma.

After completing Phase I Planning, the community moved into Phase II and convened a Kick-Off Meeting and five (5) Planning Committee Meetings over the course of two months. An average of eighty-four (84) stakeholders attended Planning Committee Meetings. The PEI Planning Committee Meetings were open to the community and 837 volunteer hours were recorded. The intent of the meetings was to determine how to address the Key Community Needs and Priority Populations within PEI Projects.

The PEI Kick-Off Planning Committee Meeting consisted of an overview of MHSA, PEI, and PEI planning efforts to date, a discussion of future meetings and an explanation of the process for stakeholders to provide input. At Committee Meeting #1, a visioning exercise was introduced and 67 participants at the meeting were asked, “*What do you see in place in Sacramento County in 3-5 years as a result of Prevention and Early Intervention Planning? How is life better for our community members?*” Responses were collected and summarized into a visioning document (See Attachment Y, Visioning Activity Summary). Part of the response included the following:

*Families are supported through culturally appropriate wellness and prevention services that promote healthy relationships and resiliency. Families are strengthened and parents are involved in all aspects of their children’s lives. Quality, affordable childcare is available and easily accessible.*

*Schools are connected to the larger community and school districts coordinate services working closely with providers. A climate of safety and wellness has been created through youth development, bully prevention, anti-*

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*gang and conflict resolution programs. The increase of on-site supportive services, after school pro-social activities, and a life skills curriculum has increased school retention and student success. Stronger partnerships with local universities have led to increased graduation rates and more youth entering college.*

*Mental Health and wellness is included in all health curriculums from preschool to college. There are comprehensive school health centers at elementary, middle and high schools serving children, youth, and families. Information on healthy relationships has been defined and integrated into curriculums, and the self-confidence of youth living in Sacramento has greatly improved.*

*Transition Age Youth (TAY) have equal access to services, regardless of income, and supports include safe drop-in centers at local malls and emancipation academies. There are services for TAY in Foster Care and comprehensive transitional supports are in place.*

At Committee Planning Meeting #2, eighty-four (84) participants focused on the Priority Population of Children and Youth in Stressed Families. Stressors that had been identified by the community during different phases of the planning process were presented to the participants and additional stressors were identified at the meeting by community members in attendance. Using the Electronic Meeting format, participants broke into small groups to rate the importance of each stressor. The top rated stressors with regard to Children and Youth in Stressed Families were: Onset of Psychiatric Illness; Child Abuse and Neglect; Domestic Violence; Homelessness; Substance Abuse; Family Abandonment; Family members with mental illness; and School Bullying. (Because Onset of Psychiatric Illness was the third community ranked Priority Population, participants were instructed to rate it the highest score possible.)

During the second half of Committee Meeting #2, participants broke into small groups. Using the Consensus Workshop Model, a model developed by the Institute of Cultural Affairs to facilitate consensus thinking, groups were asked to address the following focus question as it related to the top eight stressors, ***“What practical Prevention or Early Intervention actions will help reduce stress on children and youth?”*** Participants identified strategies and activities, clustered them by similarity, and organized them into groups, which became strategies. At the larger group level, all strategies generated from the small groups were grouped into similar categories to develop overall Strategic Directions to address Children and Youth in Stressed Families. (See Attachment AA)

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In Committee Meeting #4, Strategic Directions identified from Meeting # 3 were presented to ninety-six (96) community members in attendance for further refinement. Using the Electronic Meeting Method, participants were asked to rate the effectiveness of each Strategic Direction in addressing Children and Youth in Stressed Families. The results were projected on a large screen for participants to see. There was very little statistical difference between the strategies. Committee members had a hard time saying any one of the stressors was less important than any other. A community member suggested all participants rank the top three Strategic Directions they believed to be most effective in order to further narrow the options. Participants completed ranking, and in analyzing the rating versus the ranking, there was strong consistency in the top priorities for the community. The top Strategic directions included: 1) Pre-K-12 Support Services; 2) Family Violence Prevention; 3) In-Home Services; and 4) Building Life Skills for TAY. (See Attachment CC)

The PEI Cultural Competence Advisory Committee (PEI CCAC) has been meeting regularly since October 2008 to provide input related to reducing disparities in our culturally and ethnically diverse communities through the PEI Projects. (See attachment D). In order to get broader community input, the committee members were presented with a list of stressors and then asked to prioritize the stressors that were of most concern to them. The stressors they identified as most relevant to their communities included exposure to family violence, generational conflict, barriers to accessing to services, self-harming behaviors, youth at risk for school failure and juvenile justice involvement, discrimination, harassment and the lack of culturally competent services. Their valuable input supports the need for the Strengthening Families Project.

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

While stress is a factor of life for virtually all families, severe stress is at the core of, not only preventable mental illness, but also of other poor outcomes, such as substance abuse and family violence. It is in severely stressed families that child abuse, neglect, criminal activities, and lower utilization of preventive health services are frequently found. Children and youth from severely stressed families manifest learning difficulties, engage in aggressive behaviors, are truant and drop out of school at much higher rates than their counterparts.

According to the 2008 Sacramento Children's Report Card:

- The number of children under 18 has increased by 11% (2000-2008)
- The number of children ages 0 through 5 in Sacramento County has increased by 13% (2000-2008)

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- The number of students enrolled as English Language Learners in Sacramento County has increased by 13%. Enrollment of English Language Learners in Kindergarten classrooms has increased by 30% (2000-2006)
- The number of public school students receiving free and/or reduced priced meals has increased by 17% in Sacramento County and 11% statewide (2000-2007)
- The number of families with children under 18 in Sacramento County has increased by 6%, and the number of single-parent families has increased by 4% to reach 54,277 ( 2002-2006)

Participants of the PEI Planning Process and PEI CCAC meetings recognized and voiced concerns of their respective communities regarding the local and state data as mentioned above. The Strengthening Families Project incorporates the strategies identified in the PEI Community Planning Process into a continuum of universal and selective prevention activities for children, youth and their families. This Project targets the PEI Key Community Mental Health Need of At-Risk Children, Youth and Young Adults and the PEI Priority Population of Children and Youth in Stressed Families taking into account the stressors ranked highest by the community: child abuse, domestic violence, homelessness, substance abuse and family abandonment. Project programs will be implemented by the County, schools and community-based organizations. The Strengthening Families Project seeks to alleviate and mitigate family stressors and encourage healthy relationships across the ages. Programs within the Strengthening Families Project are described below.

**Program 1 - Early Childhood Consultation:** (*universal*) The 2009 Child Care Portfolio indicates the supply of childcare falls far short of demand. In Sacramento, 82% of parents in the workforce needed childcare for their children. With only 55,000 licensed childcare slots available for 151,000 children birth to 13 years of age, finding childcare is extremely challenging. Given the shortage of childcare options, when behavioral challenges present in the childcare environment, children are more at risk of being expelled from childcare, increasing stress on the child and the family. During the PEI Community Planning Process, access to quality childcare programs was identified as a major concern. In order to be a quality program, staff working in childcare settings need to be able to build positive, responsive relationships with the young children in their care.

The Early Childhood Consultation program will assist childcare staff in understanding the social and emotional development of young children by providing strategies and supports to assist childcare staff in creating successful experiences for children in their care. As an example, a child may be having a difficult time sitting in circle and loses his attention, becoming fidgety and disruptive. Soon the other children around him also become disruptive. The teacher becomes frustrated and gives the child a time out, creating negative feelings for the child. A consultant can come into the program, at the teacher's request to specifically

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observe the behavior of that child. The consultant observes that the child does well for the first twenty minutes. Circle time is scheduled to go for a half hour. The consultant can point out to the teacher that many young children have difficulty sitting for long periods without losing self-control and suggest shortening the circle time by five or ten minutes. This kind of strategy could change the situation for the child, the teacher and the other children in the classroom.

Currently, the Division of Mental Health partners with the Sacramento County Office of Education (SCOE) and Child Action to provide a Consultation Team that consists of one licensed Mental Health Clinician a Child Development expert, a Developmental Disabilities Specialist, a Speech Therapist, and an Occupational Therapist. This team serves the entire county and is part of the

Quality Childcare Collaborative, which is a partnership of community agencies, education, and government institutions funded by First 5. The Consultation Team receives referrals from childcare providers working in childcare centers, family childcare homes and family, friend, and neighbor caregivers. Through PEI funds, the Division of Mental Health will expand the number of mental health clinicians from one to three. These clinicians will provide behavioral consultations to early childcare and education providers, as well as broaden the scope of available services that can be offered to families. Currently, services range from one to three consultation visits depending on the need of the child or the childcare program.

**Program 2 - In-Home Support Services for Foster Children:** (*universal and selective*) Children between the ages of zero and five are at highest risk of child abuse and neglect. Nationally, one-third of all children entering foster care are zero to three years of age and 15 percent of those are babies under the age of one. In Sacramento, 2008 data shows that 1,247 children under age five (5) entered the foster care system.

Children are removed from their parents and placed in out-of-home care because a court has determined that it is not safe for them to live at home. However, children who are removed from home, particularly those who are very young, are exposed to a new danger – the emotional and developmental harm that can result from separation. Children at different stages in life react differently to separation from a parent, based primarily on their ability to understand the reasons for separation and the range and maturity of their coping strategies. The younger the child is and the longer the period of uncertainty and separation from the primary caregiver for the child, the greater the risk of emotional harm to the child.

This program will provide a Developmental Specialist to provide in-home visits with the foster child and the foster parent. A Developmental Specialist has a solid understanding of and experience in child development issues and developmental milestones.

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This individual must have the skills to assess situations and environments and provide guidance when there are concerns about the physical or emotional development of a young child.

During these visits, the specialist will assess the needs of the child in order to provide the foster parent with child development information. It has been shown that providing the foster parent with information that can explain a child's behavior, results in a more secure placement for the child. After assessment, the specialist can make appropriate linkages to other needed services the child may qualify for, including ancillary services such as speech and language or occupational therapy services. Data shows that a large number of foster children experience developmental delays in areas like speech and language or sensorimotor development. Normal development in these areas is critical to overall mental health. When a child is not able to express themselves using language, they can become frustrated and lose control. If they are not able to manage their bodies, they can get frustrated and lose control.

When appropriate, the developmental specialist will also work with the biological parent to make transitions back home easier and support the bonding and attachment relationship between the child and parent. The anticipated number of visits per child range from six to twelve over a three to six month period and will be determined on a case by case basis. If the child needs on-going mental health services, appropriate referrals and linkages will be made to the children's system of care. This program will be county-operated and staff will work closely with Sacramento County's Child Protective Services Division and First 5 Sacramento

**Program 3 - School-Based Social Skills and Violence Prevention Program:** (*universal*) During the PEI Community Planning Process, participants strongly recommended funding school-based services. The Committee recommended focusing on social skills building groups, violence prevention education, and peer support and mentoring. The School-Based Social Skills and Violence Prevention Program is a two-part comprehensive approach to provide universal prevention strategies for school-aged children and youth in stressed families across the ages. The Social Skills component will target youth between the ages of 6-12 with age appropriate information that will increase their ability to be empathetic towards others. Building on the information provided in the social skills component, the Violence Prevention Program will target youth between the ages of 13-18 with a focus on aggression and ways to manage behavior.

Based on county demographic information, a competitive selection process will be used to select districts, schools or community-based agencies located in high risk areas. The PEI Cultural Competence Committee will be consulted to provide input on how to

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make programs more culturally sensitive Working with the Sacramento County Office of Education (SCOE) local school districts and the community, leveraging opportunities will be explored and the most appropriate curriculum will be identified.

The School-Based Social Skills and Violence Prevention Program consists of two (2) components:

- A. Social Skills Groups:** The targeted ages for the social skills groups will be children between the ages of 6 to 12 and their parents or caregivers. Effective social skills programs are universal strategies that build empathy and teach compassion by assisting children in recognizing and managing emotions, developing caring and concern for others, establishing positive relationships, making responsible decisions, and handling challenging situations constructively and ethically. Schools are arenas in which children gather and interact with others and are natural training grounds for the development of good social skills. Furthermore, programs that contain a parent education component can support and enhance the social skills development in their children.

Social Skills Groups will include group activities that teach and increase skills such as emotional awareness, empathy, conflict management, problem solving, making friends, and basic interaction and getting along skills. Complementary parent education activities will teach and enhance skills such as problem solving, limit setting, anger management, non-violent discipline, and effective communication. The successful applicant will demonstrate how they will meet the program goals and how the MHSA Five Essential Elements will be incorporated into the development and implementation of this program. Staffing will reflect the ethnic, cultural and racial diversity of the students and parents being served and have bilingual fluency that reflects Sacramento's threshold languages. In collaboration with schools, community partners, and family members, effective social skills curriculum will be identified for implementation. Examples include, but are not limited, to the following:

- **Incredible Years / Dinosaur Social Skills and Problem Solving:** Curriculum for children covers topics such as learning rules, empathy, problem-solving, anger management, how to be a friend, and how to talk to others. Curriculum includes parent activities that promote positive and nurturing parenting, promote children's social competence, and reduce behavior problems.
- **Second Step:** Classroom-based social skills curriculum for children that focuses on empathy, impulse control, problem solving, anger management; six-session curriculum for parents that assists them in reinforcing children's skills. **Promoting Alternative Thinking Strategies (PATHS):** Prevention and intervention activities for children designed to enhance social skills, emotional awareness, self-control, friendship building, and problem solving skills.

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- Al's Pals: Kids Making Healthy Choices: Curriculum is designed to develop personal, social, and emotional skills in children; high levels of parent involvement.

**B. Violence Prevention:** The California Healthy Kids Survey, administered by all schools in the state, queried 7<sup>th</sup> to 11<sup>th</sup> grade students regarding school safety in 2006 and found that: approximately 10% of these students stated they felt “unsafe or very unsafe” at school; 7<sup>th</sup> grade students reported they had been “pushed or shoved” on school property at a much higher rate of 42% than 9<sup>th</sup> grade students with a rate of 35% or 11<sup>th</sup> grade students with a rate of 25%; Students reported they had been “afraid of being beaten-up” at school, which ranged from 15% in the 11<sup>th</sup> grade to 27% for 7<sup>th</sup> grade students; Students stated they saw someone with a weapon on school grounds, which ranged from 34% in both 7<sup>th</sup> and 11<sup>th</sup> grades to 40% for 9<sup>th</sup> grade students.

The Violence Prevention program targets children/youth ages 13-to-18-years-old, regardless of individual risk. Violence Prevention programs teach all students about the problem of violence and its prevention. These programs typically focus on one or more topics or skills intended to reduce aggression or violent behavior.

This program will utilize age-appropriate and culturally sensitive activities that may include a combination of the following classroom or group approaches: social skills building; problem solving skills; conflict resolution techniques; providing information about the specific types of and the problem of violence; and teaching violence resistance skills by discussion, accompanied by role playing, modeling, skill practice, feedback, and reinforcement. Other activities, such as peer mediation, youth mentoring and teaching of younger children, and a youth anti-violence campaign will also be encouraged. SCOE and/or schools and/or community-based agencies will demonstrate how they will meet program goals and how the MHSA Five Essential Elements will be incorporated into the development and implementation of this program. Staffing will reflect the ethnic, cultural and racial diversity of the students being served and have bilingual fluency that reflects Sacramento's threshold languages.

The Division will work with SCOE and/or schools to determine the best way to implement effective Violence Prevention Models through a competitive selection process. Demographic data will be used to identify districts or schools that have at-risk children and families as well as concentrations of diverse cultural groups. A requirement to participate in this program will be that lessons or activities will be provided to entire classrooms. The PEI Cultural Competence Committee will be used to provide input into how to make programs culturally sensitive. Possible curriculum or program models include, but are not limited to, the following:

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- Violence Prevention Curriculum for Adolescents: Teaches students about the causes of violence and knowledge of violence prevention skills taught through discussion.
- Teaching Students to Be Peacemakers: Teaches conflict resolution and peer mediation skills for children and youth.
- Responding in Peaceful and Positive Ways: Peer mediation, teaches social skills and problem solving, conflict resolution.
- Second Step: Classroom-based social skills curriculum for children and youth that focuses on empathy, impulse control, problem solving, anger management; six-session curriculum for parents that assists them in reinforcing children's/youth's skills.
- Safe Dates: 10-session classroom curriculum for adolescents that targets attitudes and behaviors associated with dating abuse and violence, theatrical production performed by students, poster contest, and community service.
- SMART team: Multi-media, computer-based program for adolescents that teaches anger management, conflict resolution, and perspective-taking (empathy).
- Promoting Alternative Thinking Strategies (PATHS): Prevention and intervention activities for children designed to enhance social skills, emotional awareness, self-control, friendship building, and problem solving skills.

**Program 4 - Building Life Skills for Teens and TAY:** In Sacramento County's MHSAs Community Services and Supports Planning Process, teens and TAY were identified as an underserved population. Services for teens and TAY were a top rated and ranked strategic direction during the MHSAs PEI Community Planning Process. The top rated community-defined stressors of child abuse, homelessness, substance abuse, family abandonment and domestic violence have a profound impact on this population and affect the development of emotional and critical life skills. Teens and TAY are particularly challenged during transition periods and lack adequate preparation in moving towards young adulthood. To further complicate this transition period, services are fragmented, limited and have different eligibility requirements. Many of the specific strategies suggested by participants in the Community Planning process were combined to create the Building Life Skills for Teens and TAY Program to address this unmet community need

A Request for Proposal (RFP) process will be used to identify an existing provider that is currently working with this population and can leverage and expand supports already in place for teens and TAY and their families. Services and supports include, but are not limited to the following: universal screenings for risk factors; skill-building groups; and independent life classes/workshops that address life skills necessary for becoming autonomous and productive members of the community. This program will fund 3 FTE Peer Advocates to work individually or in groups with teens and TAY youth to:

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- Help teens and TAY establish and maintain health and wellness services, including linkage to primary healthcare provider, crisis prevention and intervention strategies;
- Provide education and support for building and maintaining healthy relationships;
- Provide conflict resolution, anger management and communication skills training;
- Provide adult life skills training and mentoring;
- Provide vocational training and employment linkage;
- Expand understanding of community resources and supports;
- Provide an increased knowledge of benefits acquisition.

Duration of services will be determined by individualized plans that will be developed together by the teen/TAY, program staff, and family members, as appropriate. Services can range from the teen/TAY only needing/wanting a few life skills classes to an array of services to include life skills classes, mentoring, and intensive case management.

Special consideration will be given to a program/organization that already provides targeted outreach and engagement efforts to high-risk teens and TAY including, but not limited to, LGBTQI youth, teens and TAY with substance use concerns, youth in the foster care system, underserved racial, cultural and ethnic populations, and homeless teens and TAY. It is anticipated that this program could be implemented at two (2) or three (3) different sites/locations. Sites must be located in areas accessible to public transportation. Program staff will reflect the ethnic, cultural and racial diversity of the community being served and have bilingual fluency that reflects Sacramento's threshold languages. Potential contractor will demonstrate how they will incorporate the MHS A Five Essential Elements into the development and implementation of this program.

**Program 5 - Family Conflict Management:** The Sacramento Children's Report Card indicates that in 2006, 8,516 calls related to domestic abuse were made to law enforcement from Sacramento County residents. Calls were reported at a rate of 6.1 per 1,000 in population. Sacramento rates were consistently higher than the California state average for reports of domestic violence. In 2006, 23,313 children were referred to Sacramento County's Child Protective Services. Domestic violence and child abuse has been shown to result in developmental delays and internalized and externalized behavior problems across age groups. The Family Conflict Management Program will focus on issues that participants were most concerned about; teaching about violence prevention, developing anger management and stress reduction skills, and providing supports for those family members who may be in abusive environments. This Project utilizes a multi-level approach in assisting families in managing conflict through outreach efforts, support groups, and peer/mentoring activities.

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This program may be developed and implemented in up to two (2) at-risk communities by a community-based organization that has knowledge and experience in working with at-risk families. Providers will be selected through a competitive bid process. One full-time Mental Health Counselor and one part-time Outreach Specialist will plan and coordinate on-going outreach efforts, support groups and peer/mentoring activities. Five psycho-educational groups and one peer leadership training will be conducted each quarter. A part-time supervisor will provide supervision and support to program staff and oversight for the program. Staffing will reflect the ethnic, cultural and racial diversity of the families being served and have bilingual fluency that reflects Sacramento's threshold languages.

Facilitated groups will be multi-family, psycho-educational support groups and will cover a range of issues related to conflict management and violence prevention. Topics can include, but are not limited to: providing information about specific forms of violence; the problem of violence; violence resistance skills; empathy; problem solving; anger management; coping with stress; communication skills; and identifying emotions and pre-violence stressors. Opportunities to "spin off" groups into continuing support groups will be encouraged through the use of leadership training. Leadership training will enhance community building by creating peer leaders able to facilitate new groups. Another strategy in the Family Conflict Management Program will be the development of a peer parent/caregiver and youth leadership/coach component. Leadership and facilitation skills training will be provided to identified leaders/coaches so that they can co-lead support groups, and provide guidance and support for other parents/caregivers and youth in "stressed families" or abusive environments.

The successful applicant will be required to define specific outreach and engagement strategies for the community that will be served and how these strategies will be used to engage stressed families of unserved and underserved culturally and ethnically diverse communities. Special consideration will be given to potential contractors that can engage boys, men, and batterers to ensure participation in the program. Engagement work will focus on finding parent/caregivers and youth in the community who can be leaders, or have the potential to lead, with the goal of providing mentoring and support to others in their community. While this is one proposed model, the Division will be open to considering other strategies or models if applicants can demonstrate how they will be responsive to the needs identified by the community and how they will achieve the intended outcomes of the program. Potential contractors will also need to demonstrate how they will incorporate the MHSA Five Essential Elements into the development and implementation of this program.

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**MILESTONES AND TIMELINE:**

<b>Milestones</b>	<b>Estimated Timeline</b>
Develop RFPs for Project Programs	3 months
Planning and Development of County Operated Project Programs	3 months

**4. Programs**

Program Title	Proposed number of individuals or families through PEI expansion to be served by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Early Childhood Consultation	Individuals: 450 (annually) Families: 100	Individuals: Families:	3 months
In-Home Support for Foster Youth	Individuals: 240 (annually) Families: 240 (annually)	Individuals: Families:	3 months
School-Based Social Skills Program	Individuals: Small Groups: 600 (annually) Entire Classrooms: 1500 (annually) Families: 500 (annually)	Individuals: Families:	3 months
School-Based Violence Prevention Program	Individuals: Small Groups: 1000 (annually) Entire Classrooms: 2000 (annually) Families:	Individuals: Families:	3 months
Building Life Skills for Teens and TAY	Individuals: 200 (annually) Families: 35 (annually)	Individuals: Families:	3 months
Family Conflict Management	Individuals: Families: 300 (annually)	Individuals: Families:	3 months
<b>TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED</b>	Individuals: 3440 Families: 1175	Individuals: Families:	

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

Overall, this project emphasizes the engagement of children, youth, TAY, and families in a range of universal and selective prevention strategies. After implementation of programs, children, youth, TAY, and family members may be identified as needing mental health treatment or other services such as health care, childcare, housing, employment, or substance abuse treatment. Program providers will refer and link children, youth, TAY and their family members to appropriate services and supports within the Division's Children's System of Care, Adult System of Care, other County services, including Alcohol and Drug Services, Primary Health, and other social service and health care providers.

Though the RFP process, potential bidders will be required to define how they will identify and link individuals and families in need of further assessment and/or on-going services. Once a program is implemented, the provider will be required to establish policies and procedures for referring and linking individuals and family members to accessible and appropriate community-based resources. County-operated programs will also be required to establish policies and procedures for referring and linking individuals and family members to accessible and appropriate community-based resources.

### 6. Collaboration and System Enhancements

Sacramento County's Division of Mental Health has established ongoing relationships with mental health providers and system partners, including Alcohol and Drug Services, Child Welfare, Juvenile Justice, local school districts, primary care providers, Senior and Older Adult Services, Cultural and Ethnic Service Providers and many other community organizations. Many of these partners were involved in Sacramento County's MHSA PEI Community Planning Process and PEI CCAC. The Strengthening Families Project will build on established partnerships leading to mutually beneficial leveraging opportunities.

Many of the Strengthening Families Project Programs will be determined through an RFP process and potential contractors will be considered as significant partners in the implementation of the Project Programs. Conversely, potential contractors will be required to show evidence of establishing and maintaining partnerships among multiple public and community-based organizations. It is anticipated that potential providers will have existing outreach and support services in place that can be leveraged and enhanced. Potential providers will be required to demonstrate the capacity to understand, engage and effectively serve the identified age range and individuals and families from unserved and underserved cultural and ethnic communities. They

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must also demonstrate their ability to implement the program effectively; meet fiscal, administrative, and data collection/evaluation responsibilities; and achieve the intended outcomes of the specific program.

Existing partners and potential providers will be asked to contribute internal resources that may include space, equipment, staff, volunteers, peer support, and supervision. During the RFP process, potential providers will be asked to describe their plan for generating support, leveraging additional resources and/or funding to expand and/or sustain programs.

Programs that are county-operated will be held to similar requirements and standards. They are and will be required to foster and maintain existing partnerships, as well as build new partnerships, and to continue to build capacity to understand, engage and effectively serve the identified age range and individuals and families from unserved and underserved cultural and ethnic communities.

The Strengthening Families Project will be sustained through continued MHSA PEI funding. In implementing the various programs, the Division will monitor and assess each provider's ability to achieve outcomes and meet fiscal requirements throughout the contract period. Program evaluation will address effectiveness of programs, progress towards achieving outcomes and goals, and sustainability.

### **7. Intended Outcomes**

#### **Early Childhood Consultation**

1. Increase number of childcare providers will be able to work with children that present with challenging behaviors
2. Fewer removals from childcare programs
3. More successful preschool placements with strengthened relationships between teachers, children and families

#### **In-home Support Services for Foster Youth**

1. Young children will face less trauma and attachment disruption
2. More children will be linked with appropriate services to prevent further long-term developmental problems
3. Young children will experience more successful placements with less disruption

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### **Social Skills**

#### Individual-Level Outcomes for Children

1. Improvements in social problem solving
2. Increase awareness of emotions
3. Reduce defiance, aggressive behavior
4. Increase acts of pro-social behavior
5. Increase satisfaction with peer social interactions
6. Improvements in academic achievement
7. Improvements in school attendance

#### Individual-Level Outcomes for Parents

1. Increase knowledge of positive discipline approaches
2. Increase involvement in children's school life and other activities
3. Improvements in social problem solving
4. Increase awareness of emotions
5. Reduce aggression

#### Program/System-Level Outcomes

1. Decreases in the number of students needing intensive behavioral supports
2. Reduction in office discipline referrals for students
3. Reduction in number of children/youth experiencing juvenile justice involvement
4. Reduction in the number of families experiencing child welfare involvement

### **School Based Violence Prevention**

#### Individual-Level Outcomes

1. Increase knowledge of non-violent conflict resolution strategies
2. Increase knowledge of what triggers anger
3. Reduce aggression
4. Increase acts of pro-social behavior
5. Increase satisfaction with peer social interactions

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### Program/System-Level Outcomes

1. Improvements in the perception of school safety
2. Decrease in risk factors including aggressive behaviors
3. Increase in school attendance
4. Decrease in the number of students needing intensive behavioral supports
5. Reduction in office discipline referrals for students
6. Reduction in number of children/youth experiencing juvenile justice involvement

### **Building Life Skills for Teens and TAY**

#### Individual-Level Outcomes

1. Increase self-determination and self-sufficiency
2. Increase meaningful social relationships
3. Increase problem solving and coping skills
4. Increase youth's knowledge of available resources
5. Decrease feelings of hopelessness, anxiety, anger and depression
6. Decrease substance use/abuse

#### Program/System-Level Outcomes

1. Increase a coordinated network of comprehensive and culturally competent services for youth
2. Decrease school drop-out rates
3. Decrease suicide rates
4. Decrease in numbers of youth involved in juvenile justice

### **Family Conflict Management**

#### Individual-Level Outcomes

1. Increase the individuals/families knowledge of available resources
2. Increase the individuals/families knowledge of non-violent conflict resolution
3. Increase the individuals/families knowledge and use of problem solving skills, anger management and coping with stress

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### Program/System-Level Outcomes

1. Decrease family violence in the community
2. Increase community knowledge of family violence
3. Increase community education around recognizing signs of family violence

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

The Strengthening Families Project Programs will coordinate and collaborate with all Sacramento County Community Services and Supports (CSS) programs. The Project Programs may refer eligible individuals and family members with more serious mental health issues to CSS General System Development Programs and to CSS Full Service Partnership Programs.

Sacramento County's Workforce Education and Training (WET) Plan has the capacity for the provision of training and technical assistance for mental health providers; therefore, staff providing services through the PEI Strengthening Families Project Programs may be able to use Sacramento County's WET Actions as a training resource.

The Project Programs will have the ability to coordinate efforts and refer individuals and family members to Sacramento County's Suicide Prevention Project. The Suicide Prevention Project includes a Warm Lines Program. Warm Line providers will provide culturally relevant and appropriate activities and support services to the specific communities they serve. Additionally, Strengthening Project Programs will coordinate with and refer individuals to other PEI Project Programs as described in this plan.

At this time, Capital Facilities and Technology funds have not been identified for this Project.

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

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County: Sacramento PEI Project Name: Integrated Health and Wellness

Date: February 17, 2010

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

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

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

The Sacramento County Division of Mental Health, Phase I Community Planning Process involved a series of activities and events designed to elicit input from stakeholders in order to identify PEI Key Community Mental Health Needs and Priority Populations. For more detail on this process, please see Enclosure 3, Form 2.

The quantitative and qualitative data gathered from the PEI community stakeholder process was integrated and analyzed by the Research, Evaluation and Performance Outcomes (REPO) Unit in the Division of Mental Health. The Key Community Mental Health Needs for Sacramento County were determined to be: 1) At Risk Children, Youth, and Young Adults; 2) Psycho-Social Impact of Trauma; and 3) Suicide Risk. The Priority Populations were: 1) Children and Youth in Stressed Families; 2) Individuals Experiencing Onset of Serious Mental Illness; and 3) Individuals Exposed to Trauma.

After completing Phase I Planning, the community moved into Phase II, convening a Kick-Off and five PEI Planning Committee Meetings over the course of two months. The PEI Planning Committee Meetings were open to the community and on average there were approximately 84 individuals in attendance representing a total of 837 volunteer hours. The intent of the meetings was to determine how to address the Key Community Mental Health Needs and Priority Populations within PEI Projects.

The PEI Kick-Off Planning Committee Meeting was an overview of MHSA, PEI, and PEI planning efforts to date, a discussion of future meetings and the process for making recommendations. At Committee Meeting #1, a visioning exercise was introduced and the 67 participants at the meeting were asked, “*What do you see in place in Sacramento County in 3-5 years as a result of Prevention and Early Intervention Planning? How is life better for our community members?*” Responses were collected and summarized into a visioning document (See Attachment Y). Part of the response included the following:

*A community-wide health model is in place with early identification and intervention services. There are decentralized, multi-disciplinary community centers that serve all ages, needs, and cultures in a safe environment. Easy access to programs that serve the entire family and the whole person through a single point of access is available. Services include annual mental health screenings, behavioral health teams in primary care clinics, and the integration of mental health with ancillary services, such as physical therapy, occupational therapy, and speech therapy. Mental health is just as important as physical health and individuals and families can reach out for services without fear.*

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*Sacramento County residents are better educated on healthy aging. Services and supports for seniors are available, accessible, and well-coordinated. They have effectively reduced isolation, suicide and homelessness among our elderly community members. Senior centers and residential facilities are responsive to individual needs.*

At the PEI Planning Committee Meeting #3, ninety-four (94) participants focused on the impact of trauma. Using the Consensus Workshop Method, a model developed by the Institute of Cultural Affairs to facilitate consensus thinking, the committee participants broke into small groups to address the focus question, ***“What specific actions can we take to help people in our community cope with and recover from trauma?”*** From this focus question, strategies and activities were identified, clustered, and grouped into categories for consideration. Information from all workgroups was then clustered to form overall Strategic Directions. At Committee meeting #4, the trauma strategies from meeting #3, which had been synthesized, were presented to the Planning Committee members for approval. Screening, Assessment, and Interventions were identified as primary strategies to address the psycho-social impact of trauma.

At Committee Meeting #4, the Electronic Meeting format was used. Ninety-six (96) committee members worked in 20 small groups with a facilitator for each group, to capture information on small notebook computers linked to a master computer. This meeting focused on three questions that related to onset of psychiatric illness, trauma and stressed families. Participants were asked to rate and rank the effectiveness of strategies that had been identified from previous meetings.

The first question was designed to narrow the population experiencing the Onset of Serious Psychiatric Illness and the following question was asked, ***“Given that Onset of Serious Psychiatric Illness is one of our Priority Populations, please rate and then rank the importance of addressing the following issues: 1) Onset of depression in older adults; 2) Post-Partum depression; 3) PTSD and other anxiety disorders; 4) Depression and suicide screening in children and youth; and 5) Onset of psychosis (including bipolar depression and schizophrenia) in youth and TAY.”*** Onset of Psychosis in Youth and TAY ranked and rated the highest.

The second and third questions focused on stressed families and the impact of trauma. A number of strategies that had been identified in previous meetings were presented to the Planning Committee. Using the Electronic Meeting format, stressors and strategies were both ranked and rated. Early Screening and Assessment ranked and rated highest as a strategy

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to address stressors, and Collaboration with Physical and Mental Health ranked and rated highest as a strategy to address trauma. With the consent of the Planning Committee, MHSA staff used the information gathered from all five PEI Planning Committee Meetings to develop program concepts that addressed the priorities established by the Planning Committee. This information was shared at the last Planning Committee Meeting and input and feedback were solicited from the participants.

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

Over 15% of Sacramento County residents have no medical insurance; another 20% are insured by Medi-Cal or the California Medically Indigent Services Program (CMISP). That totals to approximately 550,000 persons of all ages who are either uninsured or under-insured and therefore, have limited access to quality healthcare options. Over 80% of these individuals are in working families and 12% of them are children or teens. Community Health Care clinics in Sacramento County specialize in care to the uninsured and under-insured and offer a range of care by culturally competent staff ([www.capitolhealthnetwork.org](http://www.capitolhealthnetwork.org)). This project will address disparities in access to mental health needs through the use of healthcare settings to reach the unserved and underserved cultural populations and those exposed to trauma.

The Integrated Health and Wellness Project addresses the needs identified in the Community Planning Process with a comprehensive approach to providing universal, selective, and early intervention activities and services across all the ages. It targets the Key Community Mental Health Need of Psycho-Social Impact of Trauma and the Priority Populations of Individuals Experiencing the Onset of a Serious Psychiatric illness and Trauma-Exposed. While not a primary target, this Project will also address Children and Youth in Stressed Families as early signs of emotional distress and serious mental illness are detected and treated.

The programs in this project will be either county-operated or community-based programs. For community-based clinic programs, a competitive bid process will be utilized to select clinics interested in adding this program component to their existing services.

**Program 1 - Screening and Assessment/Peer Support and Treatment** (*Universal, Selective, and Early Intervention*) In the PEI Community Planning Process, screening and assessment were consistently identified by the community as a top

priority for Sacramento County. Primary care settings were identified as key places to reach large numbers of community members, including older adults and individuals from unserved and underserved cultural and ethnic populations.

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This Program has three components; 1) Screening and Assessment, 2) Peer Support, and 3) Treatment. Services will be implemented in healthcare settings, which can include community-based healthcare clinics and/or county-operated primary care clinics. Clinics will be selected through an RFP process. The county will coordinate services across all of the participating clinics, working with one coordinator to develop and implement agreed upon protocols and best practices. Opportunities will be developed to share clinical expertise and support among participating clinics.

1. The Screening and Assessment component will screen and/or assess individuals for general depression, maternal depression, suicide risk, Post Traumatic Stress Disorder, substance abuse, and/or onset of serious psychiatric illness as part of a primary care visit. The DMH Resource Guide will be used to identify screening and assessment tools to be considered. Protocols will be developed and screening tools selected by the Division and participating clinic representatives. Appropriate clinic staff will be trained in using the tools that are selected as part of this component
2. Peer Support Groups will be offered at each of the participating clinic settings. Based on the identified needs of the individuals, peer support groups will be formed to provide a range of services to group members, including providing psycho-educational information on a variety of topics. Peer support groups will be run by individuals that share common concerns or who are members of the community served by the clinics. Increased language capacity by peers providing services will be targeted. Funding is included in the budget to provide stipends for group leaders, and to pay for materials necessary to run groups, food and transportation. Other health and wellness activities, such as yoga and Tai-Chi, will also be offered.
3. Treatment The Psycho-Social Impact of Trauma was identified as a Key Community Mental Health Need. This project will provide a mental health clinician at each participating clinic that can provide short-term, brief treatment services. Practitioners will be trained in Cognitive Behavioral Therapy (CBT) and Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT), a best practice model identified in the DMH Resource Guide, as well as other culturally appropriate treatment modalities that can successfully address the impact of trauma. Referrals will come from primary care staff and individuals may also self refer. An RFP Process will be used to select appropriate healthcare clinics to participate in this Project. The successful applicant will, at a minimum, be reflective of our diverse community, have bilingual fluency that can reflect Sacramento's threshold languages, and be able to demonstrate how the agency will incorporate the five MHSA Essential Elements.

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<b>Milestones</b>	<b>Estimated Timeline</b>
Develop RFPs for Project Programs	3 months
Selection of successful applicants	3 months

**Program 2 - Assessment and Treatment of Onset of Psychosis** (*Early Intervention*) Addressing the onset of psychosis, with a specific emphasis on youth and young adults was rated as one of the highest priorities during the PEI Community Planning Process. Our current public mental health system works primarily with individuals who are already diagnosed with a major mental illness. Instead of being proactive, the mental health system has been reactive. This program will address symptoms when they are still in the “pre-illness” stage before psychosis. Intervention at this critical period can make full recovery possible and prevent a lifetime of pain and debilitation.

Early detection and intervention of psychotic disorders is critical to mitigating the effects of a mental illness. Psychosis can happen to anyone but it is most likely to happen to people for the first time between the ages of 12 and 35. The goal of this program will be to detect and intervene as early as possible in order to prevent the development of disease related deficits and treatment side effects. The intended outcome will be for individuals to become full participants in their treatment and work towards reaching their own personal goals.

An RFP process will be used to select an appropriate agency with a successful history of working with youth who have experienced the first symptoms of early onset of a mental illness. In Sacramento County, the majority of mental health services are provided through contracts with mental health contract providers. In the selection process, the county will look for an agency that can build on existing services and leverage resources to build a comprehensive program that will work successfully with individuals and their family/primary support persons, to develop culturally competent treatment and service plans, assist in illness management, and provide advocacy and support to the individual with his or her external needs.

Specific services that will be provided include comprehensive psychiatric assessment, treatment plan development, client and family education, service coordination, groups, supported education and employment, and skill development. The staffing budget for this program includes a half time psychiatrist, 2 behavioral health specialists, 1 supported educational specialist, one peer advocate and one family advocate. In addition, dollars have been allocated for food for groups, travel support and stipends for clients.

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A component of the program will include outreach and education to staff working in the primary care clinics that are part of this project, providing training on how to identify the signs and symptoms of early onset of psychosis for clinic staff. The successful applicant will, at a minimum, be reflective of our diverse community, have bilingual fluency that can reflect Sacramento’s threshold languages, and be able to demonstrate how the agency will incorporate the five MHSA Essential Elements.

Milestones	Estimated Timeline
Develop RFPs for Project Programs	3 months
Selection of successful applicant	3 months

**Program 3 - Senior Navigator Program: Targeting Isolation and Depression in Older Adults** (*Universal, Selective and Early Intervention*) During the Community Support and Services (CSS) Planning Process, older adults were identified as one of Sacramento’s most underserved age groups. This continues to be true and the importance of addressing the needs of older adults has been discussed in subsequent MHSA planning processes, including WET, PEI, and during the development of the Suicide Prevention Project. The propensity for isolation and depression places this population at high-risk for suicide, trauma, depression and other untreated mental health conditions. The community determined that in-home support services were a strategic preventative intervention that could assist and support the older adult population access health and social support services. Transportation was also identified as an important strategy for older adults

System Navigator programs have been developed in various communities to assist both the individuals and communities to respond to and insure unserved and underserved populations receive access to health and behavioral health services. Frequently, programs hire community members for these programs. The most well known in California is the *Promotores*. Focusing on the Latino community, *Promotores* provides health education and access support to community members by community members. In Sacramento County, there is the “*Downtown Navigators*”. Their function is to work with individuals who are homeless in the downtown area of Sacramento to access needed services, especially behavioral and health. Like the *Promotores* philosophy to employ persons from the community, many of the Navigators are formerly homeless. The key to both programs is the staff person is an individual with whom the underserved individual can relate to, thus fostering acceptance and trust. In turn, this results with individuals accessing and using services leading to health and wellness.

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The Sacramento *Senior Navigator Program* will employ nine senior navigators to do home visits and follow-up services for the elderly to assist with improving health and wellness outcomes. It is anticipated that referrals will come from primary care settings, including the clinics that are part of this project. Referrals may also come from other community agencies and programs that work with seniors. The Surgeon General's report stated older adults prefer to receive mental health services in primary care settings. The Senior Navigators, working with clinic staff can make recommendations to the clinics for specific kinds of peer support groups that are part of this Project or refer an individual to brief therapy services at a participating clinic. A full time supervisor will be hired to provide support and training to the Senior Navigators. Transportation dollars are included in this program budget to allow for transporting seniors to and from activities in the community and at the clinic sites. The Senior Navigators hired will reflect the ethnic, cultural and racial diversity of the community of the older adults being served.

An RFP process will be developed to select an appropriate agency to manage this program. The successful applicant will have a history of working with older adults and have relationships with other programs that serve the elderly to be able to enhance, coordinate and leverage existing resources, including the Retired Senior Volunteer Program, a volunteer program with over 600 volunteers. The successful applicant will also be reflective of our diverse community, have bilingual capacity that can reflect Sacramento's threshold languages, and be able to demonstrate how the agency will incorporate the five MHSA Essential Elements.

<b>Milestones</b>	<b>Estimated Timeline</b>
Develop RFPs for Project Programs	3 months
Selection of successful applicant	3 months

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**4. Programs**

Program Title  <b>INTEGRATED HEALTH AND WELLNESS</b>	Proposed number of individuals or families through PEI expansion to be served through by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Screening and Assessment/Peer Support and Treatment	Individuals: <b>13,000 annually</b> Families:	Individuals: <b>400 annually</b> Families:	3 months
Assessment and Treatment of Onset of Psychosis	Individuals: Families:	Individuals: <b>50 annually</b> Families: <b>50 annually</b>	3 months
Senior Navigator: Targeting isolation and Depression in Older Adults	Individuals: <b>400 annually</b> Families:	Individuals: Families:	3 months
<b>TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED</b>	Individuals: <b>13,400</b> Families:	Individuals: <b>450</b> Families: <b>50 annually</b>	3 months

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

This Project is intended to enhance existing linkages between County mental health, primary care clinics, and other community settings through a system of identification and referral to other needed services. Those receiving services at the participating clinics will be screened and assessed for mental health and/or substance abuse concerns as part of the primary care visit. When appropriate, program providers will refer and link children, youth, TAY, adults and older adults to appropriate services and

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supports within the Division's Children's System of Care, Adult System of Care, other County services, including Alcohol and Drug Services, Primary Care, and other social service and health care providers. When indicated, linkages will also be made to other non-traditional mental health services, such as child care, housing, and employment.

For those who are identified in the clinics as needing additional mental health services, linkages will be made to treatment services available at each of the participating clinics, into our mental health system or linked to the private sector. In addition to treatment services, peer support groups and wellness activities will be offered. If a youth or young adult is identified as having early symptoms or the onset of a serious psychiatric illness, they will be referred to the Assessment and Treatment of Onset of Psychosis Program. Older Adults identified as having depression or other mental health concerns will be linked to services provided through the Senior Navigator Program. In addition, individuals that come to the attention of these programs will also be linked to other PEI programs and community resources

In the RFP process, potential bidders will be required to define how they plan to identify and link individuals and families in need of further assessment, and/or ongoing services. Once the program is implemented, the provider will be required to establish policies and procedures for referring and linking individuals and family members to accessible and appropriate community-based resources. Clinics that are county-operated will be held to the same requirements and standards as community-based clinics and will be required to maintain existing partnerships, as well as build new partnerships to build capacity, engage and serve the identified age groups, and cultural and ethnic communities effectively.

### 6. Collaboration and System Enhancements

Sacramento County's Division of Mental Health has long standing, ongoing relationships throughout the community through both our child and adult systems of care, where mechanisms are in place to share information, do outreach and make linkages. The Integrated Health and Wellness Project is intended to reach a broad segment of the community through the proposed new programs.

The **Screening and Assessment and Peer Support and Treatment Program** will work with up to five health clinics. These new clinic programs will coordinate with other mental health programs and other system partner services, including Alcohol and Drug Services, Child Welfare, Juvenile Justice, local school districts, Senior and Older Adult Services, Cultural and Ethnic Service

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Providers and other primary care providers to promote new opportunities for assessment, peer support and brief treatment services.

In selecting clinics to provide the **Screening and Assessment and Peer Support and Treatment Program**, the County will consider giving priority to FQHC clinics as a way to leverage existing resources. With a FQHC status, additional leveraging opportunities exist as well ability to be reimbursed at higher rates. The County has one primary clinic that is a FQHC and the Capitol Community Health Network (CCHN), a nonprofit partnership of community clinics, health centers, and health education agencies in Sacramento, also has member clinics that are Federally Qualified Health Centers (FQHCs). The County already works collaboratively with the CCHN, sharing data and information and looks forward building an even stronger relationship. By adding a mental health component to selected clinics, clinic services will be enhanced and clients and families will have additional resources to prevent the development of future, more disabling mental health problems.

**The Assessment and Treatment of Onset of Psychosis Program** will collaborate with existing services and supports and become a part of both the Child and Adult Systems of Care. Adding this program will provide new referral opportunities for families, schools and other health care providers and enhance the overall continuum of services provided in the community. **The Senior Navigator Program** will collaborate with existing programs in the community that already serve seniors, including the Department of Human Assistance, Senior and Adult Services. As this program is implemented, it will fill a much needed gap in services for older adults that live in their homes and suffer from isolation and depression, Adding this new service will provide new referral opportunities for other system partners and community agencies that work with older adults in need.

Both the **Assessment and Treatment of Onset of Psychosis** and **Senior Navigator** programs will be implemented through the RFP process. Potential providers will be expected to have outreach and support services already in place to leverage and will be required to demonstrate capacity to understand, engage, and serve the identified age ranges and cultural and ethnic communities identified by County. The Division of Mental Health will establish standards for each program and monitor and assess each provider's ability to achieve outcomes and meet fiscal requirements throughout the contract period.

All of the **Integrated Health and Wellness Project** programs will include an evaluation component. Program evaluations will address the effectiveness of each program and the progress made toward achieving the outcomes and the goals of the Project. Evaluation data will drive any future funding decisions that need to be made. Barring any unforeseen funding cuts, these programs will be sustained through continued MHSa PEI funding.

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During the RFP process, potential providers will be expected to generate support and leverage additional resources and/or funding to expand and/or sustain programs. Existing partners and potential providers will also be asked to contribute internal resources that may include space, equipment, staff, volunteers, peer support, and supervision.

### 7. Intended Outcomes

#### Program 1: Screening and Assessment/Peer Support/Treatment

##### Component 1: Screening and Assessment

###### Individual-Level Outcomes

1. Appropriate and early identification of mental health and substance abuse issues related to the impact of trauma
2. Appropriate and timely mental health services
3. Increase in culturally and linguistically appropriate services for the individual

###### Program-Level Outcomes

1. Increased number of referrals to peer-led support groups
2. Increased number of referrals to treatment groups

###### System-Level Outcomes

1. Decrease in utilization of high-cost services (i.e. emergency rooms, hospitals and jails)
2. Decrease in youth/TAY identified as needing mental health services in juvenile justice settings

##### Components 2 & 3: Peer Support and Treatment

###### Individual-Level Outcomes

1. Increase in resiliency and protective factors
2. Improved mental wellness following trauma exposure
3. Increased social supports for at-risk individuals, families and older adults

###### Program-Level Outcomes

1. Increased identification of mental health concerns

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2. Increased linkage to services

### System-Level Outcomes

1. Collaboration between primary care settings, mental health and/or other alternative settings
2. Increased awareness and recognition of mental health issues amongst primary care providers
3. Stigma reduction amongst older adults and other cultural groups
4. Decrease in utilization of high-cost services (i.e. emergency rooms, hospitals, jails)

### **Program 2: Onset of Psychosis**

#### Individual-Level Outcomes

1. Reduced risk factors
2. Reduced symptoms associated with early onset
3. Improved resilience and protective factors
4. Improved emotional and mental health
5. Improved knowledge of social and emotional factors to general health
6. Increased school and/or work success

#### Program-Level Outcomes

1. Family satisfaction
2. Increased education around illness/symptom management
3. Increased knowledge around early onset
4. Increased linkage to less intensive services

#### System-Level Outcomes

1. More community organizations providing identification and early intervention (short-term mental health services)
2. Enhanced quantity and quality of co-operative relationships with other organizations and systems
3. Reduced utilization of high-cost services (i.e. emergency rooms, hospitals, jails)
4. Improved methods for identifying, assessing, and treating psychotic disorders prior to onset

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### **Program 3: Senior Navigator: Targeting Isolation and Depression in Older Adults Outcomes:**

#### Individual-Level Outcomes

1. Reduced risk factors
2. Improved resilience and protective factors
3. Improved social and emotional wellness
4. Reduced isolation
5. Increased social interaction
6. Improved knowledge and access to community resources

#### Program-Level Outcomes

1. Client satisfaction
2. Increased linkages to community resources

#### System-Level Outcomes

1. Build community capacity
2. Enhanced use of ethnic/cultural community partners
3. Enhanced integrated health and behavioral health
4. Decreased incidence of suicide and attempts in older adults
5. Decreased utilization of high-cost services (i.e. emergency rooms and hospitals)
6. Increased collaboration between primary care settings and mental health providers

### **8. Coordination with Other MHSa Components**

The Integrated Health and Wellness Project will coordinate with other MHSa programs that serve children, TAY, families, adults and older adults. If screening and assessment at the clinics reveals that an individual meets target population, they will be referred to appropriate MHSa CSS programs. In addition, Sierra Elder Wellness, a CSS program that works with Older Adults will be a resource for the Senior Navigator Program.

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One of the WET programs still to be implemented is a Multi-Disciplinary Clinical Consultation Program. This consultation program will be a resource to the clinicians working in the Peer Support and Treatment Program that will be providing trauma-focused clinical services through the clinics.

Additionally, Sacramento County's approved Suicide Prevention Project will be developing Warm Lines that can provide phone support and referral information to individuals dealing with a variety of concerns or questions. Warm Lines can link callers to any of the programs in the Integrated Health and Wellness Project.

At this time, Capital Facilities and Technology funds have not been identified for this Project.

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

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County: Sacramento PEI Project Name: Mental Health Promotion Campaign

Date: February 17, 2010

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

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

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

Throughout the MHSA planning processes for Community Supports and Services (CSS), Workforce Education and Training (WET) and Prevention and Early Intervention (PEI), Sacramento County's stakeholders consistently identified the need to develop strategies to reduce the negative impact of stigma and discrimination towards individuals and families living with mental illness. This need emerged in two other parallel planning activities: the PEI Cultural Competence Advisory Committee (CCAC) and the Sacramento County Student Mental Health and Wellness Collaborative (SMHWC). The PEI CCAC identified stigma associated with mental health and discrimination due to race, culture and ethnicity as a significant barrier to accessing and receiving services. The SMHWC, a joint venture between Sacramento County Division of Mental Health, Sacramento County Office of Education (SCOE), Parent and Youth Advocates, and system partners, developed a strategic plan for a system of prevention and early intervention in school settings. One of the strategies identified with regard to social marketing is "develop age-appropriate, multi-language messages that positively influence attitudes about mental health and wellness, increase appropriate help-seeking behaviors, and prevent mental illness."

The CCAC is integral to the continued development of a culturally informed mental health system. During the WET Planning Process, the Division conducted Key Informant interviews with specific racial, cultural and ethnic leaders in Sacramento. Staff transcribed the Key Informant responses and produced a document entitled "*Conversations with Community Leaders: Strategies for Working with Diverse Racial, Cultural, and Ethnic Communities*". The document describes cultural issues related to mental health and includes recommendations the Division of Mental should consider in MHSA and other Division planning efforts. An important concept described is that the Western concept of mental health and/or mental illness has no direct translation in many cultures and there is reluctance to acknowledge mental health problems in some communities. Addressing the issue through outreach, education and engagement with diverse communities using culturally relevant strategies will increase understanding and help decrease stigma.

Responding to stakeholder concerns, especially consumer and family members, the CCAC and the SMHWC, the Division made a commitment that each PEI Project would incorporate strategies that reduce stigma and discrimination. Additionally, because this is such an important issue, the Division committed to developing a separate project to address stigma, discrimination and the reduction of disparities. Across stakeholder groups and planning processes, there was unanimity that cultural, racial, ethnic and age-appropriate messages must be included with any mental health promotion and anti-stigma campaign.

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The following represents key findings from various MHSA community planning processes, the CCAC and the SMHWC:

- The PEI Community Educational Forum “Children and Youth in Stressed Families” recommended targeted community outreach to conduct education on mental health, substance abuse, and the impact of stigma and discrimination for teachers, parents/caregivers, youth, and families
- The PEI Community Educational Forum “Psycho-Social Impact of Trauma” contained similar strategies and included public service campaigns, with an emphasis on multi-media efforts to various cultural communities
- The WET training recommendations identified stigma reduction strategies and skills to support consumers
- The WET training recommendations identified stigma and discrimination training led by consumer and family members
- The CCAC recommended outreach and engagement to identified cultural, racial, and ethnic communities, using leaders from their respective communities.
- The CCAC strongly recommended training for teachers and other school staff to reduce stigma and discrimination associated with mental health and racial, ethnic and cultural diversity
- The SMHWC identified several activities in the draft document, “*The Student Mental Health and Wellness Plan: A Framework for Change*” including the following:
  - social marketing campaign
  - plans for the use of de-stigmatizing language
  - messages that positively influence attitudes towards mental health and wellness
  - culturally and linguistically-appropriate multi-media campaign

The Mental Health Promotion Campaign is a direct response to consistent stakeholder input obtained throughout the MHSA planning processes. As a universal strategy, the Mental Health Promotion Campaign’s intent is to reach the broadest number of people with the intent of changing beliefs about mental illness, reducing stigma and discrimination, encouraging help-seeking behaviors and promoting wellness, recovery and resiliency.

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

There is much research and documentation indicating that individuals with mental illness are among the most misunderstood and are frequent targets of discrimination, misconceptions, distortions and abuse. This project will include different strategies to increase mental health awareness and to reduce stigma and discrimination in Sacramento County. The Division seeks to accomplish this

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through different strategies and in various venues across the county. Various groups and venues will be targeted, including, but not limited to, schools, school staff, students, families, community resource centers, community health settings, law enforcement, and faith-based groups such as the Interfaith Bureau, the Slavic Assistance Center, and others.

The Division will issue a Request for Proposal (RFP) to select providers to implement various activities in the Mental Health Promotion Campaign Project. The successful applicant will have staff that are reflective of Sacramento's diverse communities, with bilingual fluency in, at minimum, Sacramento's current threshold languages, and will need to demonstrate how the agency will incorporate the five MHSA Essential Elements. The Division will work closely with each selected provider to develop and implement the program.

Milestones	Estimated Timeline
Develop RFPs for Project Programs	3 months
Selection of successful applicants	3 months

There will be four main strategies in the Mental Health Promotion Campaign designed to ameliorate the negative impact of stigma and discrimination toward individuals and families living with mental illness:

- 1. Community Education:** Mental Health will form a collaborative with key stakeholders who can play a critical role in promoting mental health awareness and reducing stigma and discrimination in Sacramento County. Stakeholders will include, but not be limited to, consumers, consumer advocacy groups, family members and advocacy groups, schools, system partners, organizations that work with culturally and ethnically diverse communities, and other community members and stakeholders that can promote mental health education and awareness. The education and outreach efforts will be culturally and linguistically appropriate and will focus on various topics including, but not limited to: general mental health issues; early warning signs of mental illness and serious emotional disturbance; suicide prevention; and trauma. The settings will be in multiple geographic venues and will include, but not be limited to; schools, community centers, faith-based settings, and other venues based on requests for presentations. In conjunction with the Speakers Bureau (see strategy #2 below), the SMHWC, and other system partners, the project will strive to reach as many community members as possible to educate, inform and increase understanding about mental health issues. The campaign will also target activities to community

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agencies seeking to include de-stigmatizing language in service planning, public documents, and engagement activities.

- 2. Community Outreach and Engagement:** The PEI CCAC identified community outreach and education as key to addressing mental health and wellness in diverse communities. This strategy will focus on engaging the unserved and underserved racial, cultural and ethnic communities in Sacramento County. Efforts will focus on utilizing community leaders and stakeholders in targeted communities, especially the communities representing Sacramento's threshold language communities, and African-American and Native American communities.

The Mental Health Promotion Campaign will build upon existing outreach activities, including cultural celebrations within the community, such as The Pacific Rim Festival, Festival de la Familia, the Pride Festival, and employment and health fairs targeting specific racial, cultural and ethnic groups. CCAC members will be instrumental to the success of this strategy in their roles as cultural brokers.

- 3. Speakers Bureau:** Personal stories of recovery and resiliency are very powerful and one of the most effective methods in combating myths and stigma associated with mental illness. The goal of the Speakers Bureau will be to inform and educate Sacramento County communities, faith groups, educational institutions, and system partners about mental health issues and the impact of stigma and discrimination toward individuals with mental illness and/or toward families of children and adults living with mental illness. Speakers will include, but not be limited to, consumers, family members, community leaders, and transition-age youth reflective of Sacramento's diverse communities. The speakers will receive training in public speaking, as well as assistance with telling their stories in ways that are educational, engaging and informative. The speakers, utilizing state and national resources, will provide information to dispel misconceptions and myths regarding mental illness, as well as include local resources on accessing mental health services. Speakers will receive a stipend for their presentations. The overarching goal of the Speakers Bureau is to humanize the face of mental illness and reduce the stigma and discrimination towards those living with mental illness.
- 4. Multi-media Campaign:** The most comprehensive and far-reaching strategy of this project is the Multi-media Campaign. Mental Health will work with the Department's Communications and Media Officers, as well as the MHSA Steering Committee, CCAC, consumers, consumer advocacy groups, family members and advocacy groups, system partners, mental health provider agencies, and other key groups to increase awareness of mental health issues and reduce stigma and discrimination. Brochures and other print media will be developed and

**PEI PROJECT SUMMARY**

translated into Sacramento’s threshold languages and television and radio spots will target ethnic communities in threshold languages to increase the understanding of mental health wellness and recovery. The campaign will include Public Service Announcements (PSAs) and consider the use of social networking sites and other innovative strategies to reach as many community members as possible. In addition to specific cultural and ethnic groups, the multi-media campaign will also focus on age-specific populations, especially youth and older adults.

**4. Programs/Activities**

Program Title	Proposed number of individuals or families through PEI expansion to be served by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
<b>MENTAL HEALTH PROMOTION CAMPAIGN</b>			
Community Education	Individuals: 600* Families: *annually	Individuals: Families:	3
Community Outreach and Engagement	Individuals: 600* Families: *annually	Individuals: Families:	3
Speakers Bureau	Individuals: 600* Families: *annually	Individuals: Families:	3
Multi-media Campaign	Individuals: 71,659* Families: *annually	Individuals: Families:	3
<b>TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED</b>	<b>Individuals: 73,459*</b> <b>Families:</b> <b>*annually</b>	<b>Individuals:</b> <b>Families:</b>	3

\*Estimate based on 5% of the Sacramento County population

## PEI PROJECT SUMMARY

Form No. 3

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

The Mental Health Promotion Campaign Project will make referrals to Sacramento County Mental Health services and other needed services, as appropriate. By increasing public awareness and education about signs and symptoms of mental illness, there will potentially be individuals and family members who identify concerns and request services. Referrals will include, but not be limited to, Mental Health's Child and Adult Systems of Care, Alcohol and Drug Services, Primary Health, other health care providers, and social services providers. When requested, individuals involved in this campaign will also make referrals to other needed resources such as childcare, housing, and employment.

The Division will use the PEI CCAC and the Cultural Competence Committee to assist with community outreach, engagement and education activities that will target unserved and underserved racial, cultural and ethnic communities. The Division will ensure that brochures and handouts are translated into various languages and that they include information on how to access services.

### **6. Collaboration and System Enhancements**

As stated throughout, collaboration with schools, system partners, consumers, family members, cultural and ethnic communities, faith-based groups, health clinics and other stakeholders will be critical to successful implementation of the Project. Partnerships with advocacy groups such as National Alliance for Mental Illness (NAMI), Mental Health America, and California Network of Mental Health Clients, will engage communities and individuals in a dialog to help de-stigmatize mental illness. Through the other proposed PEI Projects, the PEI CCAC, and the Student Mental Health and Wellness Collaborative, Sacramento County will significantly increase and expand the reach of anti-stigma information and mental health education.

Potential providers will be required to contribute internal resources that may include space, equipment, staff, volunteers, peer support, and supervision. During the RFP process, potential providers will be required to describe their plan for generating support, leveraging additional resources, and/or funding to expand and/or sustain programs.

## PEI PROJECT SUMMARY

Form No. 3

### 7. Intended Outcomes

#### Individual-Level Outcomes

1. Increased sense of self-worth and value for consumers
2. Decrease internalized stigma
3. Increased access to services
4. Increase in early intervention treatment
5. Increased employment of consumers

#### System and Program-Level Outcomes

1. Increased acceptance of persons with mental illness
2. Decrease in fear and mistrust towards persons with mental illness
3. Decrease in discriminatory practices against persons with mental illness
4. Increase in understanding of how to access services
5. Increase in psycho-educational forums integrated into health care settings, school, faith, and cultural and ethnic communities

#### Proposed methods to measure success

1. Number of presentations
2. Number of ongoing psycho-educational groups
3. Evaluation surveys after each presentation

### 8. Coordination with Other MHSA Components

Individuals identified through this project that meet Sacramento County's target population criteria will be referred to MHSA CSS Programs or other mental health services within Sacramento's Mental Health Plan.

The Division will coordinate training efforts identified in the Workforce Education and Training (WET) Plan so as not to duplicate efforts. While not limited to the list below, training topics in WET that are relevant to this project are as follows:

- Stigma reduction in the workplace and schools

## **PEI PROJECT SUMMARY**

Form No. 3

- Education regarding consumer and family member culture
- Strategies to overcoming stigma
- Using consumers to share consumer-lived experiences
- Outreach to specific cultural groups regarding the impact of mental health
- Education regarding wellness, recovery and resiliency

Sacramento County's approved PEI Suicide Prevention Project will include warm lines that can provide phone support and referral information to individuals dealing with a variety of concerns or questions. Warm lines can link callers to any of the programs in the Strengthening Families and Integrated Health and Wellness Projects, as well as inform callers about events in the Mental Health Promotion Campaign.

Capital Facilities and Technology funds have not been identified for this Project.

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

## PEI Revenue and Expenditure Budget Worksheet

Enclosure 3  
Revised 08/08

Form No. 4

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

County Name:	Sacramento		Date:	2/17/2010
PEI Project Name:	Strengthening Families			
Provider Name (if known):	not known			
Intended Provider Category:	not yet defined			
Proposed Total No. of Individuals to be served:	FY 08-09		FY 09-10	860
Total No. of Individuals currently being served:	FY 08-09		FY 09-10	-
Total No. of Individuals to be served through PEI Expansion:	FY 08-09		FY 09-10	860
Months of Operation:	FY 08-09		FY 09-10	3

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 09-10	Total
<b>A. Expenditure</b>			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
1) 2.0 FTE Sr. MH Counselor (Licensed); 0.25 FTE MH Pro	\$ -	\$ 170,523	\$ 170,523
2) 3.0 FTE Sr. MH Counselor (Licensed); 0.25 FTE MH Pro	\$ -	\$ 244,878	\$ 244,878
b. Benefits and Taxes @ 41 %			
	\$ -	\$ 170,314	\$ 170,314
<b>c. Total Personnel Expenditures</b>	\$ -	\$ 585,715	\$ 585,715
2. Operating Expenditures			
a. Facility Cost			
	\$ -	\$ 18,770	\$ 18,770
b. Other Operating Expenses			
	\$ -	\$ 105,514	\$ 105,514
<b>c. Total Operating Expenses</b>	\$ -	\$ 124,284	\$ 124,284
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
a. School-Based Social Skills and Violence Prevention			
	\$ -	\$ 525,000	\$ 525,000
b. Building Life Skills for Teens and TAY			
	\$ -	\$ 295,000	\$ 295,000
c. Family Conflict Management			
	\$ -	\$ 195,000	\$ 195,000
<b>d. Total Subcontracts</b>	\$ -	\$ 1,015,000	\$ 1,015,000
4. Total Proposed PEI Project Budget	\$ -	\$ 1,725,000	\$ 1,725,000
<b>B. Revenues (list/itemize by fund source)</b>			
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
1. Total Revenue	\$ -	\$ -	\$ -
<b>5. Total Funding Requested for PEI Project</b>	\$ -	\$ 1,725,000	\$ 1,725,000
<b>6. Total In-Kind Contributions</b>	\$0	\$0	\$0

\*Fiscal Years have been changed per verbal direction from DMH

**Form 4 - Budget Narrative**

**SACRAMENTO COUNTY DIVISION OF MENTAL HEALTH  
PROJECT 2. STRENGTHENING FAMILIES  
BUDGET NARRATIVE**

**A. Expenditures**

**1. Personnel Expenditures - 5.5 FTE**

- a. Salaries based on Step 9 Sacramento County positions:  
5.0 FTE Sr. Mental Health Counselor (Licensed); and  
0.5 FTE Mental Health Program Coordinator

Early Childhood Consultation program staff will provide behavioral consultations to early childcare and education providers and collaborate with system partners and agencies

In-Home Support Services for Foster Children program staff will provide culturally competent in-home visits with the child and foster parent and collaborate with Child Protective Services and other stakeholders

- b. Benefits calculated at 41% of salary costs.

**2. Operating Expenditures**

- a. Facility Costs - calculated at 5% of salaries
- b. Other Operating Expenses - calculated at 24% of salaries to include: allocated costs, office supplies, telecommunications, mileage, etc. plus \$10,000 in start-up costs to purchase computer equipment for staff

**3. Subcontracts/Professional Services**

Contracts and subcontracts have not been awarded and therefore are not known at this time. Includes \$65,000 in start-up costs to purchase curriculum, tools, training associated with implementation, computer equipment, etc.

**B. Revenues**

There are no anticipated revenues contributing to this project.

**6. In-Kind Contributions**

Existing infrastructure and staff resources are anticipated to be in-kind contributions to this project; however the financial leveraging of these activities are unknown at this time. It is anticipated that potential providers would have existing outreach and support services in place that can be leveraged and enhanced. During the RFP Process, potential providers will be asked to describe their plan for generating support, leveraging additional resources and/or funding to expand and/or sustain programs. Existing partners and potential providers will be asked to contribute internal resources that may include space, equipment, staff, volunteer, peer support, and supervision.

## PEI Revenue and Expenditure Budget Worksheet

Enclosure 3  
Revised 08/08

Form No. 4

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

County Name:	Sacramento		Date:	2/17/2010
PEI Project Name:	Integrated Health and Wellness			
Provider Name (if known):	not known			
Intended Provider Category:	not yet defined			
Proposed Total No. of Individuals to be served:	FY 08-09 _____	FY 09-10 _____		3,350
Total No. of Individuals currently being served:	FY 08-09 _____	FY 09-10 _____		-
Total No. of Individuals to be served through PEI Expansion:	FY 08-09 _____	FY 09-10 _____		3,350
Months of Operation:	FY 08-09 _____	FY 09-10 _____		3

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 09-10	Total
<b>A. Expenditure</b>			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
1) 1.0 FTE MH Program Coord	\$ -	\$ 87,252	\$ 87,252
	\$ -	\$ -	\$ -
b. Benefits and Taxes @ 41 %	\$ -	\$ 35,773	\$ 35,773
<b>c. Total Personnel Expenditures</b>	\$ -	\$ 123,025	\$ 123,025
2. Operating Expenditures			
a. Facility Cost	\$ -	\$ 4,363	\$ 4,363
b. Other Operating Expenses	\$ -	\$ 17,612	\$ 17,612
<b>c. Total Operating Expenses</b>	\$ -	\$ 21,975	\$ 21,975
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
a. Screening, Assessment, Peer Support and Treatment	\$ -	\$ 1,105,000	\$ 1,105,000
b. Assessment and Treatment of Onset of Psychosis	\$ -	\$ 528,000	\$ 528,000
c. Senior Navigator	\$ -	\$ 703,000	\$ 703,000
<b>d. Total Subcontracts</b>	\$ -	\$ 2,336,000	\$ 2,336,000
4. Total Proposed PEI Project Budget	\$ -	\$ 2,481,000	\$ 2,481,000
<b>B. Revenues (list/itemize by fund source)</b>			
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
1. Total Revenue	\$ -	\$ -	\$ -
<b>5. Total Funding Requested for PEI Project</b>	\$ -	\$ 2,481,000	\$ 2,481,000
<b>6. Total In-Kind Contributions</b>	\$0	\$0	\$0

*\*Fiscal Years have been changed per verbal direction from DMH*

**Form 4 - Budget Narrative**

**SACRAMENTO COUNTY DIVISION OF MENTAL HEALTH  
PROJECT 3. INTEGRATED HEALTH AND WELLNESS  
BUDGET NARRATIVE**

**A. Expenditures**

**1. Personnel Expenditures - 1.0 FTE**

- a. Salaries based on Step 9 Sacramento County position:  
1.0 FTE Mental Health Program Coordinator  
Oversight and coordination of up to five community health clinics delivering Program 1. Screening, Assessment, Peer Support and Treatment services
- b. Benefits calculated at 41% of salary costs.

**2. Operating Expenditures**

- a. Facility Costs - calculated at 5% of salaries
- b. Other Operating Expenses - calculated at 24% of salaries to include: allocated costs, office supplies, telecommunications, mileage, etc.

**3. Subcontracts/Professional Services**

Contracts and subcontracts have not been awarded and therefore are not known at this time. Includes \$356,000 in start-up costs to purchase curriculum, tools, training associated with implementation, furniture, vehicles, computer equipment, etc.

**B. Revenues**

There are no anticipated revenues contributing to this project.

**6. In-Kind Contributions**

Existing infrastructure and staff resources are anticipated to be in-kind contributions to this project; however the financial leveraging of these activities are unknown at this time. During the RFP Process, potential providers will be asked to describe their plan for generating support, leveraging additional resources and/or funding to expand and/or sustain programs. Existing partners and potential providers will be asked to contribute internal resources that may include space, equipment, staff, volunteer, peer support, and supervision. By giving priority to Federally Qualified Health Centers (FQHCs) in Program 1, our intent is to leverage resources they are entitled to (based on their FQHC status) which would increase the number of individuals to be served.

## PEI Revenue and Expenditure Budget Worksheet

Enclosure 3  
Revised 08/08

Form No. 4

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

County Name:	Sacramento		Date:	2/17/2010
PEI Project Name:	Mental Health Promotion Campaign			
Provider Name (if known):	not known			
Intended Provider Category:	not yet defined			
Proposed Total No. of Individuals to be served:	FY 08-09 _____	FY 09-10 _____		18,365
Total No. of Individuals currently being served:	FY 08-09 _____	FY 09-10 _____		-
Total No. of Individuals to be served through PEI Expansion:	FY 08-09 _____	FY 09-10 _____		18,365
Months of Operation:	FY 08-09 _____	FY 09-10 _____		3

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 09-10	Total
<b>A. Expenditure</b>			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
1) 1.0 FTE MH Program Coord x 2 years	\$ -	\$ 174,504	\$ 174,504
	\$ -	\$ -	\$ -
b. Benefits and Taxes @ 41 %	\$ -	\$ 71,547	\$ 71,547
<b>c. Total Personnel Expenditures</b>	\$ -	\$ 246,051	\$ 246,051
2. Operating Expenditures			
a. Facility Cost	\$ -	\$ 8,725	\$ 8,725
b. Other Operating Expenses	\$ -	\$ 41,881	\$ 41,881
<b>c. Total Operating Expenses</b>	\$ -	\$ 50,606	\$ 50,606
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
a. Community Education Forums/Micro Grants	\$ -	\$ 104,000	\$ 104,000
b. Speakers Bureau	\$ -	\$ 10,080	\$ 10,080
c. Multi Media (PSAs, Brochures, Translation, Billboards, etc)	\$ -	\$ 450,000	\$ 450,000
<b>d. Total Subcontracts</b>	\$ -	\$ 564,080	\$ 564,080
4. Total Proposed PEI Project Budget	\$ -	\$ 860,737	\$ 860,737
<b>B. Revenues (list/itemize by fund source)</b>			
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
1. Total Revenue	\$ -	\$ -	\$ -
<b>5. Total Funding Requested for PEI Project</b>	\$ -	\$ 860,737	\$ 860,737
<b>6. Total In-Kind Contributions</b>	\$0	\$0	\$0

*\*Fiscal Years have been changed per verbal direction from DMH*

**Form 4 - Budget Narrative**

**SACRAMENTO COUNTY DIVISION OF MENTAL HEALTH  
PROJECT 4. MENTAL HEALTH PROMOTION CAMPAIGN  
BUDGET NARRATIVE**

**A. Expenditures**

**1. Personnel Expenditures - 1.0 FTE**

a. Salaries based on Step 9 Sacramento County position:  
1.0 FTE Mental Health Program Coordinator x 2 years  
Oversight and coordination of project implementation

b. Benefits calculated at 41% of salary costs.

**2. Operating Expenditures**

a. Facility Costs - calculated at 5% of salaries  
b. Other Operating Expenses - calculated at 24% of salaries to include: allocated costs, office supplies, telecommunications, mileage, etc.

**3. Subcontracts/Professional Services**

Contracts and subcontracts have not been awarded and therefore are not known at this time.

**B. Revenues**

There are no anticipated revenues contributing to this project.

**6. In-Kind Contributions**

Existing infrastructure and staff resources are anticipated to be in-kind contributions to this project; however the financial leveraging of these activities are unknown at this time. During the RFP Process, potential providers will be asked to describe their plan for generating support, leveraging additional resources and/or funding to expand and/or sustain programs. Existing partners and potential providers will be asked to contribute internal resources that may include space, equipment, staff, volunteer, peer support, and supervision.

**Form No.5**

County: Sacramento

Date: 2/17/2010

	Client and Family Member, FTEs*	Total FTEs	Budgeted Expenditure FY 2008-09	Budgeted Expenditure FY 2009-10	Total
<b>A. Expenditures</b>					
<b>1. Personnel Expenditures</b>					
a. PEI Coordinator	0.00	1.00	0	97,855	\$97,855
b. PEI Support Staff	0.00	1.00	0	41,275	\$41,275
c. Other Personnel (list all classifications)					\$0
<u>HS Program Planner Rng B</u>	0.00	1.00	0	97,855	\$97,855
<u>HS Program Planner Rng B</u>	0.00	1.00	0	97,855	\$97,855
<u>MH Program Coordinator</u>	0.00	0.50	0	43,626	\$43,626
					\$0
d. Employee Benefits			0	184,432	\$184,432
e. Total Personnel Expenditures	0.00	4.50	\$0	\$562,898	\$562,898
<b>2. Operating Expenditures</b>					
a. Facility Costs			\$0	\$18,923	\$18,923
b. Other Operating Expenditures			\$0	\$233,851	\$233,851
c. Total Operating Expenditures			\$0	\$252,774	\$252,774
<b>3. County Allocated Administration</b>					
a. Total County Administration Cost			\$0	\$84,328	\$84,328
<b>4. Total PEI Funding Request for County Administration Budget</b>			\$0	\$900,000	\$900,000
<b>B. Revenue</b>					
<b>1 Total Revenue</b>			0	0	\$0
<b>C. Total Funding Requirements</b>			\$0	\$900,000	\$0
<b>D. Total In-Kind Contributions</b>			\$0	\$0	\$0

\* Sacramento County does not capture Consumer/Family Member status in hiring practices.

**Form 5 - Budget Narrative**

**SACRAMENTO COUNTY DIVISION OF MENTAL HEALTH  
ADMINISTRATION BUDGET NARRATIVE**

**A. Expenditures**

**1. Personnel Expenditures -**

a. Salaries based on Step 9 Sacramento County positions:

PEI Coordinator - 1.0 FTE Human Services Program Planner Range B - will oversee coordination of planning, program development, and overall PEI component implementation

PEI Support Staff - 1.0 FTE Senior Office Assistant - will provide clerical support

Other Personnel -

1.0 FTE Human Services Program Planner Range B - will coordinate outcome data reporting for PEI component projects/programs

1.0 FTE Human Services Program Planner Range B - will coordinate and address quality assurance issues, assist with training and technical assistance, and outreach and engagement to unserved and underserved populations, and act as liaison to system partners related to PEI component implementation

0.5 FTE Mental Health Program Coordinator - will coordinate/provide oversight and technical assistance to Project 2 contracted programs

b. Benefits calculated at 48% of salary costs.

**2. Operating Expenditures**

a. Facility Costs - calculated at 5% of salaries

b. Other Operating Expenses - calculated at 27% of salaries to include: allocated costs, office supplies, telecommunications, mileage, etc. plus funds for consultation

**3. County Allocated Administration**

Based on allocated cost package provided by DBHS

**B. Revenues**

There are no anticipated revenues contributing to this project.

**6. In-Kind Contributions**

Existing infrastructure and staff resources are anticipated to be in-kind contributions; however the financial leveraging of these activities are unknown at this time.

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).

<b>County:</b>	Sacramento
<b>Date:</b>	2/17/2010

#	List each PEI Project	Fiscal Year			Funds Requested by Age Group			
		FY 08/09	FY 09/10	Total	*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
1	Suicide Prevention*	\$ -		\$ -	\$ -	\$ -	\$ -	\$ -
2	Strengthening Families	\$ -	\$ 1,725,000	\$ 1,725,000	\$ 1,104,000	\$ 517,500	\$ 86,250	\$ 17,250
3	Integrated Health and Wellnes	\$ -	\$ 2,481,000	\$ 2,481,000	\$ 173,670	\$ 645,060	\$ 669,870	\$ 992,400
4	Mental Health Promotion Cam	\$ -	\$ 1,000,000	\$ 1,000,000	\$ 150,000	\$ 300,000	\$ 250,000	\$ 300,000
				\$ -				
				\$ -				
				\$ -				
				\$ -				
				\$ -				
	Administration		\$ 900,000	\$ 900,000				
	<b>Total PEI Funds Requested:</b>	\$ -	\$ 6,106,000	\$ 6,106,000	\$ 1,427,670	\$ 1,462,560	\$ 1,006,120	\$ 1,309,650

\*A minimum of 51 percent of the overall PEI component budget must be dedicated to individuals who are between the ages of 0 and 25 ("small counties" are excluded from this requirement).

\* *Project 1 was approved by the OAC and DMH in October 2009.*

**FY 2009/10 Mental Health Services Act  
Summary Funding Request**

County: Sacramento

Date: 2/17/2010

	MHSA Component				
	CSS	CFTN	WET	PEI	Inn
<b>A. FY 2009/10 Planning Estimates</b>					
1. Published Planning Estimate <sup>a/</sup>				\$10,712,200	
2. Transfers <sup>b/</sup>					
3. Adjusted Planning Estimates	\$0	\$0	\$0	\$10,712,200	\$0
<b>B. FY 2009/10 Funding Request</b>					
1. Required Funding in FY 2009/10 <sup>c/</sup>				\$6,106,000	
2. Net Available Unspent Funds					
a. Unspent FY 2007/08 Funds <sup>d/</sup>				\$0	
b. Adjustment for FY 2008/09 <sup>e/</sup>				\$0	
c. Total Net Available Unspent Funds	\$0	\$0	\$0	\$0	\$0
<b>3. Total FY 2009/10 Funding Request</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$6,106,000</b>	<b>\$0</b>
<b>C. Funding</b>					
1. Unapproved FY 06/07 Planning Estimates					
2. Unapproved FY 07/08 Planning Estimates				\$0	
3. Unapproved FY 08/09 Planning Estimates				\$6,037,900	
4. Unapproved FY 09/10 Planning Estimates				\$68,100	
<b>5. Total Funding<sup>f/</sup></b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$6,106,000</b>	<b>\$0</b>

**Instructions for Completing the Local Evaluation of a PEI Project****County:** Sacramento County**Date:** February 17, 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:****1. a. Identify the programs (from Form No. 3 PEI Project Summary), the county will evaluate and report on to the State.**

The project selected for evaluation will be Sacramento County’s Integrated Health and Wellness project. The project consists of four programs. The programs are:

- Integrated Screening and Assessment
- Peer Support and Treatment
- Assessment and Treatment of Onset of Psychosis
- Senior Navigator: Targeting Isolation and Depression in Older Adults

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

The Integrated Health and Wellness project was select for evaluation for a variety of reasons.

1. As an integrated project, we will have the ability to evaluate people as they move through the system
2. The anticipated outcomes are easily measurable and will have the ability to have a short-term and long-term impact on the community.
3. These programs will be implemented county wide, in a variety of geographic locations, allowing for an effective evaluation of the unserved and underserved populations.

## Instructions for Completing the Local Evaluation of a PEI Project

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

Program	Person/Family-Level Outcomes	Program/System-Level Outcomes
Integrated Screening and Assessment	<ul style="list-style-type: none"> <li>• Appropriate and early identification of mental health and substance abuse issues related to the impact of trauma</li> <li>• Appropriate and timely mental health services</li> <li>• Increase in culturally and linguistically appropriate services for the individual</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of referrals to peer led support groups</li> <li>• Increased number of referrals to treatment groups</li> <li>• Decrease in utilization of high cost services (i.e. emergency rooms, hospitals and jails)</li> <li>• Decrease in youth/TAY identified as needing mental health services in juvenile justice settings</li> <li>• Increase in collaboration amongst community health/mental health providers</li> </ul>
Peer Support and Treatment	<ul style="list-style-type: none"> <li>• Increase in resiliency and protective factors</li> <li>• Improved mental wellness following trauma exposure</li> <li>• Increased social supports for at-risk individuals, families and older adults</li> </ul>	<ul style="list-style-type: none"> <li>• Increased identification of mental health concerns</li> <li>• Increased linkage to services</li> <li>• Collaboration between primary care settings, mental health and/or other alternative settings</li> <li>• Increased awareness and recognition of mental health issues amongst primary care providers</li> <li>• Stigma reduction amongst older adults and other cultural groups</li> <li>• Decrease in utilization of high cost services (i.e. emergency rooms, hospitals, jails)</li> </ul>
Assessment & Treatment of Onset of Psychosis	<ul style="list-style-type: none"> <li>• Reduced risk factors</li> <li>• Reduced symptoms associated with early onset</li> <li>• Improved resilience and protective factors</li> </ul>	<ul style="list-style-type: none"> <li>• Family satisfaction</li> <li>• Increased education around illness/symptom management</li> <li>• Increased knowledge around early onset</li> </ul>

**Instructions for Completing the Local Evaluation of a PEI Project**

	<ul style="list-style-type: none"> <li>• Improved emotional and mental health</li> <li>• Improved knowledge of social and emotional factors to general health</li> <li>• Increased school and/or work success</li> </ul>	<ul style="list-style-type: none"> <li>• Increased linkage to less intensive services</li> <li>• More community organizations providing identification and early intervention (short-term mental health services)</li> <li>• Enhanced quantity and quality of co-operative relationships with other organizations and systems</li> <li>• Reduced utilization of high cost services (i.e. emergency rooms, hospitals, jails)</li> </ul>
<p>Senior Navigator: Targeting Isolation and Depression in Older Adults</p>	<ul style="list-style-type: none"> <li>• Reduced Risk Factors</li> <li>• Improved resilience and protective factors</li> <li>• Improved social and emotional wellness</li> <li>• Reduced isolation</li> <li>• Increased social interaction</li> <li>• Improved knowledge and access to community resources</li> </ul>	<ul style="list-style-type: none"> <li>• Client satisfaction</li> <li>• increased linkages to community resources</li> <li>• Build Community Capacity</li> <li>• Enhanced use of ethnic/cultural community partners</li> <li>• Enhanced integrated health and behavioral health</li> <li>• Decreased incidence of suicide and attempts in older adults</li> <li>• Decreased utilization of high cost services (i.e. emergency rooms and hospitals)</li> <li>• Increased collaboration between primary care settings and mental health providers</li> </ul>

## Instructions for Completing the Local Evaluation of a PEI Project

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
<b><u>ETHNICITY/CULTURE</u></b>							
African American	2726	2726				2726	
Asian Pacific Islander	2453	2453				2453	
Latino	3407	3407				3407	
Native American	137	137				137	
Caucasian	3816	3816				3816	
Other (Indicate if possible)	1091	1091				1090	
<b><u>AGE GROUPS</u></b>							
Children & Youth (0-15)	984	984				984	
Transition Age Youth (16-25)	3544	3544				3544	
Adult (18-59)	3680	3680				3680	
Older Adult (>60)	5452	5452				5452	
<b>TOTAL</b>	13,630	13630				13630	
Total PEI project estimated <i>unduplicated</i> count of individuals to be served <u>13,630</u>							

Numbers are only estimates and are based on Sacramento County Primary Care statistics for FY 08/09. Numbers served may differ depending on the applicants in the RFP process. All candidates are required to document how they will serve the unserved and underserved populations.

## Instructions for Completing the Local Evaluation of a PEI Project

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

Outcomes and objectives will be measured in a variety of ways, depending on the program. The tables below indicate the outcome, what tool will be used, when it will be used and how often.

#### *Integrated Screening and Assessment*

<b>Outcome</b>	<b>Tool</b>	<b>When Used</b>	<b>Frequency</b>
Appropriate and early identification of mental health and substance abuse related to the impact of trauma	Integrated physical/behavior health assessment form	At time of intake and every 6-months for follow up	At each appointment
Appropriate and timely mental health services	Referral form used to track referrals to mental health services and other community services including peer run groups	At time of referral	At each appointment
Culturally and linguistically appropriate services	Demographic form	At time of intake	At each intake
Number of referrals to peer led groups	Referral form used to track referrals to mental health services and other community services including peer run groups	At time of referral	At the time of each referral
Number of referrals to treatment groups	Referral form used to track referrals to mental health services and other community services including peer run groups	At time of referral	At the time of each referral
Utilization of high cost services	Data extraction from the Mental Health IT system	Every quarter	Every quarter for reporting purposes
Youth/TAY with mental health issues identified in juvenile justice settings	Data extraction from the Mental Health IT system	Every quarter	Every quarter for reporting purposes
Collaboration between primary care settings, mental health and/or other alternative settings	Referral form indicating linkage to other services	At time of referral	At the time of each referral

## Instructions for Completing the Local Evaluation of a PEI Project

### *Peer Support and Treatment*

<b>Outcome</b>	<b>Tool</b>	<b>When Used</b>	<b>Frequency</b>
Assessment of resiliency and protective factors	Pre-Post test assessing resiliency and protective prior to and after groups/clinical session	Prior to and at the of each group/individual session	As indicated
Improved mental wellness following trauma exposure	Pre-Post test assessing resiliency and protective prior to and after groups/clinical session	Prior to and at the of each group/individual session	As indicated
Increased social supports	Client satisfaction survey	After completion of group/individual session	As indicated
Increased identification of mental health concerns	No forms indicated – Causal effect based on services provided through PEI program		
Increased linkage to services	Referral form indicating linkage to other services	At time of referral	At the time of each referral
Collaboration between primary care settings, mental health and/or other alternative settings	Referral form indicating linkage to other services	At time of referral	At the time of each referral
Awareness and recognition of mental health issues amongst primary care providers	No forms indicated – Causal effect based on services provided through PEI project		
Reduce stigma in older adults and cultural groups	Pre-post test addressing stigma prior to and after treatment groups/clinical session	Prior to and at the of each group/individual session	As indicated
Utilization of high cost services	Data extraction from the Mental Health IT system	Every quarter	Every quarter for reporting purposes

## Instructions for Completing the Local Evaluation of a PEI Project

### *Assessment and Treatment of Onset of Psychosis*

<b>Outcome</b>	<b>Tool</b>	<b>When Used</b>
Assessment of risk factors	Assessment tool	At intake and every quarter, or as indicated by program director
Assessment of symptoms	Assessment tool	At intake and every quarter, or as indicated by program director
Resilience and protective factors	Assessment tool	At intake and every quarter, or as indicated by program director
Assessment of emotional and mental health	Assessment tool	At intake and every quarter, or as indicated by program director
Knowledge of social and emotional factors to general health	Client satisfaction survey	At the end of treatment
School and/or work success	Assessment tool	At intake and every quarter, or as indicated by program director
Family satisfaction	Family satisfaction survey	At the end of treatment
Increased education around illness/symptom management	Client satisfaction survey/family satisfaction survey	At the end of treatment
Increased knowledge of early onset	No forms indicated – Causal effect based on services provided through PEI project	
Linkage to less intensive services	Referral/linkage form	At time of referral/linkage
Other community organizations providing early intervention services	No forms indicated – Causal effect based on services provided through PEI project	
Quantity and quality of co-operative relationships with other organizations and systems	No forms indicated – Causal effect based on services provided through PEI project	
Utilization of high cost services	Data extraction from the Mental Health IT system	Every quarter

## Instructions for Completing the Local Evaluation of a PEI Project

### *Senior Navigator: Targeting Isolation and Depression in Older Adults*

Outcome	Tool	When Used
Assessment of risk factors	Assessment tool	At intake and every quarter
Resilience and protective factors	Assessment tool	At intake and every quarter
Assessment of social and emotional wellness	Assessment tool	At intake and every quarter
Assessment of isolation and social interaction	Assessment tool	At intake and every quarter
School and/or work success	Assessment tool	At intake and every quarter, or as indicated by program director
Knowledge and access to community resources	Client satisfaction survey	
Client Satisfaction	Client satisfaction survey	
Linkages to community resources	Referral/linkage form	
Integrated health and behavioral health	Assessment tool	At intake and every quarter
Utilization of high cost services	Data extraction from the Mental Health IT system	Every quarter

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

The data will be collected on a regular basis (weekly or monthly depending on the program). The data will be analyzed by Sacramento County Mental Health program evaluator(s) and overseen by the Research and Evaluation Program Manager. The evaluator(s) will collect, track, analyze and report the findings on an on-going basis. Analysis will be done using statistical software to look at changes over time.

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

All programs, through the RFP process, must demonstrate how they will serve the unserved and underserved. Another requirement of the RFP is that services will be provided in communities with existing community based organizations that provide culturally and linguistically appropriate services. Data will be collected and analyzed on a regular basis to determine whether the programs are meeting their goals set out by the RFP. If the programs are not successful in outreaching and serving the unserved and underserved communities, technical assistance will be provided in order to ensure compliance.

## Instructions for Completing the Local Evaluation of a PEI Project

Enclosure 3

Form No. 7

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

In order to ensure fidelity to the model, on-going training for all line staff will be implemented. The County research and evaluation evaluator(s) will provide technical assistance when needed to ensure fidelity. Train the trainer model will be used to ensure that at least one person at each site is fully trained and knowledgeable of the model to assist in training other staff. If any adaptations to the model are made, the changes will be documented and justifications will be provided.

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

Quarterly reports, as well as annual reports will be distributed to the Sacramento County MHSA steering committee and posted on the MHSA website for local constituencies. Data will be available for ad hoc reporting as necessary.

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**PEI Plan Amendment Attachments  
Posting on 12-28-09**

<b>Attachment A</b>	<b>MHSA Steering Committee Member Roster</b>
<b>Attachment B</b>	<b>PEI Regional Roundtable Attendee List</b>
<b>Attachment C</b>	<b>Letter of Invitation to Bridge Meeting and Attachment</b>
<b>Attachment D</b>	<b>PEI Cultural Competence Advisory Committee Distribution List</b>
<b>Attachment E</b>	<b>Community Orientation Meeting Letter of Invitation</b>
<b>Attachment F</b>	<b>Community Orientation Meeting Agenda</b>
<b>Attachment G</b>	<b>Community Orientation Meeting Summary Graphic</b>
<b>Attachment H</b>	<b>System Partner Letter and Attachment</b>
<b>Attachment I</b>	<b>System Partner Input Paper Report Form</b>
<b>Attachment J</b>	<b>PEI Survey in English</b>
<b>Attachment K</b>	<b>PEI Survey in Chinese</b>
<b>Attachment L</b>	<b>PEI Survey in Hmong</b>
<b>Attachment M</b>	<b>PEI Survey in Russian</b>
<b>Attachment N</b>	<b>PEI Survey in Spanish</b>
<b>Attachment O</b>	<b>PEI Survey in Vietnamese</b>
<b>Attachment P</b>	<b>Listing of Community Educational Forums</b>
<b>Attachment Q</b>	<b>Graphic Art from the Underserved Cultural Populations Forum</b>
<b>Attachment R</b>	<b>Graphic Art from the Stigma and Discrimination Forum</b>
<b>Attachment S</b>	<b>Phase II Kick-Off Meeting Agenda</b>
<b>Attachment T</b>	<b>PEI Overview</b>
<b>Attachment U</b>	<b>Data Identifying Sacramento's Key Community Mental Health Needs and Priority Populations</b>
<b>Attachment V</b>	<b>PEI Data Summary</b>
<b>Attachment W</b>	<b>PEI Planning Phase II</b>
<b>Attachment X</b>	<b>PEI Planning Principles</b>
<b>Attachment Y</b>	<b>Visioning Exercise</b>
<b>Attachment Z</b>	<b>Rating of the Stressors</b>
<b>Attachment AA</b>	<b>Overall Stressors Strategies</b>
<b>Attachment BB</b>	<b>Overall Trauma Strategies</b>
<b>Attachment CC</b>	<b>Top Ranked and Rated Strategies</b>
<b>Attachment DD</b>	<b>PEI Draft Proposed Projects</b>
<b>Attachment EE</b>	<b>PEI Proposed Projects</b>
<b>Attachment FF</b>	<b>Consumer Speaks Conference Flyer</b>
<b>Attachment GG</b>	<b>Collaborative Partnerships in Sacramento County</b>

**MHSA STEERING COMMITTEE MEMBERS  
2007 - 2009**

**Attachment A**

SLOT	STAKEHOLDER GROUP:	APPOINTED BY:	MEMBER	ALTERNATE
1	Mental Health Board*	Mental Health Board	Jane Fowler	Susan McCrea
2	Co-Chair** - Mental Health Director	Department of Health & Human Services Director	Mary Ann Bennett	Dorian Kittrell
3	Service Provider - Children	Association of Mental Health Contractors	Lyn Farr (EMQ)	Sheila Self (River Oak)
4	Service Provider - Adults	Association of Mental Health Contractors	Susan Stieber (Turning Point)	Joe St. Angelo
5	Service Provider - Older Adults	Association of Mental Health Contractors	Deborah Short (HRC)	René Reis (El Hogar)
6	Law Enforcement	Criminal Justice Cabinet	R.C. Smith	Scott Jones
7	Adult Protective Services/Senior & Adult Services	Department of Health & Human Services Director	Bert Bettis	Judy Ludwick
8	Education	Sacramento County Office of Education	David W. Gordon	Joyce Wright
9	Department of Human Assistance	Department of Human Assistance Director	Toni J. Moore	Suzanne Hammer
10	Alcohol & Drug Services	Department of Health & Human Services Director	Maria Morfin	Marguerite Story-Baker
11	Cultural Competence	Cultural Competence Committee	Katherine Elliot	Hendry Ton
12	Children Protective Services	Department of Health & Human Services Director	Dovie Hostetler	Vacant
13	Health	Department of Health & Human Services Director	Dorothy Pitman	John Onate
14	Juvenile Court	Presiding Judge	Kenneth G. Peterson	Carol S. Chrisman
15	Probation	Chief of Probation	Michael Shores	John Reilly
16	Consumer - TAY	6-member panel	Reina Kaslofski	Vacant
17	Consumer - TAY	6-member panel	Kenneth Logan	Porcha Primes
18	Consumer - Adult	6-member panel	Andrea Hillerman-Crook	Valerie Retallack
19	Consumer - Adult	6-member panel	William Romero	Vacant
20	Consumer - Older Adult	6-member panel	Al Lipson	Vacant
21	Consumer - Older Adult	6-member panel	Frank Topping	Vacant
22	Family Member/Caregiver of Child age 0-17 Yrs	6-member panel	Edwina Browning Hayes	Lois Cunningham
23	Family Member/Caregiver of Child age 0-17 Yrs	6-member panel	Stephanie Ramos	Rebecca Solorio
24	Family Member/Caregiver of Adult age 18-59 Yrs	6-member panel	Tyna Allianic	Hideko Davis
25	Family Member/Caregiver of Adult age 18-59 Yrs	6-member panel	Michelle Balkis	Nafeesah Rasheed
26	Family Member/Caregiver of Older Adult age 60+ Yrs	6-member panel	Marilyn Hillerman	Gulshan Yusufzai
27	Family Member/Caregiver of Older Adult age 60+ Yrs	6-member panel	Caroline Caton	Karen Owen
28	Family Member/Consumer At-large	6-member panel	Dave Schroeder	David Kiesz

\* Note - Mental Health Board member will also be Consumer/Family Member

\*\* Note - the 2nd Co-Chair position will be a Committee member appointed by the Committee.

There are 14 Consumers and Family Members, including the Mental Health Board Member, which is 50% of the Steering Committee membership

**PEI Regional Roundtable Attendee List  
July 31-August 1, 2008**

<b>NAME</b>	<b>SECTOR REPRESENTED</b>
Ambrose, Carla	Alcohol and Drug Services
Beckhorn, Nisha	Education- Los Rios Community College
Beebe, Michael	Family Member
Brody, Delphine	Consumer
Callejas, Michelle	Sacramento County Division of Mental Health - MHSA
Cunningham, Lois	Family Member
Edison, Joni	CPS
Efken, Lynn	Sacramento County Office of Education
Elmore, Richard	Sacramento County Mental Health Treatment Center
Garrison, Kathryn	Mental Health Provider - EMQ
Hillerman, Andrea	Consumer Advocate
Hillerman, Marilyn	Family Member
Jenkins, Myel	Sacramento County Division of Mental Health - MHSA
Johnson, Ellen	Native American Community
Johnson, JoAnn	MH Ethnic Services Manager
LeBlanc, Jane Ann	Sacramento County Division of Mental Health - MHSA
Malloy, Paulette	Alcohol and Drug Services
Mangan, Pat	Sacramento County Division of Mental Health
Nakamura, Mary	Sacramento County Division of Mental Health
Netters, Tyrone	Community
Porteus, Jonathan	Community based agency
Quinley, Matthew	Sacramento County Division of Mental Health
Raney, Cheryl	SCOE
Rucker, Anne-Marie	Sacramento County Division of Mental Health
Schroeder, David	Family Advocate
Self, Sheila	Community based agency
Skrabo, Kathryn	Sacramento County Division of Mental Health - MHSA
Soto, David	Area 4 on Aging
Thull, Lynn	Community
Thurston, Holly	Sacramento County Division of Mental Health - MHSA
Tom, Leland	Sacramento County Division of Mental Health
Tracy, Gwyneth	Los Rios Community College
Vang, Pa Kou	Underserved Community - Asian
Walton, Bernice	Public Health
Williams, Dawn	Sacramento County Division of Mental Health
Wright, Joyce	Sacramento County Office of Education
Ynostroza, Joe	Underserved Community -Latino
Young, Michael	Youth Advocate



## Attachment C

### Countywide Services Agency

#### Department of Health and Human Services

#### Mental Health Services

Leland Tom, Director

#### Mental Health Services Act

Michelle Callejas, MFT  
Program Manager

## County of Sacramento

Terry Schutten, County Executive  
Penelope Clarke, Agency Administrator  
Lynn Frank, Director

Address:

Dear \_\_\_\_\_,

We would like to invite you to attend a luncheon meeting to acknowledge and thank the community members who participated in our Mental Health Services Act (MHSA) Workforce Education and Training (WET) planning process and to invite others to join us as we continue with our MHSA efforts. Many of you participated in focus groups, granted interviews regarding strategies for diversifying our workforce, attended Task Force meetings, attended Workgroup meetings and chaired Workgroups and/or the WET Taskforce. We greatly appreciate the time you have dedicated to helping us transform our mental health system of care.

The next area of focus is on the Prevention and Early Intervention component of the MHSA. We want to inform you about our planning process and let you know about opportunities to get involved. We are also considering forming an advisory committee comprised of diverse community members to provide direction on the planning process and are very interested in your opinions and suggestions regarding this idea. We are committed to improving services and reducing disparities in unserved and underserved communities and value your input on how we can accomplish these goals.

Please join us at this luncheon on Tuesday, October 7, 2008 from 12:00 to 2:00 pm at the Oak Park Community Center, 3425 Martin Luther King, Jr. Blvd, Sacramento, 95817. If you are unable to attend but would like to recommend someone to attend in your place, please let us know so that we can welcome your representative. If you have any questions, please call Mary Nakamura (876-5821), Kathryn Skrabo (875-4179) or Myel Jenkins (875-1534). We look forward to seeing you all on the 7<sup>th</sup>!

Jo Ann Johnson, Program Manager  
Mary Nakamura, Program Coordinator  
Myel Jenkins, Planner  
Kathryn Skrabo, Planner  
Michelle Callejas, Program Manager

7001-A East Parkway, Suite 300 • Sacramento, California 95823-2501 • phone (916) 875-6472 • fax (916) 875-6970  
Visit our Website at <http://www.sacdhhs.com/mhsa>

PEI Cultural Competence Advisory Committee Distribution List

<u>Full Name</u>	<u>Affiliation</u>
Abdur-Rahim Wasi	Dept of Human Assistance, County of Sacramento
Alondra L. Thompson	Private Practive
Annette Knox	La Familia Counseling Cemter
Atary Xiong	Southeast Asian Assistance Center
Barbara Laymance	Consumer Self Help
Ben Jones	Mental Health America of Northern California
Britta Guerrero	Sacramento Native American Health Center
Carmen Pacheco	El Hogar
Carol Britto	Senior and Adult Services, County of Sacramento
Carolina Flores	Community Member
Chiem-Seng Yaangh	Sacramento City USD
Cibonay Cordova	Sacramento Native American Health Center
Connie Reitman-Solas	Inter-Tribal Council of CA, Inc.
Cristiana Giordano	UC Davis Center for Reducing Health Disparities
Dawn Williams	Division of Mental Health, County of Sacramento
Deborah Kawkeka	California Rural Indian Health Board, Inc.
Derrell Roberts	Roberts Family Development Center
Dr. Lue Vang	Sacramento City USD
Dr. Serge Lee	Sacramento State University, Division of Social Work
Elaine Abelaye	Asian Resources, Inc.
Elizabeth Contreras	Alcohol and Other Drug Services, County of Sacramento
Ellen Johnson	Native American Health Center
Frank Nava	Community Member
Hendry Tong	UC Davis
Jackie Kaslow	Community Member
Jan Houle	Division of Mental Health, County of Sacramento
Jane Ann LeBlanc	Division of Mental Health, County of Sacramento
Jeanette Stedifor	Sacramento Regional Office, Career Development, Native TANF Program
Jesus Cervantes	Dept of Mental Health, County of Sacramento
Jesus Sanchez	Youth in Focus
Jo Ann Johnson	Division of Mental Health, County of Sacramento
Joe Ynostroza	CA Hispanic Commission on Alcohol & Drug Abuse, Inc.
Judy Fong Heary	Asian Pacific Counseling Center
Julie Leung	Division of Mental Health, County of Sacramento
Kao Thun	United Lu-Mien Community
Katherine Elliott, Ph.D., MPH	UC Davis Center for Reducing Health Disparities
Kathryn Skrabo	Division of Mental Health, County of Sacramento
Katrina Lee	House of Hope Ministry
Koua Franz	Hmong Women's Heritage Association
Laura Leonelli	Southeast Asian Assistance Center
Laurel Benhamida	Muslim American Society-Social Services Foundation
Lester Neblett	Sacramento Gay and Lesbian Center

PEI Cultural Competence Advisory Committee Distribution List

<u>Full Name</u>	<u>Affiliation</u>
Lorenda T. Sanchez	California Indian Manpower Consortium, Inc.
Lynnaia Keune	La Familia Counseling Center
Marilyn Hillerman	Mental Health America of Northern California
Mark Teeley	MAAP Inc.
Mary Nakamura	Division of Mental Health, County of Sacramento
Marya Endriga	CSUS
Maurine Huang	Opening Doors, Inc.
Mercedes Gonzalez-Wise	Asian Pacific Counseling Center
Michael Young	Mental Health America of Northern California, S.A.F.E.
Michelle Callejas	Division of Mental Health, County of Sacramento
Myel Jenkins	Division of Mental Health, County of Sacramento
Neng Vang	Sacramento ACT
Nicolette Dennison	Division of Mental Health, County of Sacramento
Oralia Bermudez	La Familia Counseling Center
Pa Kou Vang	Hmong Women's Heritage Association
Patrick Marius Koga	UC Davis
Pavel Nikora	Community Member
Peter A. Zaragoza, Jr.	California Indian Manpower Consortium, Inc.
Poshi Mikalson	Mental Health America of Northern California
Ray Martinez	MAAP Inc.
Reina Kaslofski	Mental Health America of Northern California, S.A.F.E.
Rene Oliver	SAMHSA
Roman Romaso	Slavic Assistance Center
Ron King	The Gardens Community Center
Roy Kim	Sacramento Employment and Training Center
Sandy Stowell	EMQ
Shahnaz Kamali, LCSW	CalWORKS
Sharon Saffold	Division of Public Health, County of Sacramento
Stephanie Ramos	Mental Health America of Northern California
Terence Imai	Mental Health Board, County of Sacramento
Thomas Vang	Sacramento Lao Family Community, Inc.
Tina Roberts	Roberts Family Development Center
Tony Lee	EMQ
Tonya L Fancher, MD MPH	University of California, Davis
Troy Wood	Division of Mental Health, County of Sacramento
Tyrone Netters	Consultant, African American Community
Valentine Lopez	Community Member
Valerie Ries-Lerman	NAMI
Virginia Saldaña-Grove	MAAP Inc.
Viva Vang	Division of Mental Health, County of Sacramento
William Romero	Wellness and Recovery Center



**Countywide Services Agency**

**Department of  
Health and Human Services**

**Mental Health Services**  
Leland Tom, Director

Terry Schutten, County Executive  
Penelope Clarke, Agency Administrator  
Lynn Frank, Director

**County of Sacramento**

Dear

In 2004, Proposition 63 was passed and became known as The Mental Health Services Act (MHSA). To date, the MHSA has generated approximately three billion dollars. This funding is being used to expand and enhance mental health services as counties throughout the state work strategically to transform the public mental health system. There are five components of the MHSA that form the foundation of this system transformation. Sacramento County has implemented the first component, Community Services and Supports (CSS), and continues to work collaboratively with the community on establishing new CSS programs to serve individuals and families living with mental illness or emotional disturbances. We are also in the final stages of planning the Workforce Education and Training (WET) component of the MHSA, which is designed to recruit, train and retain a skilled and diverse workforce.

The Division of Mental Health is now planning for another component of the MHSA – Prevention and Early Intervention (PEI). PEI represents an unprecedented opportunity to plan for services and supports that educate and engage individuals *prior* to the development of a serious mental illness or emotional disturbance. PEI is critical to shifting our mental health system from “fail first” to “serve first” and allows us to develop strategies that cultivate protective factors, reduce risk factors, build upon an individual’s skills, and increase support for children, youth, adults and families in our community.

In order to receive PEI funding, counties must conduct a planning process that includes a wide array of community stakeholders. In the initial stage, we will solicit input to prioritize the Key Community Mental Health Needs and Priority Populations set forth by the State Department of Mental Health. After data have been gathered and analyzed, we will work collaboratively with the community to develop specific strategies and projects that address the needs and populations identified in the data gathering process.

I would like to invite you or a representative to attend a PEI Orientation Meeting on Wednesday, **October 22, 2008**. We will discuss PEI funding guidelines and inform you of opportunities to get involved. As we prepare for PEI, it is critical that we partner and collaborate with community stakeholders to leverage resources and develop strategies that will yield a comprehensive Prevention and Early Intervention plan.

I hope you will join us in our efforts to promote wellness for all residents of Sacramento County – together, we can make it happen!

Sincerely,

Leland Tom, Director  
Mental Health Division

*The next component of the*  
**MENTAL HEALTH SERVICES ACT**

**PREVENTION AND EARLY INTERVENTION (PEI)**

**IS ROLLING OUT IN SACRAMENTO COUNTY**

You (or your representative) are invited to attend a PEI Orientation Meeting to learn how the Division of Mental Health will plan for new prevention services for children, youth, adults, and families.

**OCTOBER 22, 2008**  
**CSUS Alumni Center\***  
**6000 J Street**  
4:30 – 7:30 p.m.

4:30- 5:30	<i>Registration and light hors d'oeuvres</i>
Program	Welcome and Greeting
	Opening Comments
	MHSA and PEI Overview
	• PEI Requirements
	• PEI Planning Process
	Sacramento PEI Framework: Protective Factors
	Statewide Initiative: Suicide Prevention
	Closing

In order to plan appropriately, please RSVP by October 14, 2008, by e-mail, fax or phone:

- [MHSA@SacCounty.net](mailto:MHSA@SacCounty.net)
- Fax: 875-1490
- Phone: 875-MHSA(6472)

If you wish to attend and need to arrange for an interpreter or a reasonable accommodation, please contact Mary Drain one week prior to the meeting at 875-4639 or [DrainM@SacCounty.net](mailto:DrainM@SacCounty.net)

\* Parking passes will be available in front of the Alumni Center



**Mental Health Services Act  
Prevention and Early Intervention (PEI)  
Community Orientation Meeting**

CSUS Alumni Center  
October 22, 2008  
4:30- 7:30 p.m.

<i><b>Social Networking</b></i>	<b>4:30 – 5:30</b>
<b>Welcome</b>	<b>5:30 – 5:50</b>
<ul style="list-style-type: none"> <li>• <b>Leland Tom, Director, Division of Mental Health</b></li> <li>• <b>Don Nottoli, Supervisor, Sacramento County Board of Supervisors</b></li> </ul>	
<b>MHSA and PEI Overview</b>	<b>5:50 – 6:20</b>
<ul style="list-style-type: none"> <li>• <b>Michelle Callejas, MFT, MHSA Program Manager</b></li> </ul>	
<b>Break and Completion of Surveys</b>	<b>6:20 – 6:35</b>
<b>Sacramento PEI Framework: Protective Factors</b>	<b>6:35 – 7:05</b>
<ul style="list-style-type: none"> <li>• <b>Bonnie Benard, MSW Senior Program Associate, West Ed</b></li> </ul>	
<b>Statewide Initiatives: Suicide Prevention</b>	<b>7:05 – 7:15</b>
<ul style="list-style-type: none"> <li>• <b>Sandra Black, MSW, Department of Mental Health Office of Suicide Prevention</b></li> </ul>	
<b>Questions/Comments</b>	<b>7:15 – 7:30</b>



**MENTAL HEALTH SERVICES ACT**  
**PREVENTION & EARLY INTERVENTION**  
**COMMUNITY ORIENTATION**  
 OCT 22, 2008



**WELCOME & THANK YOU FOR ATTENDING!**

- THANK YOU MICHELLE & STAFF
- COMMUNITY INVOLVEMENT IS CRITICAL TO MHSA SUCCESS
- LELAND TEAM
- VITAMIN WATER (TEA) AS PREVENTION MEASURE
- PRIORITIES RESOURCES INPUT

**SUPV. DON NOTTOLI**

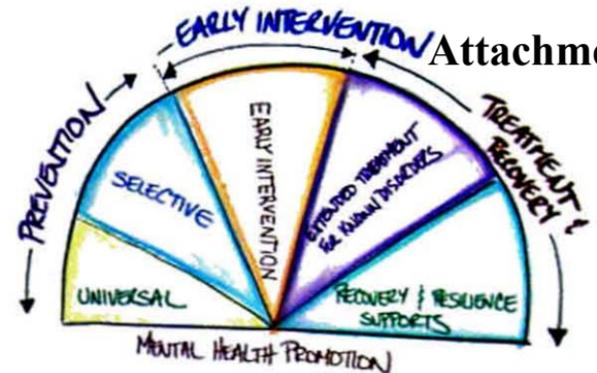
- EXPERTISE, KNOWLEDGE & EXPERIENCE HAS POSITIVELY INFLUENCED SUCCESSFUL MENTAL HEALTH SYSTEM
- B + RESOURCE + EXPERIENCE = SUCCESS
- "HELP FIRST APPROACH" IS GOOD APPROACH

**MICHELLE CALLEJAS**

- THANK YOU KATHRYN & SACRAMENTO COUNTY PEI PLAN AMENDMENT

**PEI**

SERVICES & PROGRAMS DESIGNED TO PREVENT MENTAL ILLNESS FROM OCCURRING OR FROM BECOMING MORE SEVERE & DISABLING



Attachment G

**OLD**

- FAIL FIRST
- ACCEPT LONG-TERM DISABILITY
- FOCUS ON SYMPTOMS
- LITTLE HOPE OF LEADING NORMAL LIFE
- SYSTEM DRIVEN



**NEW**

- SERVE FIRST
- WELLNESS, RECOVERY & RESILIENCE - HOPE
- FOCUS ON WHOLE PERSON
- COMMUNITY PARTICIPATION
- CLIENT/FAMILY DRIVEN

**NEED WORKPLAN TO SUCCEED**



**MUST LEVERAGE RESOURCES TO SUCCEED**



# WORKING TOGETHER TO PROMOTE WELLNESS IN SAC COUNTY



BOANNE BEWARD



★ MOVE FROM RISK FOCUS TO RESILIENCE!

## STATEWIDE 'INITIATIVES':

### SUICIDE PREVENTION



SANDRA BLACK STRATEGIC DIRECTION:

- CREATE A SYSTEM OF SUICIDE PREVENTION
- WORKFORCE & TRAINING ENHANCEMENTS
- EDUCATE COMMUNITIES TO TAKE ACTION
- PROGRAM EFFECTIVENESS & SYSTEM ACCOUNTABILITY



PLEASE CONSIDER AS YOU DEVELOP P.E.I.



## Q & A



- ▶ IS RESILIENCY PART OF COLLEGE CURRICULUM?
  - KEY PIECE AS A PROFESSOR/DUAL
  - THERAPIST MUST STILL HOPE



## ★ MAJOR MESSAGES FROM RESILIENCE RESEARCH

1. MOST PEOPLE DO MAKE IT DESPITE EXPOSURE TO RISK & ADVERSITY

3. PEOPLE MATTER!

4. IT'S HOW WE DO WHAT WE DO THAT COUNTS

- CARING RELATIONSHIPS
- MEANINGFUL PARTICIPATION
- HIGH EXPECTATIONS

2. ALL PEOPLE HAVE A RESILIENT NATURE

5. THE PROCESS OF TAPPING RESILIENCE BEGINS WITH THE BELIEF OF CARE GIVERS IN HUMAN RESILIENCE



**Countywide Services Agency**

**Department of  
Health and Human Services**

**Mental Health Services**  
Leland Tom, Director

**Mental Health Services Act**  
Michelle Callejas, MFT  
Program Manager

Terry Schutten, County Executive  
Penelope Clarke, Agency  
Administrator  
Lynn Frank, Director

## County of Sacramento

November 17, 2008

Dear System Partner:

The Mental Health Services Act (MHSA), also known as Proposition 63, was a voter initiative passed in 2004. This initiative imposes a 1% tax on all incomes over one million dollars. Revenue collected from this tax is dedicated to expanding mental health services throughout the state and transforming the public mental health system. In Sacramento County, new treatment programs were implemented through the Community Services and Supports (CSS) component of the MHSA, the first of five components of the MHSA. The Division of Mental Health planned for the CSS component through an intensive, inclusive and multi-faceted stakeholder process. We are currently engaged in a similar planning process for another component, Workforce Education and Training (WET). It is anticipated that a WET Plan will be developed and sent to the state for approval by fall. On the heels of WET planning, we are now embarking on a third stakeholder planning process for the newest component, Prevention and Early Intervention (PEI).

In September 2007, the California Department of Mental Health (DMH) issued proposed guidelines for the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan. Funding for Sacramento County will be approximately \$7.4 million annually to implement new strategies that will address key mental health needs in our community. DMH requires counties to partner with seven specific sectors and recommends that counties partner with several other sectors as well.

PEI is an unprecedented opportunity to plan services and supports that can engage individuals prior to the development of a serious mental illness or serious emotional disturbance. PEI emphasizes prevention and early intervention as key strategies to transforming California's mental health system and is critical to achieving the goal of moving toward a "help first" system.

The Division stakeholder planning process will involve gathering input on how to create a comprehensive PEI Plan that meets one or more Key Community Mental Health Needs and Priority Populations as defined by DMH. In October of 2008, the Division of Mental Health started the process by requesting ideas and opinions from the community through a community survey. Additionally, a series of community educational forums and focus groups will be held throughout the County. A PEI Task Force and workgroups will be formed to review the data and make recommendations on which strategies and programs can best meet the needs of our county.

7001-A East Parkway, Suite 300 • Sacramento, California 95823-2501 • phone (916) 875-6472 • fax (916) 875-1490  
Visit our Website at <http://www.sacdhs.com/mhsa>

PEI System Partner Input Paper  
November 14, 2008  
Page 2

Task Force recommendations will eventually go to the MHSA Steering Committee. These strategies will become the basis of new prevention and early intervention approaches and programs that will be included in our PEI plan.

In addition to the information from the survey, community educational forums and focus groups, we are requesting specific input from our system partners through what we are calling a System Partner Input Paper. Information provided in this report will provide a better understanding of what community mental health needs your organization addresses and what priority populations identified by DMH intersect with the population your organization serves. The Division will compile all the reports that are submitted and each organization that submits a report will receive a copy. We anticipate that this may be a useful tool for future collaborative efforts or grants.

To submit a System Partner Input Paper, please complete the attached forms and return no later than December 12, 2008. If you have any questions please contact Kathryn Skrabo, PEI Program Planner, at 875-4179.

**For more detailed explanations of the terms above, please review the Prevention and Early Intervention Program and Expenditure Guidelines available at:**

[http://www.dmh.ca.gov/Prop\\_63/MHSA/Prevention\\_and\\_Early\\_and\\_Intervention/default.asp](http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_and_Intervention/default.asp)

Sincerely,

Leland Tom, Director  
Division of Mental Health

Attachments



## MHSA Prevention and Early Intervention System Partner Input Paper

Thank you for taking the time to complete the System Partner Input Paper. This input will be used to assist the Division of Mental Health in better understanding services that are currently available in Sacramento County and to better define unmet community mental health needs. The report should be no more than five (5) pages. Please return this completed page and narrative input to Kathryn Skrabo, MHSA Program Planner at [skrabok@saccounty.net](mailto:skrabok@saccounty.net) by December 12, 2008. Your response makes a difference!

System/Organization

Contact Person:

Address:

Phone No:

Email address:

The California Department of Mental Health, in conjunction with the Mental Health Services Oversight and Accountability Commission (OAC), has developed a list of Key Community Mental Health Needs and Priority Populations which counties must address in their PEI Plans. Since we do not have funding to address all the needs and populations, we are seeking community and system partner input in helping to identify which needs and populations should be prioritized.

The Key Community Mental Health Needs PEI can focus on are:

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

The Priority Populations PEI can focus on are:

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

**1. Please indicate which Key Community Mental Health Needs are reflected in the population you serve (check all that apply).**

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>Unequal Access to Mental Health Services</li> <li>Psycho-Social Impact of Trauma</li> <li>At-risk Children, Youth and Young Adult Populations</li> </ul> | <ul style="list-style-type: none"> <li>Stigma and Discrimination</li> <li>Suicide Risk</li> </ul> |
|---|---|

**2. Please indicate which Priority Populations would most benefit from prevention and early intervention supports and strategies (check all that apply).**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>Underserved Cultural Populations</li> <li>Children/Youth At-Risk of School Failure</li> <li>Individuals Experiencing Onset of Serious Psychiatric Illness</li> </ul> | <ul style="list-style-type: none"> <li>Children/Youth in Stressed Families</li> <li>Individuals Exposed to Trauma</li> <li>Children/Youth At-Risk of Juvenile Justice Involvement</li> </ul> |
|---|--|

**3. What age group(s) does your organization serve or represent? (check all that apply).**

- Children & Youth (0-15)
- Transition Age Youth (16-25)
- Adults
- Older Adults (60+)



## MHSA Prevention and Early Intervention System Partner Input Paper

## Attachment I

In each of the sections listed below, please provide information that best describes your organization and the population you serve. Data will drive the PEI planning process, therefore, when possible, please reference your data sources. Completed responses and cover sheets can be submitted to Kathryn Skrabo at [skrabok@saccounty.net](mailto:skrabok@saccounty.net)

Thank you for your assistance in this important opportunity to bring prevention and early intervention services to Sacramento County!

### **Section One: Organization Background**

Please provide a brief overview of your organization and include:

- a. Mission of your organization
- b. Services provided by your organization
- c. Population served (eligibility, age, demographics, etc.)
- d. Does your organization participate in any partnerships or collaborations with other system partners and/or community-based agencies to meet the needs of the population you serve? If so, please explain.

### **Section Two: Programs and Practices**

Does your organization currently provide or contract out for mental health and/or prevention services? If so,

- a. What are the services provided?
- b. What population receives the services?
- c. Describe any evidence-based or promising practices or programs being used.
- d. If evidenced-based or promising practices or programs are being used, what have been the outcomes?

### **Section Three: Mental Health Need in Sacramento County**

Based on your response to questions 1 and 2 regarding PEI Priority Populations and Key Community Mental Health Needs (from page 1, #1 and #2), please explain how these unmet needs impact the population you serve. What data sources let you know this?

### **Section Four: Suicide Risk**

Suicide Risk is a Key Community Mental Health Need and a Statewide Initiative. What kind of infrastructure (i.e. training, technical assistance) do you think would be useful to your system in addressing suicide risk?

### **Section Five: Stigma and Discrimination**

Stigma refers to attitudes and beliefs that motivate individuals to fear, reject and avoid those who are labeled, diagnosed or perceived to have a serious mental illness. The reduction of stigma and discrimination is a Key Priority of the Mental Health Services Act and is a PEI Statewide Initiative. What does stigma and discrimination look like in the population you serve?

### **Section Six: Optional**

Is there anything else you would like us to know about your system or organization that relates to prevention and early intervention?



## **Sacramento County Mental Health Services Act**

### **Prevention and Early Intervention Community Survey**

The Sacramento County Division of Mental Health is in the process of planning for Prevention and Early Intervention programs in the community.

Prevention and Early Intervention (PEI) is a component of the California Mental Health Services Act. PEI is intended to address and reduce the risk factors and/or stressors that contribute to the onset of serious mental illness, as well as maintain the well being of individuals in the community.

This survey is intended to gather community input around needs for Sacramento County residents that will help to promote mental wellness and reduce factors that contribute to the onset of mental illness.

Your participation in this survey is appreciated and your input is critical for the Prevention and Early Intervention planning process.

Please send surveys to:

7001-A East Parkway, Suite 300  
Sacramento, CA 95823  
Attn: Dawn Williams

Or fax to:

916-876-5254

If you have any questions please contact Dawn Williams at 916-875-0832 or e-mail [williamsd@saccounty.net](mailto:williamsd@saccounty.net)

**The deadline for submitting your survey is November 14, 2008**

**If you completed the survey before, thank you for your input. Please do not complete the survey again as we are trying to avoid duplication.**

**SACRAMENTO COUNTY  
PREVENTION AND EARLY INTERVENTION  
COMMUNITY SURVEY**

**Addressing Key Community Mental Health Needs**

The State defines 5 community mental health needs that must be considered while planning for Prevention and Early Intervention. We understand ALL of these needs are important, but Sacramento County needs your opinion on the order of importance. Please rank these 5 needs in order of importance from most important (1) to least important (5).

<b>Community Mental Health Needs</b>	<b>Rank 1 through 5 (1=most important)</b>
Unequal Access to Mental Health Services (may be due to cultural factors, perceived stigma, etc.)	
Impact of Trauma (may be from exposure to factors such as domestic violence, abuse/neglect/abandonment, sexual abuse/rape, death of a loved one, homelessness, war, etc.)	
At-Risk Children, Youth and Young Adults (e.g. at risk of school failure, justice involvement, homelessness, out-of-home placement)	
Stigma and Discrimination (e.g. having a mental illness, foster youth, sexual orientation)	
Suicide Risk	

**Addressing Priority Populations**

The State defines 6 priority populations that must be considered while planning for Prevention and Early Intervention. We understand ALL of these populations are important, but Sacramento County needs your opinion on the order of importance. Please rank these 6 populations in order of importance from most important (1) to least important (6).

<b>Priority Populations</b>	<b>Rank 1 through 6 (1=most important)</b>
Underserved cultural populations	
Individuals exposed to trauma	
Individuals experiencing onset of a serious psychiatric illness	
Children/youth in stressed families	
Children/youth at risk of school failure	
Children/youth at risk of juvenile justice involvement	

**State-Administered Projects**

The State is implementing at least 3 statewide Prevention and Early Intervention projects:

- Suicide Prevention
- Stigma and Discrimination Reduction (will address discrimination impacting people’s mental health)
- Student Mental Health Initiative (will support college campuses and K-12 public schools to improve recognition and responses to students experiencing mental distress)

If Sacramento County had money to reinforce the statewide initiatives locally, would you support spending money on:

- Yes  No Suicide Prevention?
- Yes  No Stigma and Discrimination Reduction?
- Yes  No Student Mental Health Initiative?

Of the 3 initiatives, what is the order of importance for Sacramento County? Please rank these 3 statewide projects in order of importance from most important (1) to least important (3).

<b>Statewide Project</b>	<b>Rank 1 through 3 (1=most important)</b>
Suicide Prevention	
Stigma and Discrimination	
Student Mental Health Initiative	

**Community Education Forums**

As part of the community planning process for Prevention and Early Intervention, Sacramento County will be holding a series of community forums addressing key community needs and priority populations. In order to get an idea of community interest, please answer the following questions.

Would you attend community education forums?  Yes  No

If yes, please indicate those you would attend (please mark all that you are interested in).

- Suicide Risk
- Understanding Cultural Populations
- Stigma and Discrimination (statewide project)
- Children and Youth in Stressed Families
- Individuals Experiencing the Onset of Serious Psychiatric Illness
- Psycho-Social Impact of Trauma
- Children and Youth at risk of Juvenile Justice Involvement
- Student Mental Health Initiative (statewide project)
- For Youth by Youth

**Demographic Information: Please tell us about yourself**

Name (optional): \_\_\_\_\_

Today's date: \_\_\_\_\_

Your Age in Years: \_\_\_\_\_

<b>What is your Gender?</b>	<b>What is your Sexual Orientation?</b>
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay <input type="checkbox"/> Questioning <input type="checkbox"/> Lesbian <input type="checkbox"/> Decline to answer

<b>What is your Zip Code?</b> <input style="width:50px;" type="text"/>	<b>Are you a Veteran?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline
--	---

<b>What is your Race/Ethnic Background?</b>	<b>(check all that apply)</b>
<input type="checkbox"/> African American <input type="checkbox"/> American Indian/Native American <input type="checkbox"/> Bosnian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Hmong	<input type="checkbox"/> Laotian <input type="checkbox"/> Mien <input type="checkbox"/> Russian/Formal Soviet Union <input type="checkbox"/> Ukrainian <input type="checkbox"/> Vietnamese <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Other (specify _____)

<b>What is your Preferred Language?</b>	<b>(check only one)</b>
<input type="checkbox"/> American Sign Language <input type="checkbox"/> Arabic <input type="checkbox"/> Armenian <input type="checkbox"/> Cambodian <input type="checkbox"/> Cantonese <input type="checkbox"/> English <input type="checkbox"/> Farsi <input type="checkbox"/> French <input type="checkbox"/> Hebrew <input type="checkbox"/> Hmong	<input type="checkbox"/> Ilocano <input type="checkbox"/> Italian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Lao <input type="checkbox"/> Mandarin <input type="checkbox"/> Mien <input type="checkbox"/> Polish <input type="checkbox"/> Portuguese <input type="checkbox"/> Other Non-English
	<input type="checkbox"/> Other Sign Language <input type="checkbox"/> Russian <input type="checkbox"/> Samoan <input type="checkbox"/> Spanish <input type="checkbox"/> Thai <input type="checkbox"/> Turkish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other (specify _____)

<b>Who/What are you representing?</b>	<b>(check all that apply)</b>
<input type="checkbox"/> Interested community member <input type="checkbox"/> Social service provider <input type="checkbox"/> Physical health provider <input type="checkbox"/> Law enforcement <input type="checkbox"/> Drug/alcohol service provider <input type="checkbox"/> Ethnic services provider <input type="checkbox"/> Parent <input type="checkbox"/> Consumer of mental health services <input type="checkbox"/> Family member of consumer	<input type="checkbox"/> Youth serving organization <input type="checkbox"/> Elementary school teacher <input type="checkbox"/> Middle school teacher <input type="checkbox"/> High school teacher <input type="checkbox"/> County Mental Health service provider <input type="checkbox"/> Contract Mental Health service provider <input type="checkbox"/> LGBTQ community <input type="checkbox"/> Faith-based community <input type="checkbox"/> Other (specify _____)

<b>Do you have any additional comments?</b>



沙加缅度县  
精神健康法

预防和早期治疗社区问卷调查

沙加缅度县精神健康处正规划在社区进行精神疾病的预防和早期治疗。

预防和早期治疗是加利福尼亚精神健康服务法的一个组成部分。预防和早期治疗的目的是减少导致严重精神疾病的危险因素和精神压力，从而使社区的每一成员能保持健康的生活。

这个问卷调查的目的是收集沙加缅度县居民的意见，看看他们对提高精神健康生活和减少导致精神疾病的危险因素有哪一些方面的要求。

我们十分感谢你们的参与。你们的意见对预防和早期治疗的规划过程有重要的作用。

请将问卷调查寄到：

7001-A East Parkway, Suite 300  
Sacramento, Ca 95823  
Attn: Dawn Williams

或传真到：

916-876-5254

如有任何问题请联络 Dawn Williams [916-875-0832](tel:916-875-0832) 或传电邮到  
[williamsd@saccounty.net](mailto:williamsd@saccounty.net)

提交问卷调查的期限是 2008 年 11 月 14 日

如果你以前完成过这个问卷调查，我们感谢你的参与和意见。请不要再一次回答这个问卷，以免出现重复的问卷。

## 沙加缅度县 预防和早期治疗社区问卷调查

### 社区精神健康服务需要解决的主要问题

州政府规定，在精神疾病的预防和早期治疗的规划过程中，要考虑改善社区对精神健康服务五个方面的问题。我们认为这五个方面的问题都很重要，但沙加缅度县政府希望知道你对这五个问题重要性的排序。请对这五个问题的重要性进行排序，从1到5，1是最重要的，而5是最不重要的。

社区精神健康服务需要解决的问题	1 到 5 重要性排序， (1 最重要)
病人接受精神健康服务的机会不均等（可能的原因包括文化因素，被认为不正常而被歧视等）	
精神创伤的影响（可能缘由于家庭暴力，社区暴力活动的目击者或受害人，经受过暴力/被忽视/被遗弃，经受过性侵犯/强奸，亲人亡故，无家可归，战争，等等）	
有问题的儿童，青少年和年轻的成年人（包括学业失败的危险，涉及违法活动，无家可归，被离家安置）	
与精神健康有关的歧视和耻辱（家庭成员，护理人以及与精神病人同住的人被歧视）	
自杀的危险因素	

### 优先服务人群

州政府规定，在精神疾病的预防和早期治疗的规划过程中，要优先考虑社区中的六个人群。我们认为这六个人群都很重要，但沙加缅度县政府希望知道你对这六个人群重要性的排序。请对这六个人群的重要性进行排序，从1到6，1是最重要的，而6是最不重要的。

优先服务人群	1 到 6 重要性排序， (1 最重要)
服务不足的少数族裔	
受过精神创伤的人群	
正发生严重精神疾病的人	
家庭承受压力的儿童/青年	
有学业失败危险的儿童/青年	
涉及青少年犯法的儿童/青年	

**州政府管理的项目**

州政府正在实施的精神疾病预防和早期治疗项目至少有三个：

- **预防自杀**
- **减少歧视**（将关注与精神健康有关的歧视 - 对家庭成员，护理人以及与精神病人同住的人被歧视）
- **学生精神健康活动**（将支持大学校园和从育儿园到高中的公立学校，帮助它们改进对有精神压力的学生的认知和反应）。

如果沙加缅度县有资金在本县加强州政府管理的项目，你支持在下列项目上的支出吗？

- |                             |                              |           |
|-----------------------------|------------------------------|-----------|
| <input type="checkbox"/> 支持 | <input type="checkbox"/> 不支持 | 预防自杀？     |
| <input type="checkbox"/> 支持 | <input type="checkbox"/> 不支持 | 减少歧视？     |
| <input type="checkbox"/> 支持 | <input type="checkbox"/> 不支持 | 学生精神健康活动？ |

在以上三个项目中，你认为它们对沙加缅度县的重要性如何？请对这三个州项目的重要性进行排序。从 1 到 3，1 是最重要的，而 3 是最不重要的。

州政府管理的项目	1 到 3 重要性排序， (1 最重要)
预防自杀	
减少歧视	
学生精神健康活动	

**社区教育论坛**

作为社区精神疾病的预防和早期治疗规划的一部分，沙加缅度县将进行一系列的社区论坛活动，来讨论社区在精神健康服务上需要改进的方面和优先服务人群。为了获得社区的意见，请回答下述问题。

你会参加社区的教育论坛吗？  会  不会

如果你会，请指明你将参加哪一个（请标明所有你感兴趣的项目）。

- 自杀的危险因素
- 理解少数族裔
- 与精神健康有关的歧视(州政府管理的项目)
- 有压力家庭的儿童/青年
- 正发生严重精神疾病的人
- 精神创伤的社会心理影响
- 涉及青少年犯法的儿童/青年
- 学生精神健康活动(州政府管理的项目)
- 行动青年，服务青年

人口资讯：请告诉我们你的情况

姓名（可不填）： \_\_\_\_\_

今天的日期： \_\_\_\_\_

你的年龄： \_\_\_\_\_

<b>你的性别？</b>	<b>你的性取向？</b>
<input type="checkbox"/> 男性 <input type="checkbox"/> 女性 <input type="checkbox"/> 双性	<input type="checkbox"/> 异性 <input type="checkbox"/> 男性同性恋 <input type="checkbox"/> 女性同性恋 <input type="checkbox"/> 双性恋 <input type="checkbox"/> 有疑问 <input type="checkbox"/> 不想回答
你的邮政编码？ <input style="width:50px;" type="text"/>	你是退伍军人吗？ <input type="checkbox"/> 是 <input type="checkbox"/> 不是 <input type="checkbox"/> 不回答
<b>你的族裔文化背景？</b> (标明所有适合你情况的)	
<input type="checkbox"/> 非裔美国人 <input type="checkbox"/> 美洲印第安人/土著人 <input type="checkbox"/> 波黑人 <input type="checkbox"/> 柬埔寨人 <input type="checkbox"/> 华人 <input type="checkbox"/> 西班牙裔/拉丁美裔人 <input type="checkbox"/> 棉蒙人 <input type="checkbox"/> 老挝人	<input type="checkbox"/> 苗裔人 <input type="checkbox"/> 俄罗斯/前苏联人 <input type="checkbox"/> 乌克兰人 <input type="checkbox"/> 越南人 <input type="checkbox"/> 白人 <input type="checkbox"/> 其他 (说明 _____)
<b>你喜欢的语言？</b> (只选一种)	
<input type="checkbox"/> 美国手语 <input type="checkbox"/> 阿拉伯语 <input type="checkbox"/> 阿美尼亚语 <input type="checkbox"/> 柬埔寨语 <input type="checkbox"/> 广东话 <input type="checkbox"/> 英语 <input type="checkbox"/> 法斯语 <input type="checkbox"/> 法语 <input type="checkbox"/> 希伯来语 <input type="checkbox"/> 棉蒙语	<input type="checkbox"/> 依洛卡诺语 <input type="checkbox"/> 意大利语 <input type="checkbox"/> 日语 <input type="checkbox"/> 朝鲜语 <input type="checkbox"/> 老挝语 <input type="checkbox"/> 普通话/国语 <input type="checkbox"/> 苗语 <input type="checkbox"/> 波兰语 <input type="checkbox"/> 葡萄牙语 <input type="checkbox"/> 其他非英语
<b>你所代表的组织/团体？</b> (标明所有适合你情况的)	
<input type="checkbox"/> 感兴趣的社区成员 <input type="checkbox"/> 社会服务人员 <input type="checkbox"/> 身体健康服务人员 <input type="checkbox"/> 执法部门 <input type="checkbox"/> 戒药/戒酒服务人员 <input type="checkbox"/> 族裔文化服务人员 <input type="checkbox"/> 家长 <input type="checkbox"/> 精神病人 <input type="checkbox"/> 精神病人的家人	<input type="checkbox"/> 青年服务组织 <input type="checkbox"/> 小学老师 <input type="checkbox"/> 初中老师 <input type="checkbox"/> 高中老师 <input type="checkbox"/> 县心理健康医务人员 <input type="checkbox"/> 心理健康合同医务人员 <input type="checkbox"/> 同性恋社区 <input type="checkbox"/> 信仰社区组织 <input type="checkbox"/> 其他 (说明 _____)
<b>你还有其他意见吗？</b>	



**Cheeb Nroog Sacramento  
Txoj Cai Txhawb Kev Puas Hlwb**

**Tsab Ntawv Tshawb Fawb Txog Kev Tiv Thaiv thiab Kev Cuam Tshuam  
Thaum Tseem Ntxov**

Cheeb Nroog Sacramento Fab Txhawb Kev Puas Hlwb tab tom npaj cov Kev Pab Tiv Thaiv thiab Kev Cuam Tshuam Thaum Tseem Ntxov rau hauv lub zej zog.

Kev Pab Tiv Thaiv thiab Kev Cuam Tshuam Thaum Tseem Ntxov (Prevention and Early Intervention) (PEI) yog ib feem ntawm California Txoj Cai Txhawb Kev Puas Hlwb (Mental Health Services Act). PEI yog tsim los pab thiab txo cov teeb meem thiab/los yog cov kev nyuab siab uas tsuam ntxiv rau txoj kev puas hlwb loj, nrog rau txoj kev noj qab haus huv ntawm cov tib neeg hauv lub zej zog.

Tsab ntawv tshawb fawb no yog sau lub zej zog cov ncauj lus qhia txog cov kev tu ncu ntawm cov neeg pej xeeb nyob rau hauv Cheeb Nroog Sacramento kom pab txhawb tau txoj kev noj qab haus huv ntawm lub siab lub ntsws thiab txo cov kev tsuam ntxiv rau txoj kev puas hlwb.

Peb txaus siab rau koj txoj kev koom tes nrog txoj kev tshawb fawb no thiab koj cov ncauj lus tseem ceeb heev rau cov txheej txheem npaj cov Kev Pab Tiv Thaiv thiab Kev Cuam Tshuam Thaum Tseem Ntxov.

Thov xa tsab ntawv tshawb fawb rau:  
7001 –A East Parkway. Chav 300  
Sacramento, CA 95823  
Los yog Fax rau:  
916-876-5254

Yog koj muaj lus nug thov hu rau Dawn Williams ntawm 916-875-0832 los yog xa email rau willians@saccounty.net

Hnub kawg ua yuav xa tsab ntawv tsawb fawb yog Lub kaum ib hli 14, 2008

**Yog koj twb teb cov lus tshawb fawb no dhau los lawm, ua koj tsaug rau koj cov ncauj lus. Thov tsis txhob teb cov lus tshawb fawb dua vim peb tsis xav tau tib cov lus teb qub.**

**CHEEB NROOG SACRAMENTO  
TSAB NTAWV TSHAWB FAWB TXOG  
KEV TIV THAIV THIAB KEV CUAM TSHUAM THAUM TSEEM NTXOV**

**Hais Txog Cov Kev Tu Ncuu Tseem Ceeb Ntawm Txoj Kev Puas Hlwb Hauv Lub Zej Zog**

Lub Xeev pom muaj 5 yam kev tu ncuu tseem ceeb ntawm txoj kev puas hlwb uas yuav tsum muab los xam txog thaum npaj cov Kev Tiv Thaiv thiab Kev Cuam Tshuam Thaum Tseem Ntxov. Peb to taub hais tias TAG NRHO cov kev tu ncuu no yeej tseem ceeb heev, tiam sis Cheeb Nroog Sacramento xav paub hais tias yam twg tseem ceeb tshaj rau koj yog muab lawv los cim sib law liag. Thov cim raws li qib tseem ceeb rau koj uas qhov tseem ceeb tshaj (cim 1) mus rau qhov tsis tseem ceeb tshaj (cim 5).

<b>Cov Kev Puas Hlwb Hauv Lub Zej Zog</b>	<b>Cim 1 txog 5 (1=tseem ceeb tshaj)</b>
Kev Cuag Cov Kev Pab Rau Txoj Kev Puas Hlwb Tsis Sib Luag (tej zaum yog tim kab lis kev cai ntawm cov haiv neeg, kev xav phem, thiab tej yam li ntawd)	
Puas Nrog Kev Raug Mob Raug Ntshai Loj (tej zaum los ntawm kev sib ceg sib ntaus hauv lub tsev neeg, pom los yog raug neeg hauv zej zog ua phem rau, tsim txom/tsis saib xyuas/tsis yuav, raug kev yuam ua dev ua npua/mos deev, ib tug hlub tuag, txoj kev tsis muaj tsev nyob, tsov rog, thiab tej yam li ntawd)	
Cov Me Nyuam, Cov Hluas thiab Cov Neeg Loj Muaj Feem Ntsib Teeb Meem (xws li muaj feem yuav kawm ntawv poob, koom kev ua phem txhaum cai, txoj kev tsis muaj tsev nyob, raug tshem tawm tsev)	
Kev Xav Phem thiab Kev Ntxub Ntxaug (txuam nrog txoj kev puas hlwb – rau cov neeg hauv tsev, cov neeg zov thiab cov neeg muaj kev puas hlwb)	
Muaj Feem Xav Txov Tus Kheej Txoj Sia	

**Hais Txog Cov Hom Neeg**

Lub Xeev pom muaj 6 hom neeg uas yuav tsum muab los xam txog thaum npaj cov Kev Tiv Thaiv thiab Kev Cuam Tshuam Thaum Tseem Ntxov. Peb to taub hais tias TAG NRHO cov hom neeg no yeej tseem ceeb heev, tiam sis Cheeb Nroog Sacramento xav paub hais tias yam twg tseem ceeb tshaj rau koj yog muab lawv los cim sib law liag. Thov cim raws li qib tseem ceeb rau koj uas qhov tseem ceeb tshaj (cim 1) mus rau qhov tsis tseem ceeb tshaj (cim 6).

<b>Cov Hom Neeg Tseem Ceeb</b>	<b>Cim 1 txog 6 (1=tseem ceeb tshaj)</b>
Cov neeg pab tsis cuag	
Cov neeg raug kev mob kev ntshai loj	
Cov neeg muaj kev puas siab ntsws loj heev	
Cov me nyuam/cov hluas nyuab siab hauv cov tsev neeg	
Cov me nyuam/cov hluas muaj feem yuav kawm ntawv poob	
Cov me nyuam/cov hluas muaj feem yuav koom kev ua phem txhaum cai	

Lub Xeev yuav muaj 3 txoj Kev Tiv Thaiv thiab Kev Cuam Tshuam Thaum Tseem Ntxov thoob plaws hauv lub xeev :

- Kev Tiv Thaiv Kev Txov Tus Kheej Txoj Sia
- Kev Txo Cov Kev Xav Phem thiab Kev Ntxub Ntxaug (yuav pab txog cov kev xav phem thiab kev ntxub ntxaug uas txuam nrog txoj kev puas hlwb – rau cov neeg hauv tsev, cov neeg zov thiab cov neeg muaj kev puas hlwb)
- Kev Pab Neeg Kawm Ntawv Txoj Kev Puas Hlwb (yuav txhawb cov tsev kawm ntawv qib siab thiab cov tsev kawm ntawv qib K-12 kom ras paub txog thiab muab kev pab rau cov neeg kawm ntawv uas muaj kev nyuab siab nyuab ntsws)

Yog hais tias Cheeb Nroog Sacramento muaj nyiaj los muab cov kev pab no rau cov pej xeev hauv lub zos, koj pom zoo kom muab cov nyiaj siv rau:

- Yog  Tsis yog Kev Tiv Thaiv Kev Txov Tus Kheej Txoj Sia?
- Yog  Tsis yog Kev Txo Cov Kev Xav Phem thiab Kev Ntxub Ntxaug?
- Yog  Tsis yog Kev Pab Neeg Kawm Ntawv Txoj Kev Puas Hlwb?

Ntawm 3 txoj kev pab no, koj xav hais tias qhov twg tseem ceeb tshaj rau Cheeb Nroog Sacramento, yog muab tso sib law liag? Thov cim qhia raws li qib tseem ceeb rau koj uas qhov tseem ceeb tshaj (cim 1) mus rau qhov tsis tseem ceeb tshaj (3).

<b>Txoj Kev Pab Thoob Hauv Lub Xeev</b>	<b>Cim 1 txog 3 (1=tseem ceeb tshaj)</b>
Kev Tiv Thaiv Kev Txov Tus Kheej Txoj Sia	
Kev Txo Cov Kev Xav Phem thiab Kev Ntxub Ntxaug	
Kev Pab Neeg Kawm Ntawv Txoj Kev Puas Hlwb	

**ZeJ Zog Neeg Sib Tham Txog Kev Kawm Ntawv**

Tam li ib feem ntawm cov txheej txheem npaj Kev Tiv Thaiv thiab Kev Cuam Tshuam Thaum Tseem Ntxov, Cheeb Nroog Sacramento yuav muaj ntau lub rooj rau cov zej zog neeg sib tham txog cov kev tu ncuat tseem ceeb thiab cov hom neeg tseem ceeb. Kom paub tswv yim txog cov neeg zej zog lub siab nyiam, thov teb cov nqe lus nug nram no.

Koj puas kam koom nrog cov neeg zej zog sib tham txog kev kawm ntawv?  Kam  Tsis kam

Yog kam, thov qhia seb cov twg yog cov koj xav koom nrog (thov kos tag nrho cov koj txaus siab rau).

- Muaj Feem Xav Txov Tus Kheej Txoj Sia
- To Taub Txog Cov Kab Lis Kev Cai Ntawm Cov Haiv Neeg
- Kev Xav Phem thiab Kev Ntxub Ntxaug (thoob hauv lub xeev)
- Cov me nyuam thiab cov hluas nyuab siab hauv cov tsev neeg
- Cov neeg muaj kev puas siab ntsws loj heev
- Puas Nrog Kev Raug Mob Raug Ntshai Los Rau Lub Siab Ntsws thiab Kev Sib Raug Zoo
- Cov me nyuam thiab cov hluas muaj feem yuav koom kev ua phem txhaum cai
- Kev Pab Neeg Kawm Ntawv Txoj Kev Puas Hlwb (thoob hauv lub xeev)
- Rau Cov Hluas los ntawm Cov Neeg Hluas

Npe (nyob ntawm siab yeem): \_\_\_\_\_

Hnub tim rau hnub no: \_\_\_\_\_

Koj Lub Hnub Nyoog: \_\_\_\_\_

<p><b>Koj yog hom neeg dab tsi?</b></p> <p><input type="checkbox"/> Txiv neej  <input type="checkbox"/> Poj niam  <input type="checkbox"/> Poj niam txiv neej ua ke</p>	<p><b>Koj Yeem Kev Sib Deev Li Cas?</b></p> <p><input type="checkbox"/> Poj niam deev txiv neej/txiv neej deev poj niam  <input type="checkbox"/> Txiv neej deev txiv neej  <input type="checkbox"/> Poj niam deev poj niam</p> <p><input type="checkbox"/> Poj niam deev txiv neej thiab poj niam tib si/txiv neej deev poj niam txiv neeg tib si  <input type="checkbox"/> Xav paub  <input type="checkbox"/> Tsis teb</p>	
<p><b>Koj tus Zip Code yog dab tsi?</b> <input style="width: 50px;" type="text"/></p>	<p><b>Koj Puas Yog Qub Tub Rog?</b></p> <p><input type="checkbox"/> Yog <input type="checkbox"/> Tsis yog <input type="checkbox"/> Tsis teb</p>	
<p><b>Koj Yog Hom Neeg/Haiv Neeg Twg? (kos txhua hom uas yog)</b></p>		
<p><input type="checkbox"/> Neeg Asmeskas Dub  <input type="checkbox"/> Neeg Asmeskas Khab/Neeg Asmeskas Txawm Teb Chaws  <input type="checkbox"/> Bosnian  <input type="checkbox"/> Cambodian  <input type="checkbox"/> Neeg Suav  <input type="checkbox"/> Neeg Mev Hispanic/Latino  <input type="checkbox"/> Neeg Hmoob  <input type="checkbox"/> Neeg Nplog</p>	<p><input type="checkbox"/> Neeg Co  <input type="checkbox"/> Russian/Soviet Union Thaum Ub  <input type="checkbox"/> Ukrainian  <input type="checkbox"/> Neeg Nyab Laj  <input type="checkbox"/> Neeg Dawb/Neeg Asmeskas  <input type="checkbox"/> Lwm hom (qhia tseeb _____)</p>	
<p><b>Hom Lus Koj Yeem Siv Hais Yog (tsuas kos ib yam xwb) Dab Tsi?</b></p>		
<p><input type="checkbox"/> Piav Tes Lus Asmeskas  <input type="checkbox"/> Arabic  <input type="checkbox"/> Armenian  <input type="checkbox"/> Cambodian  <input type="checkbox"/> Cantonese  <input type="checkbox"/> Lus Askiv  <input type="checkbox"/> Farsi  <input type="checkbox"/> Lus Fab Kis  <input type="checkbox"/> Hebrew  <input type="checkbox"/> Lus Hmoob</p>	<p><input type="checkbox"/> Ilocano  <input type="checkbox"/> Italian  <input type="checkbox"/> Lus Nyij Pooj  <input type="checkbox"/> Lus Kaus Lim  <input type="checkbox"/> Lus Nplog  <input type="checkbox"/> Mandarin  <input type="checkbox"/> Lus Co  <input type="checkbox"/> Polish  <input type="checkbox"/> Portuguese  <input type="checkbox"/> Lwm yam Lus Tsis                  Yog Lus Askiv</p>	<p><input type="checkbox"/> Lwm Yam Lus Piav Tes  <input type="checkbox"/> Russian  <input type="checkbox"/> Samoan  <input type="checkbox"/> Lus Mev  <input type="checkbox"/> Lus Thaib  <input type="checkbox"/> Turkish  <input type="checkbox"/> Lus Nyab Laj  <input type="checkbox"/> Lwm yam (qhia tseeb _____)</p>
<p><b>Koj sawv cev rau leej twg/hom dab tsi? (kos txhua hom uas yog)</b></p>		
<p><input type="checkbox"/> Neeg zej zog uas txaus siab  <input type="checkbox"/> Chaw pab kev noj kev haus rau pej xeem  <input type="checkbox"/> Chaw pab kev kho lub cev  <input type="checkbox"/> Tub ceev xwm  <input type="checkbox"/> Chaw pab txiav tshuaj yeeb/dej caw  <input type="checkbox"/> Chaw pab lwm haiv neeg  <input type="checkbox"/> Niam txiv  <input type="checkbox"/> Neeg tau cov kev pab txhawb kev puas hlwb  <input type="checkbox"/> Ib tug hauv lub tsev neeg uas muaj tus tau cov kev pab</p>	<p><input type="checkbox"/> Lub koom haum pab neeg hluas  <input type="checkbox"/> Xib fwb qhia ntawv qib elementary  <input type="checkbox"/> Xib fwb qhia ntawv qib nruab nrab  <input type="checkbox"/> Xib fwb qhia ntawv qib High school  <input type="checkbox"/> Cheeb Nroog Chaw Txhawb Kev Puas Hlwb  <input type="checkbox"/> Chaw Cog Lus Muab Kev Txhawb Rau Kev Puas Hlwb  <input type="checkbox"/> Zej zog neeg LGBTQ  <input type="checkbox"/> Zej zog neeg ntseeg ntuj  <input type="checkbox"/> Lwm hom (qhia tseeb _____)</p>	
<p><b>Koj puas muaj lwm cov ncauj lus dab tsi ntxiv?</b></p>		



**Округ Сакраменто  
Закон о психиатрическом обслуживании**

**Опрос общественности по вопросам  
профилактики и раннего вмешательства**

Отдел психического здоровья округа Сакраменто в настоящее время разрабатывает программы профилактики и раннего вмешательства.

Профилактика и раннее вмешательство является частью Закона штата Калифорния о психическом обслуживании. Данные программы призваны снизить факторы риска и стресса, влияющие на возникновение серьезных психических заболеваний, а также поддерживать здоровье населения.

Целью данного опроса является сбор информации и мнений жителей округа Сакраменто относительно мероприятий, которые способствуют психическому здоровью и снижают факторы, ведущие к психическим заболеваниям.

Мы благодарим вас участие в данном опросе. Ваше мнение является очень важным для планирования программ профилактики и раннего вмешательства.

**Пожалуйста высылайте заполненные формы опроса не позже 14-го ноября, 2008 по адресу:**

7001-A East Parkway, Suite 300  
Sacramento, CA 95823  
Att: Dawn Williams

Или по факсу:  
916-876-5254

С вопросами обращайтесь к Dawn Williams по тел.(916)875-0832 или e-mail [williamsd@saccony.net](mailto:williamsd@saccony.net)

**Если вы уже приняли участие в опросе, мы благодарим вас за это. Пожалуйста, не заполняйте анкету опроса во второй раз. Мы хотим избежать дублирования мнений.**

**ОКРУГ САКРАМЕНТО  
ПРОФИЛАКТИКА И РАННЕЕ ВМЕШАТЕЛЬСТВО  
ОПРОС ОБЩЕСТВЕННОГО МНЕНИЯ**

**Решение основных потребностей психического здоровья населения**

Правительство штата определяет 5 потребностей психического здоровья, которые необходимо учитывать при планировании профилактики и раннего вмешательства. Мы понимаем, что ВСЕ эти потребности являются важными. В то же время, округу Сакраменто нужно ваше мнение по поводу степени их важности. Пожалуйста, оцените важность этих 5 потребностей, от самой важной (1) до наименее важной (5).

<b>Потребности психического здоровья населения</b>	<b>Степень важности (1 – 5) (1= самая важная)</b>
Нравный доступ к услугам психического здоровья (возможно, по причине культурных факторов, предрассудков и т.п.)	
Последствия травмы (возможно, как следствие домашнего насилия, акта насилия в общине, отказа от ухода, сексуального насилия, смерти близкого человека, бездомности, войны и т.п.)	
Дети, подростки и молодые люди, находящиеся в группе риска (например, угроза исключения из школы, конфликта с законом, бездомности, изъятия из семьи)	
Предрассудки и дискриминация (связанные с психическими расстройствами – по отношению к членам семьи, обслуживающему персоналу и лицам с психическими расстройствами)	
Риск самоубийства	

**Приоритетные группы населения**

Правительство штата определяет 6 приоритетных групп населения, интересы которых необходимо учитывать при планировании профилактики и раннего вмешательства. Мы понимаем, что ВСЕ эти группы являются важными. В то же время, округу Сакраменто нужно ваше мнение по поводу степени их важности. Пожалуйста, оцените важность этих 6 групп населения, от самой важной (1) до наименее важной (6).

<b>Приоритетные группы населения</b>	<b>Степень важности (1 – 6) (1= самая важная)</b>
Недостаточно обслуживаемые этнические группы	
Лица, подверженные травмам	
Лица с начальными стадиями психических заболеваний	
Дети/подростки в проблемных семьях	
Дети/подростки, находящиеся под угрозой исключения из школ	
Дети/подростки под угрозой конфликта с правосудием для несовершеннолетних	

**Проекты, реализуемые правительством штата**

Правительство штата реализует как минимум 3 проекта профилактики и раннего вмешательства по всему штату:

- Предотвращение самоубийств
- Ликвидация предрассудков и дискриминации (направленная на предрассудки и дискриминацию, связанные с психическими расстройствами – по отношению к членам семьи, обслуживающему персоналу и лицам с психическими расстройствами)
- Психическое здоровье учащихся (помощь колледжам и государственным школам в улучшении понимания и помощи учащимся с психическими расстройствами)

Если бы у правительства округа Сакраменто появились средства на местную поддержку вышеуказанных проектов штата, вы бы поддержали выделение денег на:

- Да  Нет Проект предотвращения самоубийств?
- Да  Нет Проект ликвидации предрассудков и дискриминации?
- Да  Нет Проект психического здоровья учащихся?

Какова, по вашему мнению, степень важности трех вышеуказанных проектов для округа Сакраменто? Пожалуйста, оцените важность этих 3 проектов, от самого важного (1) до наименее важного (3).

Проект правительства штата	Степень важности (1 – 6) (1= самый важный)
Предотвращение самоубийств	
Ликвидация предрассудков и дискриминации	
Психическое здоровье учащихся	

**Общественные образовательные форумы**

Составной частью общественного процесса планирования профилактики и раннего вмешательства округ Сакраменто видит проведение серии общественных форумов для приоритетных групп населения по рассмотрению основных потребностей населения. Ваши ответы на следующие вопросы дадут нам представление об интересах населения.

Посетили бы вы общественные образовательные форумы?  Да  Нет

Если да, укажите те, которые бы вы посетили (отметьте интересующую вас тему).

- Риск самоубийства
- Понимание этнических групп
- Предрассудки и дискриминация (проект штатного уровня)
- Дети и подростки в проблемных семьях
- Лица с начальными стадиями серьезных психических заболеваний
- Психо-социальные последствия травм
- Дети/подростки под угрозой конфликта с правосудием для несовершеннолетних
- Психическое здоровье учащихся (проект штатного уровня)
- Для молодежи от молодежи

**Демографическая информация: пожалуйста, расскажите о себе**

Имя и фамилия (не обязательно): \_\_\_\_\_

Сегодняшняя дата: \_\_\_\_\_

Ваш возраст: \_\_\_\_\_

<b>Ваш пол</b>		<b>Ваша сексуальная ориентация</b>	
<input type="checkbox"/> Мужчина	<input type="checkbox"/> Женщина	<input type="checkbox"/> Гетеросексуалист	<input type="checkbox"/> Бисексуалист
<input type="checkbox"/> Трансгендер		<input type="checkbox"/> Гомосексуалист	<input type="checkbox"/> Под вопросом
		<input type="checkbox"/> Лесбиянка	<input type="checkbox"/> Отказываюсь отвечать
<b>Ваш почтовый индекс</b> _____	<b>Являетесь ли вы военным ветераном?</b>		
	<input type="checkbox"/> Да <input type="checkbox"/> Нет <input type="checkbox"/> отказываюсь отвечать		
<b>Каково ваше расовое/этническое происхождение? (отметьте то, что относится к вам)</b>			
<input type="checkbox"/> Афроамериканец	<input type="checkbox"/> Американский индеец	<input type="checkbox"/> Босниец	<input type="checkbox"/> Камбоджиец
<input type="checkbox"/> Китаец	<input type="checkbox"/> Латиноамериканец	<input type="checkbox"/> Монг	<input type="checkbox"/> Лаосец
<input type="checkbox"/> Мьян	<input type="checkbox"/> Русский / бывший Советский Союз	<input type="checkbox"/> Украинец	<input type="checkbox"/> Вьетнамец
<input type="checkbox"/> Белый	<input type="checkbox"/> Смешанная раса (укажите _____)	<input type="checkbox"/> Другое (укажите _____)	
<b>Какой ваш основной язык? (отметьте только один)</b>			
<input type="checkbox"/> Американский язык глухонемых	<input type="checkbox"/> Арабский	<input type="checkbox"/> Армянский	<input type="checkbox"/> Камбоджийский
<input type="checkbox"/> Кантонский	<input type="checkbox"/> Английский	<input type="checkbox"/> Фарси	<input type="checkbox"/> Французский
<input type="checkbox"/> Иврит	<input type="checkbox"/> Монг	<input type="checkbox"/> Илоканский	<input type="checkbox"/> Итальянский
<input type="checkbox"/> Японский	<input type="checkbox"/> Корейский	<input type="checkbox"/> Лаосский	<input type="checkbox"/> Мандаринский
<input type="checkbox"/> Мьян	<input type="checkbox"/> Польский	<input type="checkbox"/> Португальский	<input type="checkbox"/> Другой неанглийский
<input type="checkbox"/> Другой язык глухонемых	<input type="checkbox"/> Русский	<input type="checkbox"/> Самоанский	<input type="checkbox"/> Испанский
<input type="checkbox"/> Тайский	<input type="checkbox"/> Турецкий	<input type="checkbox"/> Вьетнамский	<input type="checkbox"/> Другой (укажите _____)
<b>Кто вы? Кого вы представляете? (отметьте все, что к вам относится)</b>			
<input type="checkbox"/> Заинтересованный представитель общественности	<input type="checkbox"/> Социальный работник	<input type="checkbox"/> Медицинский работник	<input type="checkbox"/> Работник правоохранительных органов
<input type="checkbox"/> Работник служб по борьбе с алкоголем и наркотиками	<input type="checkbox"/> Работник этнических служб	<input type="checkbox"/> Родитель	<input type="checkbox"/> Клиент психиатрических услуг
<input type="checkbox"/> Член семьи клиента психиатрических услуг	<input type="checkbox"/> Представитель организации, обслуживающей молодежь	<input type="checkbox"/> Учитель младших классов (Elementary School)	<input type="checkbox"/> Учитель средних классов (Middle School)
	<input type="checkbox"/> Учитель старших классов (High School)	<input type="checkbox"/> Работник психиатрической службы округа	<input type="checkbox"/> Работник независимой психиатрической службы
	<input type="checkbox"/> Представитель сексуальных меньшинств	<input type="checkbox"/> Представитель религиозной общины	<input type="checkbox"/> Другое (укажите _____)
<b>Ваши дополнительные замечания</b>			



## Condado de Sacramento Acta de Servicios de Salud Mental

### Encuesta Comunitaria de Prevención e Intervención A Tiempo

La División de Salud Mental del Condado de Sacramento está realizando el proceso de planeación comunitaria para los Programas de Intervención y Prevención A Tiempo

La Intervención y Prevención A Tiempo (PEI siglas en inglés) es un componente del Acta de Servicios de Salud Mental de California. PEI tiene la intención de tratar y reducir los factores de riesgo y/o problemas que contribuyen al desarrollo de enfermedades mentales serias, así como también de mantener el bienestar de los individuos en la comunidad.

El propósito de esta encuesta es la de coleccionar información por parte de la comunidad acerca de las necesidades de los residentes del Condado de Sacramento lo cual ayudarán a promover el bienestar mental y reducir los factores que contribuyen al incremento de las enfermedades mentales.

Su participación en esta encuesta es crítica y su opinión es apreciada para el planeamiento del proceso de Intervención y Prevención A Tiempo.

Favor de enviar la encuesta a:  
7001-A East Parkway, A Suite 300  
Sacramento, CA 995823  
Atención a: Dawn Williams

O haga un Fax a:  
(916) 876-5254

Si tiene preguntas favor de comunicarse con Dawn Williams al número (916) 875-0832  
O escriba a su correo electrónico a: [williamsd@saccounty.net](mailto:williamsd@saccounty.net)

**La fecha límite para entregar esta encuesta es Noviembre 14, 2008**  
**Si usted completó la encuesta anteriormente, gracias por su participación. Por favor no complete esta encuesta de nuevo ya que estamos tratando de evitar duplicaciones.**

**EL CONDADO DE SACRAMENTO**  
**Encuesta Comunitaria de**  
**Prevención e Intervención A Tiempo**

**Considerando las Necesidades Claves de Salud Mental de la Comunidad**

El Estado define 5 necesidades comunitarias de salud mental que deben ser consideradas mientras se planea la Intervención y Prevención a Tiempo. Sabemos que TODAS las necesidades son importantes, pero el Condado de Sacramento necesita su opinión en orden de importancia. Favor de categorizar estas 5 necesidades en orden de importancia de la más importante (1) a la menos importante (5)

<b>Necesidades Comunitarias de Salud Mental</b>	<b>Categoría 1 a 5</b> (1=más importante)
Acceso Desigual a Servicios de Salud Mental (Puede ser a causa de factores culturales, estigma percibido, etc.)	
Impacto de Trauma (puede ser por haber experimentado factores como violencia doméstica, testigo o víctima de un acto comunitario de violencia, abuso/negligencia/abandono, abuso sexual/violación, muerte de una persona querida, desamparo, guerra, etc.)	
Niños, Jóvenes y Adultos Jóvenes en Riesgo (ejemplo: a riesgo de fracaso en la escuela, problemas con la justicia, jóvenes sin lugar donde vivir, viviendo fuera del hogar familiar)	
Estigma y Discriminación (padeciendo de enfermedades mentales, jóvenes viviendo en hogares del cuidado por parte de la corte, orientación sexual)	
Riesgo de Suicidio	

**Considerando las Poblaciones Prioritarias**

El Estado define 6 poblaciones como prioritarias que deben ser consideradas mientras se planea la Intervención y Planeación A Tiempo. Sabemos que TODAS estas poblaciones son importantes, pero el Condado de Sacramento necesita su opinión en orden de importancia. Favor de darle categoría a estas 6 poblaciones en orden de importancia de la más importante (1) a la menos importante (6).

<b>Poblaciones Prioritarias</b>	<b>Categoría 1 a 6</b> (1=más importante)
Poblaciones culturales que reciben pocos servicios	
Individuos expuestos a trauma	
Individuos experimentando enfermedades siquiátricas por primera vez	
Niños/jóvenes en familias problemáticas	
Niños/jóvenes con riesgo de fracasar en la escuela	
Niños/jóvenes a riesgo de implicarse con la justicia juvenil	

**Proyectos Administrados por el Estado**

El Estado está implementando por lo menos 3 proyectos en todo el Estado para Intervención y Prevención A Tiempo

- Prevención de Suicidio
- Reducción de Estigma y Discriminación (se considerará la discriminación que impacta la salud mental de las personas )
- Iniciativa de Salud Mental de los Estudiantes (apoyaremos recintos universitarios y escuelas públicas K-12 para improvisar reconocimiento y la respuesta a estudiantes que están experimentando problemas mentales)

Si el Condado de Sacramento tuviera dinero para reforzar iniciativas a nivel Estatal localmente, usted apoyaría el gasto del dinero en:

- Sí  No ¿Prevención de Suicidio?
- Sí  No ¿Reducción de Estigma y Discriminación?
- Sí  No ¿Iniciativa de Salud Mental Estudiantil?

De estas 3 iniciativas, ¿cual piensa usted que es el orden de importancia para el Condado de Sacramento? Favor de categorizar estos 3 proyectos Estatales en orden de importancia del más importante (1) al menos importante (3).

Proyecto Estatal	Categoría 1 a 3 (1=mas importante)
Prevención de Suicidio	
Discriminación y Estigma	
Iniciativa de Salud Mental Estudiantil	

**Foros de Educación Comunitarios**

Como parte del proceso de planeación comunitaria para Prevención e Intervención A Tiempo, el Condado de Sacramento va a tener una serie de foros comunitarios considerando las necesidades claves de la comunidad y la prioridad de las poblaciones. Para tener una idea sobre el interés comunitario, favor de contestar las siguientes preguntas.

¿Usted atendería foros de educación comunitaria?  Sí  No

Si respondió sí, favor de indicar los que usted atendería (favor de marcar los que usted esté interesado(a)).

- Riesgo de Suicidio
- Entendiendo las diferentes Poblaciones Culturales
- Estigma y Discriminación (proyecto estatal)
- Niños/jóvenes en familias en familias problemáticas
- Individuos experimentando el inicio de una serie de enfermedades siquiátricas
- Impacto de Trauma o problemas Psicosociales
- Niños y Jóvenes con riesgo de implicarse con la Justicia Juvenil
- Iniciativa de Salud Mental Estudiantil (proyecto estatal)

**Información Demográfica: Por favor díganos sobre usted**

Nombre (opcional): \_\_\_\_\_

Fecha de hoy: \_\_\_\_\_

Su Edad en Años: \_\_\_\_\_

<b>¿Cuál es su Género?</b>		<b>¿Cuál es su Orientación Sexual?</b>	
<input type="checkbox"/> Masculino	<input type="checkbox"/> Femenino	<input type="checkbox"/> Transexual	
<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Gay	<input type="checkbox"/> Lesbiana	<input type="checkbox"/> Bisexual
			<input type="checkbox"/> Indeciso
			<input type="checkbox"/> Prefiero no contestar
<b>¿Cuál es su Código Postal?</b> <input style="width: 100px;" type="text"/>		<b>¿Usted es Veterano(a)?</b>	
		<input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> Declino	
<b>¿Cuál es su Raza/ Etnicidad?</b>		<b>(marque todos los que apliquen)</b>	
<input type="checkbox"/> Afro Americano	<input type="checkbox"/> Indio Americano/Americano Nativo	<input type="checkbox"/> Bosnio	<input type="checkbox"/> Camboyano
<input type="checkbox"/> Chino	<input type="checkbox"/> Hispano/Latino	<input type="checkbox"/> Hmong	<input type="checkbox"/> Laosiano
<input type="checkbox"/> Mien	<input type="checkbox"/> Ruso(a)/Anteriormente llamado Unión Soviética	<input type="checkbox"/> Ucraniano	<input type="checkbox"/> Vietnamita
<input type="checkbox"/> Blanco/Anglosajón	<input type="checkbox"/> Otro (especifique _____)		
<b>¿Cual es su lengua preferida? (solamente marque una)</b>			
<input type="checkbox"/> Lengua de signos Americana	<input type="checkbox"/> Árabe	<input type="checkbox"/> Armenio	<input type="checkbox"/> Camboyano
<input type="checkbox"/> Cantonés	<input type="checkbox"/> Inglés	<input type="checkbox"/> Farsi	<input type="checkbox"/> Francés
<input type="checkbox"/> Hebreo	<input type="checkbox"/> Hmong	<input type="checkbox"/> Ilocano	<input type="checkbox"/> Italiano
<input type="checkbox"/> Japonés	<input type="checkbox"/> Coreano	<input type="checkbox"/> Lao	<input type="checkbox"/> Mandarín
<input type="checkbox"/> Mien	<input type="checkbox"/> Polaco	<input type="checkbox"/> Portugués	<input type="checkbox"/> Otro No-Inglés
<input type="checkbox"/> Otra Lengua de Signos	<input type="checkbox"/> Ruso	<input type="checkbox"/> Samoano	<input type="checkbox"/> Español
<input type="checkbox"/> Tailandés	<input type="checkbox"/> Turco	<input type="checkbox"/> Vietnamita	<input type="checkbox"/> Otro (especifique _____)
<b>¿A Quién/Qué está representando? (marque todos los que apliquen)</b>			
<input type="checkbox"/> Miembro interesado de la comunidad	<input type="checkbox"/> Proveedor de servicios sociales	<input type="checkbox"/> Proveedor de salud física	<input type="checkbox"/> Aplicación de Ley
<input type="checkbox"/> Proveedor de servicios de drogas/alcohol	<input type="checkbox"/> Proveedor de servicios étnicos	<input type="checkbox"/> Padre/Madre de familia	<input type="checkbox"/> Cliente de servicios de salud mental
<input type="checkbox"/> Miembro de familia del cliente	<input type="checkbox"/> Organización sirviendo a la juventud	<input type="checkbox"/> Maestro (a) de escuela primaria	<input type="checkbox"/> Maestro (a) de escuela secundaria
	<input type="checkbox"/> Maestro (a) de escuela preparatoria	<input type="checkbox"/> Proveedor de Salud Mental del Condado	<input type="checkbox"/> Proveedor Contratista de Salud Mental
	<input type="checkbox"/> Comunidad LGBTQ	<input type="checkbox"/> Comunidad basada en la Fe	<input type="checkbox"/> Otro (especifique _____)
<b>¿Tiene comentarios adicionales?</b>			



**Luật Thuộc Về Dịch Vụ Sức Khỏe Tâm Thần của  
Quận Hạt Sacramento**

**Cuộc Khảo Sát Cộng Đồng Về Vấn Đề Ngăn Chặn và Can Thiệp Sớm**

Cơ Quan Phục Vụ Sức Khỏe Tâm Thần của Quận Sacramento đang dự tính cho những chương trình Phòng Bệnh và Ngăn Bệnh Sớm trong cộng đồng.

Chương trình Ngăn Chặn và Can Thiệp Sớm (PEI) là một phần của những dự tính nằm trong Chương Trình Phục Vụ Sức Khỏe Tâm Thần của California. PEI có định ý để quan tâm và giảm bớt những vấn đề rủi ro và/ hay những sự căng thẳng về tinh thần- điều góp phần tạo ra sự khởi đầu mạnh mẽ của những căn bệnh tâm thần nghiêm trọng, và duy trì sự khỏe mạnh của mỗi cá nhân trong cộng đồng.

Cuộc khảo sát này có định ý để tập hợp ý kiến của cộng đồng nhằm cung cấp thông tin xung quanh các nhu cầu cho người cư trú ở quận hạt Sacramento, điều này sẽ thúc đẩy sự tốt đẹp về tinh thần và giảm bớt những vấn đề mà góp phần trở thành những căn bệnh tâm thần.

Sự tham gia của bạn trong cuộc khảo sát này được hoan nghênh và ý kiến của bạn rất là quan trọng cho quá trình dự kiến của chương trình Ngăn Chặn và Can Thiệp Sớm.

Xin bạn gửi bản khảo sát này tới :

7001-A East Parkway, Suite 300  
Sacramento, CA. 95823  
Attn : Dawn Williams

Hoặc fax tới : (916) 876-5254

Nếu bạn cần thêm chi tiết xin liên lạc Dawn Williams (916)875-0832 hay e-mail cho [williamssd@saccounty.net](mailto:williamssd@saccounty.net)

Ngày chót để gửi bản khảo sát này là Ngày 14 Tháng 11 Năm 2008

**Cám ơn bạn về việc cung cấp tài liệu. Nếu bạn đã hoàn tất cuộc khảo sát trước đó, để tránh những vấn đề trùng hợp, xin bạn vui lòng đừng làm lại cuộc khảo sát này.**

**Cuộc Khảo Sát Cộng Đồng Về Vấn  
Đề Ngăn Chặn và Can Thiệp Sớm  
của Quận Hạt Sacramento**

**Sự Lưu Ý Những Nhu Cầu Sức Khỏe Tâm Thần Cần Thiết Trong Cộng Đồng**

Tiểu Bang xác định 5 vấn đề cần thiết cho sức khỏe tâm thần trong cộng đồng phải được xem xét trong kế hoạch của Ngăn Chặn và Can Thiệp Sớm. Chúng tôi hiểu **TẤT CẢ** sự cần thiết này là quan trọng, những Quận Hạt Sacramento cần ý kiến của bạn theo trình tự sắp xếp quan trọng. Xin vui lòng sắp xếp 5 nhu cầu này theo một thứ tự quan trọng từ cái quan trọng nhất (1) đến ít quan trọng nhất (5).

<b>Điều Cần Thiết Về Sức Khỏe Tâm Thần Trong Cộng Đồng</b>	<b>Sắp Xếp Từ 1 đến 5 (quan trọng nhất=1)</b>
Dịch Vụ Sức Khỏe Tâm Thần Không Đồng Đều (có thể vì các nhân tố văn hóa, nhận thấy sự lãng mạ về vấn đề này, và vân vân.)	
Kết Quả của Sự Khích Động (có thể từ đụng đoạt những yếu tố như bạo lực trong gia đình, chứng kiến hoặc là nạn nhân của bạo lực, sự ngược đãi/thờ ơ/ruồng bỏ, sự lạm dụng/cưỡng đoạt tình dục, cái chết của người yêu, vô gia cư, chiến tranh và vân vân.)	
Trẻ Em, Thiếu Niên và Thanh Niên Đang Có Nguy Cơ (Học hành thất bại , khó khăn liên quan đến pháp lý, vô gia cư, bị bắt buộc lia gia đình)	
Sự Lãng Mạ và Sự Đối Xử Phân Biệt (liên quan với bệnh tâm thần – đối với các thành viên trong gia đình mắc bệnh tâm thần, trẻ mồ côi, hoặc vì khác giới)	
Rủi Ro Tự Sát	

**Sự Lưu Ý Các Dân Cư Ưu Tiên**

Tiểu Bang xác định 6 dân số ưu tiên phải được xem xét trong kế hoạch của vấn đề Phòng Bệnh và Ngăn Bệnh Sớm. Chúng tôi hiểu **TẤT CẢ** dân số là quan trọng, nhưng Quận Hạt Sacramento cần ý kiến của bạn theo trình tự sắp xếp quan trọng. Vui lòng sắp xếp 6 dân số này theo một thứ tự quan trọng từ cái quan trọng nhất (1) đến ít quan trọng nhất (6).

<b>Những Dân Số Ưu Tiên</b>	<b>Sắp Xếp Từ 1 đến 6 (quan trọng nhất=1)</b>
Các nền văn hóa thiếu sự phục vụ	
Những người bị kích động	
Những người đang trải bị bệnh tâm lí nghiêm trọng	
Trẻ em/thanh niên sống trong những gia đình có sự căng thẳng	
Trẻ em/thanh niên gặp khó khăn trong việc học bị thất bại	
Trẻ em/thanh niên gặp khó khăn liên quan đến pháp lý vì thành niên	

Tiểu Bang đang thi hành ít nhất 3 dự án Ngăn Chặn và Can Thiệp Sớm toàn bang:

- Ngăn Chặn Tự Sát
- Việc Thu Hẹp Sự Lãng Mạ và Phân Biệt Đối Xử (liên quan với bệnh tâm thần – đối với các thành viên trong gia đình, người chăm sóc và những cá nhân mắc bệnh tâm thần)
- Giải Quyết Sức Khỏe Tâm Thần cho Sinh Viên (sẽ hỗ trợ cho những trường đại học và trường công K-12 để cải thiện sự nhận thức và hưởng ứng của những sinh viên đang trải qua những đau đớn tinh thần)

Nếu chính quyền Quận Hạt Sacramento có kinh phí để củng cố hành động giải quyết khắp bang, bạn sẽ ủng hộ tiền cho:

- Có  Không Ngăn Chặn Tự Sát?
- Có  Không Thu Hẹp Sự Lãng Mạ và Phân Biệt Đối Xử?
- Có  Không Giải Quyết Sức Khỏe Tâm Thần Cho Sinh Viên

Trong 3 cách giải quyết này, bạn nghĩ như thế nào về trình tự quan trọng của chúng cho Quận Hạt Sacramento? Vui lòng sắp xếp 3 dự án mang tính phổ biến toàn ban này theo một trình tự quan trọng từ cái quan trọng nhất (1) đến ít quan trọng nhất (3).

<b>Kế Hoạch Toàn Bang</b>	<b>Sắp Xếp Từ 1 đến 3</b> (quan trọng nhất=1)
Ngăn Chặn Tự Sát	
Sự Lãng Mạ và Phân Biệt Đối Xử	
Giải Quyết Sức Khỏe Tâm Thần cho Sinh Viên	

**Diễn Đàn Giáo Dục Cộng Đồng**

Như một phần nằm trong tiến trình kế hoạch cộng đồng của vấn đề Ngăn Chặn và Can Thiệp Sớm, Quận Hạt Sacramento đang tổ chức một loạt diễn đàn cộng đồng gửi nhận xét về những nhu cầu cần thiết trong cộng đồng và dân cư ưu tiên. Để biết ý kiến cho lợi ích cộng đồng, vui lòng trả lời những câu hỏi sau.

Bạn sẽ tham dự những diễn đàn giáo dục cộng đồng không?  Có  Không

Nếu có, làm ơn chỉ những việc bạn sẽ tham gia (xin đánh dấu vào những vấn đề bạn thích).

- Rủi Ro Tự Sát
- Cư Dân Văn Hóa
- Sự Lãng Mạ và Phân Biệt Đối Xử (dự án toàn bang)
- Trẻ Em và Thanh Niên Sống Trong Những Gia Đình Có Tính Căng Thẳng
- Những Người Đang Bị Bệnh Tâm Lí Nghiêm Trọng
- Chấn Thương Từ tác Động Tâm Lý Xã Hội
- Trẻ Em hay Thanh Niên Gặp Khó Khăn Liên Quan Đến Pháp Lý Vị Thành Niên
- Sức Khỏe Tinh Thần cho Sinh Viên ( dự án toàn bang)
- Cho Thanh Niên Bồi Thanh Niên

**Thông Tin Lý Lịch: Vui lòng nói cho chúng tôi biết về bạn**

**Attachment O**

Tên (không bắt buộc): \_\_\_\_\_

Ngày Hiện Tại: \_\_\_\_\_

Bạn Bao Nhiêu Tuổi: \_\_\_\_\_

<b>Giới tính của bạn?</b>		<b>Thiên hướng tình dục của bạn?</b>	
<input type="checkbox"/> Nam	<input type="checkbox"/> Nữ	<input type="checkbox"/> Chuyển đổi giới tính	
<input type="checkbox"/> Người tình dục khác giới	<input type="checkbox"/> Đồng tính nam	<input type="checkbox"/> Đồng tính nữ	
<input type="checkbox"/> Người lưỡng tính	<input type="checkbox"/> Mang tính dò hỏi	<input type="checkbox"/> Từ chối trả lời	
<b>Mã vùng của bạn?</b> <input style="width: 50px;" type="text"/>		<b>Bạn có phải là cựu chiến binh?</b>	
		<input type="checkbox"/> Có <input type="checkbox"/> Không <input type="checkbox"/> Từ chối	
<b>Bạn thuộc chủng tộc/dân tộc nào?</b>		<b>(Ghi nhận tất cả những cái thích hợp)</b>	
<input type="checkbox"/> Mỹ gốc Phi	<input type="checkbox"/> Mỹ gốc Á/ Mỹ bản xứ	<input type="checkbox"/> Bosnian	<input type="checkbox"/> Campuchia
<input type="checkbox"/> Trung quốc	<input type="checkbox"/> Mễ/Nam Mỹ	<input type="checkbox"/> Hmong	<input type="checkbox"/> Lào
<input type="checkbox"/> Miến điện	<input type="checkbox"/> Nga/ Liên bang Xô Viết cũ	<input type="checkbox"/> Ucraina	<input type="checkbox"/> Việt Nam
<input type="checkbox"/> Người da trắng/ Cap ca	<input type="checkbox"/> Chủng tộc khác (ghi rõ _____)		
<b>Ngôn ngữ ưa thích của bạn?</b>		<b>(chỉ ghi nhận một ngôn ngữ)</b>	
<input type="checkbox"/> Ngôn ngữ kí hiệu của Mỹ	<input type="checkbox"/> Arap	<input type="checkbox"/> Ac-me-ni	<input type="checkbox"/> Tiếng Campuchia
<input type="checkbox"/> Tiếng Quảng đông	<input type="checkbox"/> Anh	<input type="checkbox"/> Farsi	<input type="checkbox"/> Pháp
<input type="checkbox"/> Hebrew	<input type="checkbox"/> Hmong	<input type="checkbox"/> Ilocano	<input type="checkbox"/> Ý
<input type="checkbox"/> Nhật Bản	<input type="checkbox"/> Hàn quốc	<input type="checkbox"/> Lao	<input type="checkbox"/> Tiếng Quan thoại
<input type="checkbox"/> Miến Điện	<input type="checkbox"/> Ba Lan	<input type="checkbox"/> Bồ Đào Nha	<input type="checkbox"/> Khác tiếng Anh
<input type="checkbox"/> Ngôn ngữ kí hiệu khác	<input type="checkbox"/> Nga	<input type="checkbox"/> Samoan	<input type="checkbox"/> Tây Ban Nha
<input type="checkbox"/> Thái lan	<input type="checkbox"/> Thổ Nhĩ Kỳ	<input type="checkbox"/> Việt Nam	<input type="checkbox"/> Ngôn ngữ khác (ghi rõ _____)
<b>Bạn đại diện cho ai/tổ chức nào?</b>		<b>(ghi nhận tất cả những cái thích hợp)</b>	
<input type="checkbox"/> Thành viên cộng đồng có liên quan	<input type="checkbox"/> Nhà cung cấp dịch vụ xã hội	<input type="checkbox"/> Nhà cung cấp về dịch vụ sức khỏe thể chất	<input type="checkbox"/> Hội tuân thủ pháp luật
<input type="checkbox"/> Người phân phối dịch vụ rượu/ma túy	<input type="checkbox"/> Nhà cung cấp dịch vụ liên quan đến dân tộc	<input type="checkbox"/> Cha mẹ	<input type="checkbox"/> Khách hàng của dịch vụ sức khỏe tinh thần
<input type="checkbox"/> Thành viên gia đình của khách hàng	<input type="checkbox"/> Các tổ chức phục vụ thanh niên	<input type="checkbox"/> Giáo viên trường sơ cấp	<input type="checkbox"/> Giáo viên trường trung cấp
	<input type="checkbox"/> Giáo viên trường trung học	<input type="checkbox"/> Nhà cung cấp dịch vụ sức khỏe tinh thần của Quận	<input type="checkbox"/> Nhà thầu cung cấp dịch vụ sức khỏe tinh thần
	<input type="checkbox"/> Cộng đồng LGBTQ	<input type="checkbox"/> Cộng đồng thuộc về cơ sở niềm tin	<input type="checkbox"/> Thành phần khác ( ghi rõ _____)
<b>Bạn có muốn đóng góp những nhận xét bổ sung hay không?</b>			

## Prevention and Early Intervention (PEI) Community Educational Forums

The PEI Community Educational Forums are informational dialogs intended to highlight the Key Community Mental Health Needs and Priority Populations established by the California Department of Mental Health for the PEI component of the Mental Health Services Act. Each county, through a community stakeholder process, is required to narrow its focus and select the Key Community Needs and Priority Populations that are considered the most important by that community.

Each Community Educational Forum will provide information about the selected needs and populations related to each forum. These forums are one of several ways the Division of Mental Health is collecting community input and data to assist in determining what Key Community Mental Health Needs and Priority Populations are most important to the Sacramento community.

### Forum # 1 –Suicide Risk

November 18, 2008, 2:30 – 5:00 pm  
Coloma Community Center  
4623 T Street  
Sacramento, CA 95819

### Forum # 2 – Underserved Cultural Populations

December 18, 2008, 2:30 – 5:00 pm  
Voter Registration and Elections  
7000 65th Street, Suite A  
Sacramento, CA 95823

### Forum # 3 – Children and Youth in Stressed Families

January 20, 2009, 2:30 – 5:30 pm  
Elks Lodge #6  
6446 Riverside Boulevard  
Sacramento, CA 95831

### Forum # 4 – Individuals Experiencing Onset of Serious Psychiatric Illness

January 28, 2009, 5:30 – 8:00 pm  
Department of Health and Human Services  
Conference Room 1  
7001-A East Parkway, Sacramento, CA 95823

### Forum # 5 – Psycho-Social Impact of Trauma

February 2, 2009, 5:30 – 8:00 pm  
Department of Human Assistance  
2700 Fulton Avenue  
Sacramento, CA 95825

### Forum # 6 – Children and Youth At-Risk of Juvenile Justice Involvement

February 17, 2009, 2:30 – 5:00 pm  
Oak Park Community Center  
3425 Martin Luther King Jr. Boulevard  
Sacramento, CA 95817

### Forum # 7 – Stigma and Discrimination

February 25, 2009, 5:30 – 8:00 pm  
Department of Human Assistance  
2450 Florin Road  
Sacramento, CA 95822

### Forum # 8 – For Youth, By Youth

March 6, 2009, 5:30 – 8:00 pm  
Oak Park Community Center  
3415 Martin Luther King, Jr. Boulevard  
Sacramento, CA 95817

**Important Note:** Due to budget cuts, the Division will be unable to provide food or beverages at these Forums.

**If you wish to attend and need to arrange for an interpreter or a reasonable accommodation, please contact Mary Drain one week prior to each meeting at (916) 875-4639 or [DrainM@SacCounty.net](mailto:DrainM@SacCounty.net).**

Questions? Email us at [MHSA@SacCounty.net](mailto:MHSA@SacCounty.net) or call (916) 875-MHSA

Visit our Website at [www.sacdhs.com/MHSA](http://www.sacdhs.com/MHSA)

# MHSA

PREVENTION & EARLY INTERVENTION (PEI)

- COMMUNITY FORUM • DEC 18, 2008 •
- UNDERSERVED CULTURAL POPULATIONS •



## OVERVIEW OF DISPARITIES IN ACCESSING SERVICES

DR. DEEB-SOSSA

▶ UNDERSERVED PRIMARILY POOR MINORITIES TRYING TO SUCCEED WITH LITTLE GOVT HELP

### CHALLENGES FOR CALIFORNIA

- ▶ POVERTY RATES - AMERICAN INDIAN PARTICULARLY HARD HIT
- ▶ MANY LANGUAGES - Hmong
- ▶ FINANCIAL BURDENS - AFRICAN AMERICAN
- ▶ UNDERUTILIZATION OF MENTAL HEALTH SERVICES
- ▶ GEOGRAPHIC ISOLATION
- ▶ SOCIAL & CULTURAL BARRIERS

### SOME BARRIERS

- LACK OF AVAILABILITY
- LACK OF AWARENESS
  - STIGMA
- GEOGRAPHIC ISOLATION
- LACK OF CONTINUITY
- LEGAL STATUS
- NO CULTURAL/LANGUAGE SERVICES
- BARRIERS W/IN MH SYSTEM
- AFFORDABILITY

### RECOMMENDATIONS

- ID NEEDS OF COMMUNITY
- SUSTAINABLE RELATIONSHIPS
- COLLABORATION
  - ADDRESS PAST / PRESENT TRAUMA
- BUILD HOSTING COMMUNITY MEETS
- INTEGRATED SERVICE
- BROADEN SCOPE OF PREVENTION

## PANEL DISCUSSION



### Attachment Q

▶ FA KOU VANG → Hmong MENTAL HEALTH / WELLNESS

▶ UNIQUE FACTORS TO ADDRESS:

- RELIGIOUS BELIEFS
- DEPRESSION/ANXIETY
- ACCESS CHALLENGES
- STIGMA
- LANGUAGE BARRIERS

▶ MAURINE HUANG → REFUGEE MENTAL HEALTH

▶ UNIQUE FACTORS TO ADDRESS:

- "AFRAID" TO GO "HOME" (1. COUNTRY)
- LOSS OF SENSE OF SELF
- NEW CULTURE
- POST-TRAUMATIC STRESS
- RESETTLEMENT EXPERIENCE
- HORRORS OF PAST
- SMALL REFUGEE POPULATIONS (LANGUAGE ISSUES)
- FRIENDS / FAMILY IN "HOME" COUNTRY

▶ MARBELLA SALA → CENTER FOR REDUCING HEALTH DISPARITIES PROGRAM MANAGER

▶ UNIQUE FACTORS TO ADDRESS IN LATINO POPULATION

- VERY DIVERSE POPULATION
- FEELING OF ISOLATION (IMPACTS CHILDREN)
- MISTRUST
- DISCRIMINATION
- FAMILY DISRUPTION
- LOSS OF IDENTITY
- STRESS (FINANCIAL) RESOURCE
- FEAR OF DEPORTATION
- DRUGS
- LACK OF TRANSPORTATION
- LONG HOURS AT WORK
- STIGMA

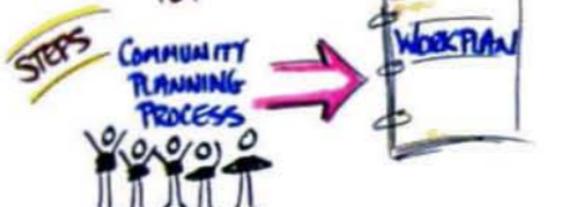
## WELCOME: MHSA & PEI OVERVIEW

MHSA = TRANSFORMING MENTAL HEALTH SYSTEM

▶ PEI: KEY TO TRANSFORMATION

- ◆ SERVE FIRST
- ◆ INCREASE AWARENESS
- ◆ BUILD COMMUNITY CAPACITY
- ◆ EMOTIONAL HEALTH AS IMPORTANT AS PHYSICAL HEALTH

▶ REDUCING DISPARITIES IS KEY ELEMENT OF PEI

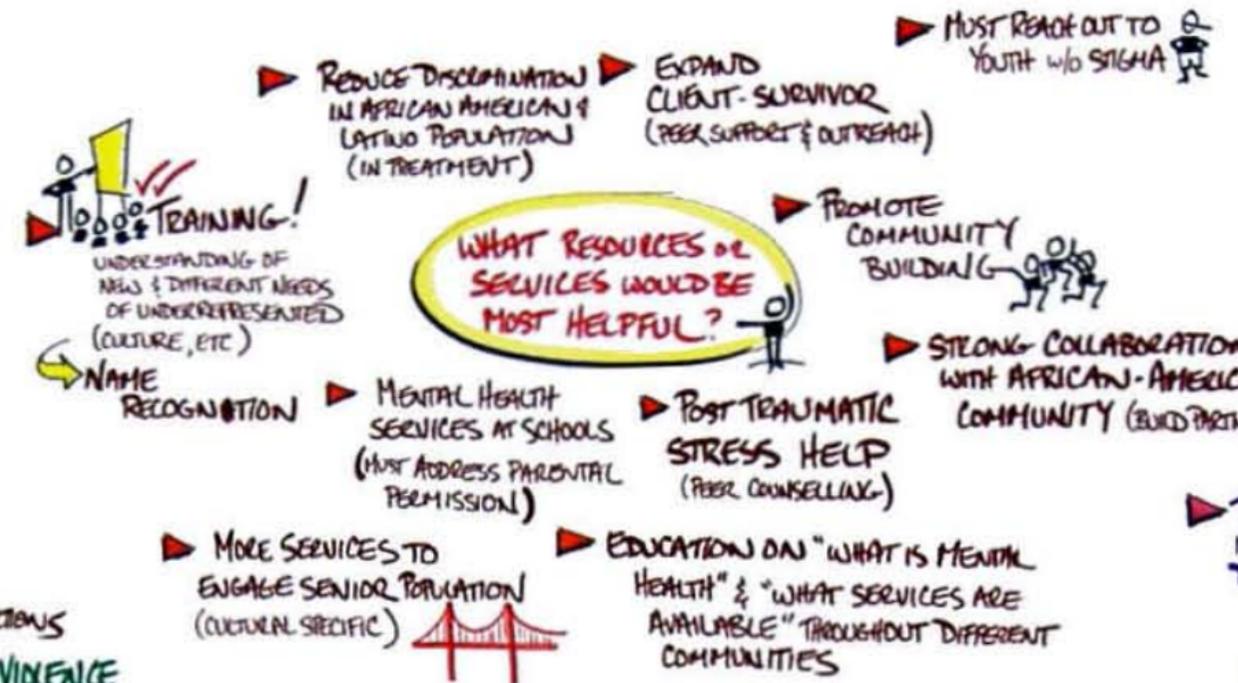


Sacramento County PEI Plan Amendment

# Q & A

# Attachment Q

- NEED TO BUILD COLLABORATIVE PARTNERSHIPS
- SAME ISSUES WERE PRESENT 40-50 YEARS AGO  
- DIFFERENT GROUPS, SAME ISSUES
- DON'T FORGET ABOUT REFUGEES w/ SMALL POPULATIONS
- NEED PROFESSIONALS WHO ARE COMPETENT & CAN BUILD RELATIONSHIPS
- CAN SHAMANS BE FORMALLY INCORPORATED?  
- THERE ARE EXAMPLES OF THIS IN CENTRAL VALLEY  
- NEED TO BE EDUCATED IN WESTERN MEDICAL INTERACTIONS
- AFRICAN AMERICAN YOUTH IMPACTED BY VIOLENCE  
- ALSO IMPACTS HISPANICS



**MENTAL HEALTH SERVICES ACT**  
 PREVENTION & EARLY INTERVENTION  
 COMMUNITY FORUM #7  
**STIGMA & DISCRIMINATION**  
 2/25/09

**STIGMA & DISCRIMINATION OVERVIEW**  
 BY LAUREL HILDRED

PowerPoint Provided



- VIOLENCE & ABUSE
- DISCRIMINATION IN HOUSING
- EDUCATION SYSTEM
- EMPLOYMENT
- MEDIA

- INTERNALIZED STIGMA
  - ISOLATION
  - SUBSTANCE ABUSE
  - SUICIDE
- MANY FACE MULTIPLE OPPRESSIONS
  - RACISM
  - LANGUAGE
  - INAPPROP. SERVICES
- FOSTER YOUTH

■ FAMILY MEMBERS & CAREGIVERS

■ MENTAL HEALTH SYSTEM

**SOME LESSONS LEARNED**

- ◆ BUILD UNITY
- ◆ ADVOCATES
- ◆ CONTACT STRATEGIES
- ◆ STIGMA REDUCTION STRATS.
- ◆ RESEARCH-BASED PRACTICE

**DELPHINE BRODY**  
 CONSUMER PERSPECTIVE  
 PowerPoint Provided

- STRATEGIES FOR TRANSFORMATION
  - NEW RESEARCH (CLIENT DRIVEN QUALITATIVE)
  - CLIENT LED TRAININGS
  - ESTABLISH TRUST
  - PROTECT CLIENTS RIGHTS
  - TRANSFORM SYSTEM
    - SELF-DIRECTED DECISION MAKING
    - MAJOR STRUCTURAL CHANGES

**MARILYN HILLERMAN**  
 ADULT FAMILY PERSPECTIVE

- MY JOURNEY
  - DAUGHTER STARTED EXPERIENCING BI-POLAR SYMPTOMS @ 25
  - GOOD NEWS = THANKFUL FOR PEOPLE WHO HELPED (FAMILY, LAW ENFORCEMENT, PROFESSIONALS, STRANGERS)
  - BAD = STIGMA/DISCRIMINATION
    - IGNORANCE, INTOLERANCE, BAD ASSUMPTIONS, UNSOLICITED ADVICE OVERLOAD, 'CONTROL' ISSUES, ABUSIVE BEHAVIOR
    - ANTIQUATED PROCESSES - CALLED OUT CONSUMERS



**VICKIE MENDOZA**  
 CHILD FAMILY PERSPECTIVE

- 3 CHILDREN DIAGNOSED WITH MENTAL HEALTH ISSUES
  - DAUGHTER HAS BEEN SUICIDAL
  - SON BI POLAR
- DISCRIMINATION = BAD ADVICE FROM DOCTOR, "BE A BETTER MOM"
- ENDED UP EDUCATING LOCAL JUDGE
- FAMILY & FRIENDS DIDN'T UNDERSTAND - WOULD AVOID HOUSE
- EDUCATE! PEOPLE, POLICE, FAMILY & COMMUNITY

**JESUS SANCHEZ**  
 LGBTQ PERSPECTIVE

- "LARRY" MURDERED FOR ASKING MALE FRIEND TO BE HIS VALENTINE
- MOST LGBTQ YOUTH FELT STIGMATIZED, DEPRESSED



- NEED MORE ATTENTION ON LGBTQ ISSUES
  - RESOURCES/SERVICES
  - ACCESS
  - RACIAL DIVERSITY (SUPPORT)
  - SUPPORT w/in COMMUNITIES OF COLOR
  - DEMYSTIFY
  - TRAIN COMMUNITY, TEACHERS
  - VISIBILITY OF SUPPORT & SERVICES

**OLGA BIRGANIS**  
 FORMER SLMIC PERSPECTIVE

- HANDLES MENTAL HEALTH CASES (IMMIGRANTS)
- ISSUES:
  - LANGUAGE BARRIERS
  - NO SUPPORT WITHIN THEIR COMMUNITY
  - LOSS OF IDENTITY
  - BAD ASSUMPTION OF MH PROFESSIONALS
  - LIMITED SERVICE DUE TO LANGUAGE GAPS
  - NOT FAMILIAR WITH "SYSTEM"
  - FEAR - NOT AWARE OF CONFIDENTIALITY

SHARED DECISION MAKING WITH LIVED EXPERIENCES

CONTACT STRATEGIES (e.g. SPEAKER BUREAUS)

AT LOCATIONS w/ OLDER ADULTS

Resources @ Attachment R/ HOSPITALS

EQUAL ACCESS CHANGES

Resources & Education for PERSON WHO HAS M.H. ILLNESS (IN ADDITION TO COMMUNITY) BY CONSUMERS FOR CONSUMERS

NEED DATA SPLIT OUT FOR ETHNIC GROUPS

PRIMARY CARE

PRIMARY CARE HAS MORE M.H. SERVICES (ACCESS ISSUE)

WHAT RESOURCES WOULD BE MOST HELPFUL?

CLIENT/FAMILY FULLY EMPLOYED

WHERE SHOULD RESOURCES BE LOCATED?

COMMUNITY

SCHOOLS MORE COUNSELORS

SERVICES FOR OLDER ADULTS

TRAUMA INFORMED SERVICES

PRE SCHOOL & ELEMENTARY SCHOOL (SERVICE FOR CHILDREN)

TRAINING w/w MENTAL HEALTH SYSTEM

EDUCATION (SEX ED) FOR LG-BTQ YOUTH - LOOKING FOR STATEWIDE POLICY CHANGE

MENTOR FOR LG-BTQ YOUTH - HOW DO YOU DO THIS? - LIABILITY ISSUES

TRAINING FOR OLDER ADULTS

JOB WORKSITE FOR SUICIDE PREVENTION

LAW ENFORCEMENT SHOULDN'T RESPOND TO M.H. ISSUES

COMMUNITY BASED ETHNIC SERVICING AGENCIES

Faith BASED AGENCIES

TRAINING!

MORE COUNSELORS AT SCHOOL (MORE AVAILABILITY & EXPERIENCE w/ M.H.) CULTURALLY APPROPRIATE - TRAINED ON LGBT TERMS

FOR SERVICE PROVIDERS - INTEGRATED TRAINING - SPECIALIZED TRNG (FOR PSYCHIATRIST esp) FOR ETHNIC COMMUNITIES - FOR PROVIDERS BY ETHNIC COMMUNITIES

EDUCATE IMMIGRANT COMMUNITIES - BIOLOGICAL MODELS - CONFIDENTIALITY



**Mental Health Services Act  
Prevention and Early Intervention (PEI)**

**Phase II Kick-Off Meeting  
October 1, 2009, 6:30 – 8:30pm  
Scottish Rite Masonic Center  
6151 H Street  
Sacramento, CA 95819**

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**WELCOME**

Michelle Callejas, MFT, Program Manager, Mental Health Services Act

**OPENING COMMENTS**

Mary Ann Bennett, Director, Division of Mental Health

**PEI OVERVIEW**

Michelle Callejas, MFT, Program Manager, Mental Health Services Act

**DATA REVIEW**

Tracy Herbert, Ph.D., Program Manager, Research, Evaluation and Performance Outcomes

**QUESTIONS AND COMMUNITY COMMENT**

**PHASE II PLANNING**

Michelle Callejas, MFT, Program Manager, Mental Health Services Act

**QUESTIONS AND COMMUNITY COMMENT**

**Sacramento County, Division of Mental Health  
Mental Health Services Act  
Prevention and Early Intervention Overview**

**Background**

Prevention and Early Intervention (PEI) is one of five main components of the Mental Health Services Act (MHSA). The Division of Mental Health is continuing an extensive community planning process to determine how MHSA dollars dedicated to PEI should be spent to meet the needs in our community. Requirements for PEI planning are clearly defined by the State Department of Mental Health (DMH) and the state Mental Health Services Oversight and Accountability Commission (OAC).

**What is the purpose of the Prevention and Early Intervention component?**

PEI approaches in and of themselves are transformational in the way they restructure the mental health system to adopt a “help-first” approach. MHSA calls for an approach to prevention that is integrated, accessible, culturally competent, strength-based, effective, and that targets investments with the aim of avoiding costs (in human suffering and resources) for longer-term treatment services.

**PREVENTION**

The Prevention element in the MHSA PEI guidelines is defined as the following: “Prevention in mental health involves reducing risk factors or stressors, building protective factors and skills, and increasing support.” The intent of the PEI component is to engage persons prior to the development of a serious mental illness or serious emotional disturbance. Prevention promotes positive cognitive, social and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances.

Prevention interventions may be classified according to their target groups:

- **Universal** strategies target the general public or a whole population that has not been identified on the basis of individual risk.
- **Selective** strategies target individuals or a subgroup whose risk of developing mental illness is significantly higher than average.

**EARLY INTERVENTION**

An Early Intervention strategy addresses a condition early in its manifestation, is of relatively low intensity, short in duration (usually less than one year), and has the goal of supporting well-being in major life domains and avoiding the need for more extensive mental health services.

**What are the PEI Key Community Mental Health Needs defined by the State and OAC?**

- **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 Adults:** PEI efforts will increase prevention efforts and response to early signs of emotional and behavioral health problems among specific at-risk populations.
- **Stigma and Discrimination:** PEI efforts will reduce stigma and discrimination affecting individuals with mental health illness, mental health problems or a social/emotional/behavioral disorder and/or for seeking services and supports for mental health issues.
- **Suicide Risk:** PEI will increase public knowledge about the signs of suicide risk and appropriate actions to prevent suicide.

### Who are the Priority Populations that can be served?

- 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 being members of ethnically/racially diverse communities; gay, lesbian, bisexual, transgender communities, etc.) and would benefit from PEI programs and interventions.
- Individuals Experiencing Onset of Serious Psychiatric Illness (all ages): 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. *Examples include*: older adults experiencing onset of depression, new mothers experiencing onset of post-partum depression, children/youth that may be experiencing suicidal ideation, and individuals experiencing signs and symptoms that are indicative of high risk for psychotic illness.
- Children/Youth in Stressed Families: Children and youth placed out of home or those in families where there is substance abuse, violence, depression or other mental illnesses or lack of care-giving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems. *Examples include*: Children/youth exposed to trauma stressors or adverse childhood experiences such as childhood abuse, neglect, homelessness, which is correlated with alcoholism, alcohol abuse, depression, intimate partner violence, multiple sex partners, sexually transmitted diseases, and suicide attempts.
- Trauma-Exposed (all ages): Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service. *Examples include*: Those exposed to child or domestic abuse, neglect, enduring deprivation, isolation, poverty, homelessness, violence (personal or witnessed), racism, discrimination, intergenerational or historical trauma.
- Children/Youth at Risk for School Failure: Children and youth at risk of school failure due to emotional and behavioral problems. *Examples include*: School-based prevention and youth development interventions which have proven to be most effective when increasing personal and social assets while at the same time, improving the quality of the environment in which students are educated.
- Children/Youth at Risk of 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 programs. *Examples include*: Programs implemented by cross-system collaborations or partnerships among systems/agencies/community based organizations; programs that involve the entire family such as family skill building, family therapy, and positive youth development.

### PEI Projects/Plans must incorporate the following PEI Principles:

- MHSAs Five Essential Elements;
  - Community Collaboration
  - Cultural Competence
  - Client/Family Driven
  - Wellness, Recovery, and Resiliency
  - Integrated Service Experience for Clients/Families
- Leverage Resources and Funding Sources including ones not typically identified as mental health;
- Reduce Disparities by providing culturally competent and linguistically appropriate programs, providing programs in natural settings (such as schools, churches, primary care clinics), and utilizing and expanding community and cultural strengths and resources;

- Integrate Stigma and Discrimination Reduction in all PEI programs, specifically stigma and discrimination associated with having a mental illness or a social/emotional/behavioral disorder and/or for seeking services and supports for mental health issues;
- Inclusive, self-defined definition of family;
- Collaborations that reach beyond usual partners to include new and emerging community resources;
- Demonstrate meaningful outcomes for individuals, families and communities;
- Address one or more Key Community Mental Health Needs *and* one or more Priority Populations.

### **Community Planning Process:**

- Community Planning Process must be conducted consistent with the CCR, Title 9, Division 1, Chapter 14, Sec 3300;
  - Ensuring that stakeholders have the opportunity to participate,
  - Stakeholder participation include representatives and family members of unserved and underserved populations,
  - Stakeholder participation reflects the diversity of the demographics of Sacramento County,
  - Outreach to and participation of clients with serious mental illness and/or SED and their family members,
  - Provision of training related to MHSA and the Mental Health System to ensure meaningful participation,
- Inclusion of Sectors and System Partners;
  - Underserved and unserved communities,
  - Education,
  - Individuals with serious mental illness and their families,
  - Providers,
  - Health,
  - Social Services,
  - Law Enforcement,
- Data must drive the planning process;
- PEI Plan shall be circulated for review and comment for at least 30 days;
- Public Hearing following the 30 day review period;
- Substantive comments received as part of the 30 day review period and public hearing and the Division's response are included in the PEI Plan.

### **PEI Funding:**

- Fifty-one (51) percent of our overall PEI component budget must be dedicated to individuals who are between the ages of 0 to 25;
- PEI funds cannot supplant existing services;
  - Funds cannot replace other state or county funds used to provide mental health services in FY 04/05,
  - Funds cannot be used on programs that existed at the time of the enactment of MHSA nor can they be used to expand the capacity of those services,
- PEI funds are not intended for filling gaps in treatment and recovery services;
- PEI funds are to be leveraged with other resources and/or funding.

For more information regarding Sacramento County's MHSA and PEI activities, visit our website at: <http://www.sacdhhs.com/mhsa> or go to the Department of Mental Health website at: [www.dmh.ca.gov](http://www.dmh.ca.gov)

## PEI DEFINITIONS and ABBREVIATIONS

Mental Health Services Oversight and Accountability Commission (OAC): A 16-member body established with the passage of the MHSA. The OAC ensures that MHSA services are cost effective and provided in accordance with recommended best practices subject to local and state oversight. The OAC has approval authority for the PEI and Innovation components of the MHSA.

Evidenced-Based Practice (EBP): For Sacramento’s PEI planning, EBPs are practices that include a rigorous research component, have been replicated and expert/peer reviewed with demonstrated positive outcomes, are reliable and valid, and have been published in professional journals. “Evidence-based practice stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.” (SAMHSA National Registry of Evidence-Based Programs and Practices)

Promising Practice: Lacks the research rigor and replication of EBP but has positive evidence of success and outcomes; has been published in professional journals; requires more research to move to the category of EBP. An example of a Promising Practice is Family Connections.

Community Defined Practice: Community-defined evidence validates practices that have a community-defined evidence base for effectiveness in achieving mental health outcomes for underserved communities. It also defines a process underway to nationally develop specific criteria by which practices’ effectiveness may be documented using community-defined evidence that eventually will allow the procedure to have an equal standing with evidence based practices currently defined in the peer-reviewed literature. (National Network to Eliminate Disparities Latino Work Group)

Culture: The integrated pattern of human behavior that includes thought communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs (Cross et al, 1989). A particular individual’s cultural identity may involve the following parameters among others: ethnicity, race, language, age, country of origin, acculturation, gender, socioeconomic class, disabilities, religious/spiritual beliefs, sexual orientation and gender identity.

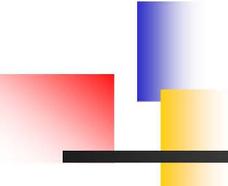
Workshop Consensus Method: A process whereby large groups of people come together to reach decisions and/or outcomes that all can live with in order to move forward together in planning, community building, or problem solving. It can be used with large groups and includes several processes to achieve respectful listening and build upon and honor all participants’ contributions.

PEI Plan: The overall plan that contains all the PEI Projects identified through a community stakeholder process.

PEI Project: Focuses on one or more key community needs and/or priority populations. The first PEI Project submitted to the state for approval is the Suicide Prevention Project. It is anticipated there will be 2-3 more projects developed as part of the overall PEI Plan.

PEI Program: Consists of one or more strategies designed to achieve outcomes that can address needs across age groups. A PEI Project may have more than one program. For example, the Suicide Prevention Project has several programs: 1) a crisis line, 2) warmlines, 3) a public education campaign, and 4) training.

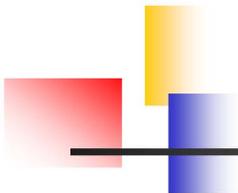
Leverage: Leverage may come in different forms, such as in-kind or direct. Examples of in-kind might include computers, play equipment. Direct leverage might consist of collaboration with another provider for a particular program or it might be a staffing grant. The key to leverage is that it increases the capacity to serve more individuals/families/communities.



# MHSA Prevention and Early Intervention

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Data Identifying Sacramento's Key  
Community Needs and Priority  
Populations

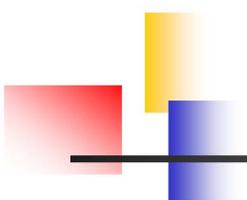


# Data Sources

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- Community Survey
- Regularly Convened Meetings
  - Sacramento County Office of Education Student Mental Health Initiative (SCOE)
  - Prevention and Early Intervention Cultural Competence Advisory Committee (PEI CCAC)
  - Cultural Competence Committee and System-wide Community Outreach Committee (CCC-Outreach)
- System Partner Input Paper
- Community Educational Forums

# Key Community Needs: Community Survey



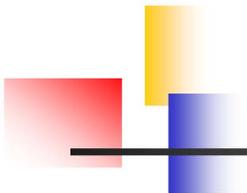
	<b>Average Ranking</b>	<b>Overall Priority</b>
At-Risk Children, Youth and Young Adults	2.3	1
Impact of Trauma	2.6	2
Suicide Risk	3.0	3
Unequal Access to MH Services	3.4	4
Stigma and Discrimination	3.6	5

# Key Community Needs: Meetings

	Overall Priority	SCOE (N=20)	PEI CCAC (N=14)	CCC-Outreach (N=12)
At-Risk Children, Youth and Young Adults	1	1	2	3
Impact of Trauma	2	2	4	5
Suicide Risk	3	5	5	4
Unequal Access to MH Services	4	3.5	1	2
Stigma and Discrimination	5	3.5	3	1

# Key Community Needs: SPIP

	At Risk Children	Impact of Trauma	Suicide Risk	Unequal Access	Stigma
School Districts	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
Criminal Justice	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
ADS	<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>
Public Health	<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>
WEAVE	<b>X</b>	<b>X</b>			
CPS	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
DHA	<b>X</b>			<b>X</b>	
SETA	<b>X</b>			<b>X</b>	
First 5		<b>X</b>			
Agency 4 on Aging		<b>X</b>		<b>X</b>	



# Recommendation: KCN Focus

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- At Risk Children, Youth and Young Adults
  - Psycho-Social Impact of Trauma

# Priority Populations: <sup>Attachment U</sup> Community Survey

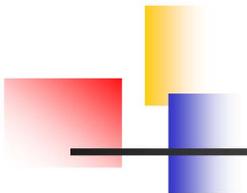
	<b>Average Ranking</b>	<b>Overall Priority</b>
Children/Youth in Stressed Families	3.0	1
Individuals Experiencing Onset of Serious MI	3.2	2
Individuals Exposed to Trauma	3.3	3
Children/Youth at Risk of School Failure	3.6	4
Children/Youth at Risk of JJ Involvement	3.7	5
Underserved Cultural Populations	4.3	6

# Priority Populations: Meetings

	Overall Priority	SCOE (N=20)	PEI CCAC (N=14)	CCC-Outreach (N=12)
Children/Youth in Stressed Families	1	1	2	3.5
Individuals Experiencing Onset of Serious MI	2	6	5.5	3.5
Individuals Exposed to Trauma	3	4.5	4	5
Children/Youth at Risk of School Failure	4	2	3	2
Children/Youth at Risk of JJ Involvement	5	4.5	5.5	6
Underserved Cultural Populations	6	3	1	1

# Priority Populations: SPIP

	Children/Youth in Stressed Families	Onset of MI	Trauma Exposed	Risk of School Failure	Risk of JJ Involvement	Underserved Cultural Populations
School Districts	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
Criminal Justice	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
ADS	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>		
Public Health	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
WEAVE	<b>X</b>		<b>X</b>			
CPS	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
DHA	<b>X</b>	<b>X</b>		<b>X</b>		<b>X</b>
SETA				<b>X</b>	<b>X</b>	<b>X</b>
First 5	<b>X</b>			<b>X</b>		
Agency 4 on Aging		<b>X</b>	<b>X</b>			



# Recommendation: PP Focus

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- Children/Youth in Stressed Families
- Individuals Experiencing Onset of Serious MI
  - Individuals Exposed to Trauma

**MHSA: Prevention and Early Intervention****Data Identifying Sacramento's Key Community Needs and Priority Populations****Executive Summary**

Quantitative and qualitative data were gathered from a variety of sources and integrated to identify Sacramento County's Key Community Needs and Priority Populations for the Prevention and Early Intervention component of the Mental Health Services Act.

**Key Community Needs (KCN)**

Data suggested that all five KCN were important to the community, however, the top three KCN identified by the Community Survey were:

1. **"At-Risk Children, Youth and Young Adults"**: those exhibiting early signs of emotional and behavioral health problems.
2. **"Psycho-Social Impact of Trauma"** : populations of all ages experiencing trauma
3. **"Suicide Risk"** : increase public knowledge of signs of suicide risk and action to prevent suicide

**Priority Populations (PP)**

Data suggested that all six PP were important to the community, however, the top three PP identified by the Community Survey were:

1. **"Children/Youth in Stressed Families"** : those placed out of home or those in families where there is substance abuse, violence, depression or other mental illnesses or lack of care-giving adults (e.g., childhood abuse, neglect, homelessness, partner violence, alcohol abuse, depression, suicide attempts)
2. **"Individuals Experiencing Onset of Serious MI"** : those identified as presenting signs of mental illness first break (e.g., older adult experiencing onset of depression, new mothers experiencing onset of post-partum depression, youth experiencing suicidal ideation, those with signs and symptoms indicative of high risk for psychotic illness)
3. **"Individuals Exposed to Trauma"** : those exposed to traumatic events or prolonged traumatic conditions including grief, loss, isolation (e.g., child/domestic abuse, poverty, homelessness, racism, discrimination, intergenerational/historical trauma)

## Data Sources

### **1. Community Survey**

The Sacramento County Division of Mental Health conducted a survey to gather input around the MHSA prevention and early intervention needs in the community. Community members were asked to rank, in order of importance, the five KCN and six PP defined by the State. A total of 1,795 surveys were returned, with over 1,500 individuals prioritizing either KCN and/or PP. Respondents represented an extremely diverse group in terms of age, ethnicity, sexual orientation, preferred language, and stakeholder group.

### **2. Regularly Convened Meetings (SCOE, PEI CCAC, CCC-Outreach)**

Three groups of individuals provided feedback regarding the KCN and PP: (i) Sacramento County Office of Education Student Mental Health Initiative Planning Group (SCOE); (ii) the Division of MH Prevention and Early Intervention Cultural Competence Advisory Committee (PEI CCAC); and (iii) the Cultural Competence Committee and System-wide Community Outreach Committee (CCC-Outreach). In contrast to the prioritization methodology used in the Community Survey, individuals in these groups were provided “dots” to use to vote for the most important KCN and PP. Substantial qualitative information was also gathered at these meetings.

### **3. System Partner Input Paper (SPIP)**

The System Partner Input Paper was designed to elicit input regarding what KCN and PP system partner organizations address. The Division of MH received responses from 16 partner organizations representing the following 10 service sectors and/or organizations: School Districts (4); Criminal Justice (3); Alcohol and Drug Services (1); Public Health (1); WEAVE (1); Child Protective Services (2); Department of Human Assistance (1); SETA (1); First Five (1); Area 4 Agency on Aging (1). In contrast to the information gathering strategy used by the previous groups, responders to the SPIP were asked to indicate (i) “the KCN reflected in the population you serve” and (ii) “the PP that would most benefit from PEI supports and strategies.” Respondents then indicated all that applied rather than ranking in order of priority. Substantial qualitative information was also gathered in the SPIP.

### **4. Community Educational Forums**

The Division of Mental Health conducted 8 Community Educational Forums on the following topics: Children and Youth in Stressed Families, Early Onset of Psychiatric Illness, For Youth by Youth, Children at Risk of Juvenile Justice, Stigma and Discrimination, Suicide Prevention, Underserved Cultural Populations and Psychosocial Impact of Trauma. A total of 473 individuals attended these forums and they represented an extremely diverse group in terms of, ethnicity and stakeholder group. Substantial qualitative information was gathered during the forums.

**Key Community Needs**

Data

The KCN as determined by the Community Survey are shown in the table below (N=1,583). Respondents were asked to indicate the KCN with the highest priority using a number “1”, the next highest priority using a number “2”, etc. Therefore, the lower number in the “Average Ranking” column, the higher the priority the community assigned to the KCN.

Table (A) Community Survey

	<b>Average Ranking</b>	<b>Overall Priority</b>
At-Risk Children, Youth and Young Adults	2.3	1
Impact of Trauma	2.6	2
Suicide Risk	3.0	3
Unequal Access to MH Services	3.4	4
Stigma and Discrimination	3.6	5

The table below illustrates the KCN in descending order of number of votes provided by attendees of the regularly convened meetings, and compares them to the Overall Priority given in the Community Survey. (Please note: The number of people in each group is approximate and varies somewhat depending on the specific item.)

Table (B) Regularly Convened Meetings

	<b>Overall Priority</b>	<b>SCOE (N=20)</b>	<b>PEI CCAC (N=14)</b>	<b>CCC-Outreach (N=12)</b>
At-Risk Children, Youth and Young Adults	1	1	2	3
Impact of Trauma	2	2	4	5
Suicide Risk	3	5	5	4
Unequal Access to MH Services	4	3.5	1	2
Stigma and Discrimination	5	3.5	3	1

The table below illustrates the KCN indicated by each of the service sectors and/or organizations responding to the SPIP.

Table (C) SPIP

	<b>At Risk Children</b>	<b>Impact of Trauma</b>	<b>Suicide Risk</b>	<b>Unequal Access</b>	<b>Stigma</b>
School Districts	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
Criminal Justice	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
ADS	<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>
Public Health	<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>
WEAVE	<b>X</b>	<b>X</b>			
CPS	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
DHA	<b>X</b>			<b>X</b>	
SETA	<b>X</b>			<b>X</b>	
First 5		<b>X</b>			
Agency 4 on Aging		<b>X</b>		<b>X</b>	

## Discussion

Although Table B indicates some variability regarding the priorities depending upon the responding group, there are two important points to note. First, the top two priorities of SCOE are consistent with the Community Survey. Second, the groups representing Cultural Competence perspectives placed a much greater emphasis on Unequal Access to MH Services and Stigma and Discrimination than did the Community Survey. Although these 2 KCN were not prioritized within the top 3 overall, the Division does have a commitment to address them. Specifically, efforts to reduce disparities in access to early MH interventions will be addressed in all PEI projects undertaken. Further, the Division will be embarking on a media campaign to address stigma and discrimination affecting individuals with MH illness and social/emotional/behavioral disorders.

The SPIP information (Table C) is supportive of the findings regarding the priority of At Risk Children, Youth and Young Adults and the Impact of Trauma. Also in support of the previous findings, SPIP information supports the importance of addressing Unequal Access to MH Services and Stigma and Discrimination.

The qualitative information gathered during this process also supports the priority rankings. For example, multiple groups referenced the need to identify and intervene early with individuals exhibiting initial signs of emotional and behavioral health problems. Almost all groups also identified the need to minimize the negative psycho-social impacts of trauma. Some examples of traumatic events included intergenerational trauma resulting from culturally specific events, trauma associated with being placed in foster homes as well as the abuse and neglect prior to being placed in a foster home, violence in the school, neighborhood or family, homelessness, and the hate crimes, bullying and harassment that can result from cultural differences (including LGBTQ).

## Recommendation

Data suggested that all five KCN were important to the community, however, the top three identified by the Community Survey were: “At-Risk Children, Youth and Young Adults,” “Psycho-Social Impact of Trauma” and “Suicide Risk.” All KCN, however, will be addressed with PEI projects. First, as noted earlier, the Division will incorporate efforts to reduce disparities in access to early MH interventions in all PEI projects. Second, the Division will be embarking on a media campaign to address stigma and discrimination affecting individuals with MH illness and social/emotional/behavioral disorders. Finally, the Division has already submitted a Suicide Prevention Project for funding with PEI dollars.

Therefore, **the recommendation is to focus on “At-Risk Children, Youth and Young Adults” and “Psycho-Social Impact of Trauma” in the upcoming planning process.**

**Priority Populations**

Data

The PP as determined by the Community Survey are shown in the table below (N=1,552). Respondents were asked to indicate the PP with the highest priority using a number “1”, the next highest priority using a number “2”, etc. Therefore, the lower number in the “Average Ranking” column, the higher the priority the community assigned to the PP.

Table (D) Community Survey

	<b>Average Ranking</b>	<b>Overall Priority</b>
Children/Youth in Stressed Families	3.0	1
Individuals Experiencing Onset of Serious MI	3.2	2
Individuals Exposed to Trauma	3.3	3
Children/Youth at Risk of School Failure	3.6	4
Children/Youth at Risk of JJ Involvement	3.7	5
Underserved Cultural Populations	4.3	6

The table below illustrates the PP in descending order of number of votes provided by attendees of the regularly convened meetings, and compares them to the Overall Priority given in the Community Survey. (Please note: The number of people in each group is approximate and varies somewhat depending on the specific item.)

Table (E) Regularly Convened Meetings

	<b>Overall Priority</b>	<b>SCOE (N=20)</b>	<b>PEI CCAC (N=14)</b>	<b>CCC-Outreach (N=12)</b>
Children/Youth in Stressed Families	1	1	2	3.5
Individuals Experiencing Onset of Serious MI	2	6	5.5	3.5
Individuals Exposed to Trauma	3	4.5	4	5
Children/Youth at Risk of School Failure	4	2	3	2
Children/Youth at Risk of JJ Involvement	5	4.5	5.5	6
Underserved Cultural Populations	6	3	1	1

The table below illustrates the PP indicated by each of the service sectors and/or organizations responding to the SPIP.

Table (F) SPIP

	<b>Children/Youth in Stressed Families</b>	<b>Onset of MI</b>	<b>Trauma Exposed</b>	<b>Risk of School Failure</b>	<b>Risk of JJ Involvement</b>	<b>Underserved Cultural Populations</b>
School Districts	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
Criminal Justice	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
ADS	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>		
Public Health	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
WEAVE	<b>X</b>		<b>X</b>			
CPS	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>

DHA	X	X		X		X
SETA				X	X	X
First 5	X			X		
Agency 4 on Aging		X	X			

### Discussion

Table E shows a great deal of variability regarding the priorities depending upon the responding group. When compared to the Community Survey, the greatest differences are an emphasis on Underserved Cultural Populations and Children/Youth at Risk of School Failure. Although these two PP were not prioritized within the top 3 overall, the Division does have a commitment to address them. Specifically, efforts to engage those unlikely to seek help from traditional MH services will be addressed in all PEI projects undertaken. With respect to Children/Youth at Risk of School Failure, the Division will be addressing this PP in at least two ways: (1) by participation in the Student Mental Health Initiative and (2) addressing the KCN of At Risk Children, Youth and Young Adults.

The SPIP information (Table F) is supportive of the findings regarding the priority of Children/Youth in Stressed Families, Early Onset of MI, and Trauma Exposed. Also in support of the previous findings, SPIP information supports the importance of addressing Underserved Cultural Populations and Children/Youth at Risk of School Failure.

The qualitative information gathered during this process also supports the priority rankings. Many groups linked the priority populations of “Children/Youth in Stressed Families” with “Individuals Exposed to Trauma”. Using the examples of trauma cited in the KCN section, multiple references were made to the depression, anxiety, spousal conflict/violence, child abuse, self-medication and family chaos that can result from exposure to trauma. Significant family stressors may also be related to having an LGBTQ individual in the family, or from bearing children in the context of poverty and/or youth. In terms of individuals experiencing early onset of MI, a stressor and trauma in of itself, a variety of examples were discussed, including the impact of post-partum depression, depression and isolation in the elderly, and families with a member who is showing early signs of psychosis.

### Recommendation

Data suggested that all six PP were important to the community, however, the top three identified by the Community Survey were: “Children/Youth in Stressed Families,” “Individuals Experiencing Onset of Serious MI” and “Individuals Exposed to Trauma.” All PP, however, will be addressed with PEI projects. First, as noted earlier, the Division will incorporate efforts to engage those unlikely to seek help from traditional MH services in all PEI projects. Second, with respect to Children/Youth at Risk of School Failure and Juvenile Justice Involvement, the Division will be addressing these PP in at least two ways: (1) by participation in the Student Mental Health Initiative and (2) addressing the KCN of At Risk Children, Youth and Young Adults.

Therefore, **the recommendation is to focus on “Children/Youth in Stressed Families,” “Individuals Experiencing Onset of Serious MI” and “Individuals Exposed to Trauma” in the upcoming planning process.**

**MENTAL HEALTH SERVICES ACT  
Prevention and Early Intervention Planning Phase II**

**Community Kick-Off Meeting October 1, 2009**

- Top Key Community Mental Health Needs**
- At-Risk Children, Youth, and Young Adults
    - Psycho-Social Impact of Trauma
  - Suicide (Project 1 – already submitted to DMH)

- Top Priority Populations**
- Children and Youth in Stressed Families
  - Individuals Experiencing Onset of Serious Psychiatric Illness
    - Trauma-Exposed (all ages)

**Community Committee Meeting 1 – Orientation**

**Community Committee Meeting 2 – Stressors**

**Community Committee Meeting 3 – Trauma**

**Community Committee Meeting 4 – TBD**

**Mental Health Division – Develop draft PEI Work Plan recommendations based on input from Committee**

**Community Committee Meeting 5 – Provide feedback on draft recommendations**

**Mental Health Division –**

- Finalize Plan (budgets, attachments, etc)
  - Post for 30 days
  - Public Hearing
- Submission to DMH

# SACRAMENTO COUNTY

## Mental Health Services Act

### Prevention and Early Intervention (PEI) Planning Principles

1. Reduce disparities by selecting actions that are culturally competent and linguistically appropriate
2. Utilize natural settings such as schools, churches, and primary care clinics
3. Utilize and expand successful community and cultural strengths and resources
4. Integrate stigma and discrimination reduction strategies in all PEI projects
5. Utilize an inclusive, self-defined definition of family
6. Expand partnerships to include new and emerging community resources
7. PEI projects will demonstrate meaningful outcomes for individuals, families, and communities
8. Consider leveraging and funding sources not traditionally identified as mental health



**Visioning Activity Summary  
PEI Committee Meeting #1  
10/13/09**

**In 3-5 years, as a result of the implementation of the Prevention and Early Plan, Sacramento County will.....**

Our community will have total and committed collaboration where everyone takes responsibility for community wellness and safety. Community members, professionals and other system partners collaborate to engage families and support them in their wellness through multi-generational activities. Community groups, churches, schools, and athletic programs are trained to be first responders and can meet the needs of the individual and an advanced gatekeeper system is in place.

Families are supported through culturally appropriate wellness and prevention services that promote healthy relationships and resiliency. Families are strengthened and parents are involved in all aspects of their children's lives. Quality, affordable childcare is available and easily accessible.

A community-wide health model is in place with early identification and intervention services. There are decentralized, multi-disciplinary community centers that serve all ages, needs, and cultures in a safe environment. Easy access to programs that serve the entire family and the whole person through a single point of access is available. Services include annual mental health screenings, behavioral health teams in primary care clinics, and the integration of mental health with ancillary services such as physical therapy, occupational therapy, and speech therapy. Mental health is just as important as physical health and individuals and families can reach out for services without fear.

Consumer-driven services are in place and run by consumers. Peer specialists provide services in institutions where clients are otherwise isolated, i.e. jail, board and care homes, and shelters. A cross-system of medical, faith-based, and other team-based services focus on target populations. Culturally competent and integrated remedies are available to provide supports for pregnant and/or new moms.

Sacramento County residents are better educated on healthy aging. Services and supports for seniors are available, accessible, and well-coordinated. They have effectively reduced isolation, suicide and homelessness among our elderly community members. Senior centers and residential facilities are responsive to individual needs.

Schools are connected to the larger community and school districts coordinate services working closely with providers. A climate of safety and wellness has been created through youth development, bully prevention, anti-gang and conflict resolution programs. The increase of on-site supportive services, after school pro-social activities, and a life skills curriculum has increased school retention and student success. Stronger partnerships with local universities have led to increased graduation rates and more youth entering college.

Mental Health and wellness is included in all health curriculums from preschool to college. There are comprehensive school health centers at elementary, middle and high schools serving children, youth, and families. Information on healthy relationships has been defined and integrated into curriculums, and the self-confidence of youth living in Sacramento has greatly improved.

Transition Age Youth (TAY) have equal access to services, regardless of income, and supports include safe drop-in centers at local malls and emancipation academies. There are services for TAY in Foster Care and comprehensive transitional supports are in place.

An expansion of respite services for families has created an array of services, including childcare support and a parent liaison network. Respite facilities are located throughout the community and are easily accessible.

We know our community is thriving because our data reveals positive outcomes for children, youth, families and our community at large. Data collection has also been improved and includes information on all sectors of our community, including numerous racial/cultural/ and ethnic groups and lesbian, gay, bisexual, transgender, and questioning community members.

At the conclusion of the community tour on which Time magazine staff was conducted, the reporters expressed admiration for the broad range of emotional wellness programs in place and congratulated Sacramento County on being named “Community of the Year”.

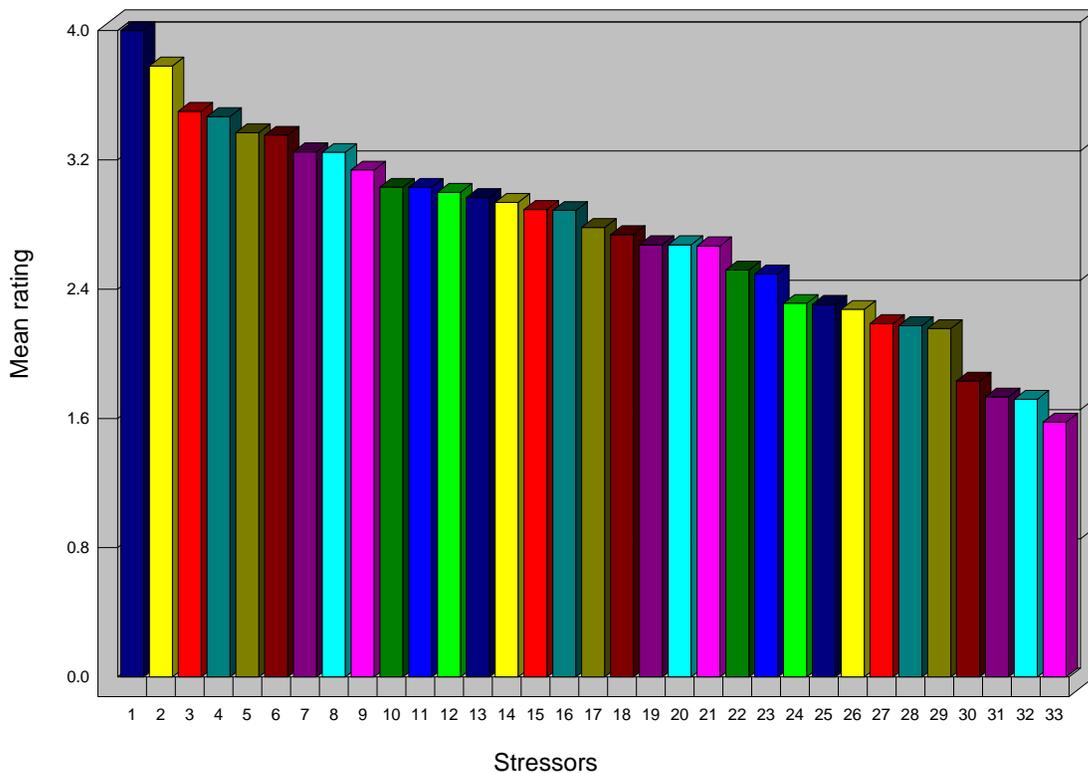
### Rating of the Stressors

The participants evaluated the stressors within the family that are most likely to lead to emotional and/or behavior problems for children and youth. They used the following scale:

- 4 = Most Likely
- 3 = Likely
- 2 = Somewhat Likely
- 1 = Least Likely

### Summary Graph

Rated Stressors



(16 responses)

Means and Variability Table

# Item	Average Rating	Variability
1. Onset of psychiatric illness	4.0	0%
2. Child abuse and neglect (physical, sexual, and emotional)	3.8	26%
3. Domestic violence	3.5	33%
4. Homelessness	3.5	32%
5. Substance abuse	3.4	33%
6. Family abandoning	3.4	43%
7. Family members with mental illness	3.3	44%
8. School bullying	3.2	37%
9. Disruption in parent/child relationships	3.1	44%
10. Children having children	3.0	41%
11. School failure (for children and youth)	3.0	34%
12. Hate crime	3.0	62%
13. Being a victim of a crime	3.0	61%
14. Physical health issues	2.9	35%
15. Refugee status	2.9	46%
16. Family with Disable/special needs family member	2.9	42%
17. Conflict within own community/culture	2.8	39%
18. Involvement with legal systems (juvenile justice, CPS, etc)	2.7	78%
19. Community violence	2.7	35%
20. Poverty	2.7	51%
21. Loss and grief	2.7	43%
22. isolation across the spectrum	2.5	56%
23. Loss of culture	2.5	42%
24. Divorce	2.3	51%
25. Blended/adoptive family issues	2.3	46%
26. Generational conflict	2.3	41%
27. Lack of affordable, quality care for children and youth	2.2	51%
28. Unemployment	2.2	40%
29. Financial pressures	2.2	52%
30. Transition from being a minor to an adult	1.8	59%
31. Technological/media abuse	1.7	43%
32. Elder abuse and neglect (physical, sexual, and emotional)	1.7	49%
33. Lack of awareness	1.6	38%

**Overall Strategies from All Groups**

These are the main strategies that were the consensus strategies from each breakout groups. All of the ideas that were submitted are on the tables at the end of the report.

<p><b>Community Based Services &amp; Support</b></p> <ul style="list-style-type: none"> <li>• Community based family support systems</li> <li>• One-stop community resources in natural settings</li> <li>• Creative Therapy</li> <li>• Community &amp; Targeted Outreach</li> <li>• Community Support &amp; Resources</li> <li>• Violence Prevention for Youth and Families</li> <li>• Family Centered Services</li> <li>• Community Empowerment Strategies</li> <li>• Multi-disciplinary Collaboration</li> </ul>	<p><b>Strengthening Families</b></p> <ul style="list-style-type: none"> <li>• Children Safe in Home</li> <li>• Family Based Services &amp; Treatment</li> <li>• Creating Supportive Family &amp; Community Environments</li> <li>• Safe Respite Options for Stressed Families</li> <li>• Parenting Support &amp; Intervention</li> <li>• Family Skill Building</li> <li>• Grief &amp; Loss Support</li> </ul>
<p><b>Screening, Assessment and Crisis Intervention</b></p> <ul style="list-style-type: none"> <li>• Early Screening &amp; Assessment</li> <li>• Early Identification &amp; Prevention</li> <li>• Education &amp; training around risk factors</li> <li>• Crisis intervention services to protect/ support children and youth</li> </ul>	<p><b>Access to Services and Support</b></p> <ul style="list-style-type: none"> <li>• Intervention &amp; Support</li> <li>• Services for All</li> <li>• Accessible &amp; Affordable Housing</li> <li>• Affordable &amp; accessible therapy &amp; psycho educational services for families</li> <li>• Interventions, supports &amp; access</li> </ul>
<p><b>School Based Services</b></p> <ul style="list-style-type: none"> <li>• Pre-school Support Systems</li> <li>• School-based services for Healthy Interaction</li> <li>• School-based Counseling</li> <li>• Providing Educational Opportunities</li> <li>• School Based Services</li> <li>• Increase Tolerance &amp; Bullying Prevention</li> </ul>	<p><b>Culturally Appropriate TAY Services</b></p> <ul style="list-style-type: none"> <li>• Training &amp; Transitional Resources for Foster Youth</li> <li>• Peer Support</li> <li>• Providing Services &amp; Support for Youth</li> <li>• TAY Education</li> <li>• Culturally Appropriate Peer Services</li> <li>• Peer Support Services</li> </ul>

## Overall Trauma Strategies from All Groups

These are the main strategies that were the consensus strategies from each breakout group.

### Overarching

- Linguistically culturally and spiritually competent services
- Culturally and age appropriate networks

### Providing Quality Assessment, Linkages, and Treatment

- Collaboration of Physical and Mental Health care pre and post trauma
- Therapeutic response to trauma
- Availability of highly trained trauma specific service providers
- Appropriate assessment with coordinated referrals and linkages
- Trauma screenings in medical care
- Access to affordable and effective services for all
- Implement holistic early intervention and treatment
- Diverse options for treatment
- Holistic health and wellness care

### Preventing the Impact of Trauma

- Various forms of education specific to trauma
- Educate those who are impacted by trauma
- Family education and support
- Training and treatment for natural support systems
- Building life skills with peers and professionals
- Survivor centered training and support
- Evidence based trauma focused training
- Culturally appropriate training and treatment for mental health providers
- Review and implement successful trauma prevention programs
- School-based trauma prevention
- Educating to promote healthy family systems
- Education and community awareness through various media outlets
- Public education and awareness campaign

### Supporting Community Access

- Practical support for trauma recovery
- Trauma specific support for services
- Provide for the physical needs of those impacted by trauma
- Non-traditional support programs
- Availability of accessible personal coping activities
- Peer to peer support
- To provide culturally sensitive support groups (peer and other)
- Reaching out and providing support
- Access to information on resources
- 24 hr direct communication support
- Safe community support and resources
- 24 hour access to support
- Community based activities and media
- 24 hour community based resource center
- Community wellness and resiliency

**\* Top 3 as Ranked by Participants**  
**\* Colors indicate Top 3 as Rated by Participants on Computers**

<b>Onset of Psychiatric Illness</b>	
Onset of Psychosis	29
Depression and Suicide	27
PTSD and Other Anxiety	26
Depression in Older Adults	14
Post-Partum Depression	8

<b>Stressors</b>	
Early Screening and Assessment	20
Pre-K - 12 Support Services	18
Family Violence Prevention	16
In-Home Services	13
Building Life Skills for TAY	13
Parent/Caregiver Supports	13
Family Focused Counseling	11
Family Education and Skill Building	10
Increased Knowledge of School Staff	10
Safe Respite	7
Peer Support for TAY	6
Bullying Prevention	6
School Based Counseling	5
Emotional Supports for TAY	4
Grief and Loss	2

<b>Trauma</b>	
Collaboration with Physical and MH Health	25
Building Life Skills with Peers	14
Holistic Health and Wellness Care	11
Education and Training on Trauma	11
Linguistically, Culturally, and Spiritually Competent Services	10
Provide Appropriate Assessment	9
Trauma Specific Training for Providers	8
EBP Trauma-Focused Training	8
Public Education and Awareness	8
24-Hour Direct Communication Support	7
Expand Post-Trauma Victim Support	6
Diverse Options for Treatment	5
Faith-Based Partnerships	5
Training and Treatment for Natural Supports	3
School-based Peer to Peer	0

Rated #1
Rated #2
Rated #3

**Mental Health Services Act  
PEI Draft Proposed Projects**

**Project 1: Strengthening Families Project**

- Key Community Mental Health Need: At Risk Children, Youth and Young Adults
- Priority Population: Children and Youth in Stressed Families
- Addresses the community’s top rated stressors of Child Abuse and Neglect (physical, sexual, emotional); Domestic Violence; Homelessness; and Substance Abuse
- The targeted age group is 0 – 25; however, those 26 and older living in homes in which these stressors occur may also receive services and supports
- The listed activities are taken from the community’s top rated and ranked strategies: **Early Screening and Assessment, including AOD, Pre-K – 12 Supports, Family Violence Prevention and Intervention, and In-Home Services.**
- Consideration is being given to having a special emphasis on Transition Age Youth (TAY) 16 – 25. It combines activities from the strategies of **Building Life Skills and Healthy Relationships for TAY; Peer Support and Mentoring Services for TAY; Emotional Supports and Services for TAY; and Pre-K – 12 Supports.**
- These activities are those being considered to address with PEI funding. While we will not be able to fund all of them, we will do our best to implement as many as possible based on cost analysis and leveraging opportunities.

Ages Served	0-5	6-15	16-25	26-59	60+
<b>Universal and Selective Activities</b>	<ul style="list-style-type: none"> <li>• Mental Health Consultation in Child Care Settings</li> <li>• Mental Health evaluation at school level</li> <li>• Child/Youth safety plans prior to need</li> <li>• Social skills groups</li> <li>• Developmental Screens</li> <li>• Home visits targeting abuse/neglect</li> <li>• Home visits for high-risk infants and mothers</li> </ul>	<ul style="list-style-type: none"> <li>• Accessible Supports for witnessing DV</li> <li>• Teach violence prevention/stress reduction</li> <li>• Mental Health evaluation at school level</li> <li>• Social skills groups</li> <li>• School-wide social-emotional assessments</li> <li>• Screenings in schools to determine students who are at-risk</li> <li>• Child/Youth safety plans</li> </ul>	<ul style="list-style-type: none"> <li>• Establish Peer Anti-Violence Task Force</li> <li>• Easy access to supports for witnessing DV</li> <li>• Teach violence prevention/stress reduction</li> <li>• Mental Health evaluation at school level</li> <li>• School-wide systematic social-emotional assessments</li> <li>• Screenings in schools to determine students who are at-risk</li> <li>• Mentoring and Youth Development</li> </ul>	<ul style="list-style-type: none"> <li>• Anger Management Counseling for all</li> <li>• Easy access to DV services</li> <li>• Teach violence prevention and stress reduction</li> </ul>	<ul style="list-style-type: none"> <li>• Anger Management Counseling for all</li> <li>• Services and supports for family violence</li> <li>• Teach violence prevention and stress reduction</li> </ul>

**Mental Health Services Act  
PEI Draft Proposed Projects**

**Ages Served**

**0-5**

**6-15**

**16-25**

**26-59**

**60+**

- Substance abuse education regarding trauma and emotions for youth
- Training and transitional services for foster youth
- Support for LGBTQ Youth
- Teach health and wellness e.g., exercise, proper nutrition, basic health care, Tai Chi, Yoga, and other alternative health practices
- Healthy eating information classes that are culturally sensitive
- Community-based accessibility

**Natural Settings**

- Child Care settings
- Head Start/Early Head Start
- Schools
- Homes
- Community Resource Centers
- Faith-based settings

- Schools
- Community Resource Centers
- Community Based Organizations
- Homes
- Faith-based settings

- Schools
- Community Resource Centers
- Community Based Organizations
- Homes
- Faith-based settings

- Community Resource Centers
- Community Based Organizations
- Homes
- Faith-based settings

- Community Resource Centers
- Community Based Organizations
- Homes
- Faith-based settings

## Project 2: Integrated Health and Wellness Project

- Key Community Mental Health Needs: At Risk Children, Youth and Young Adults; Psycho-social Impact of Trauma; and Suicide Risk
- Priority Populations: Individuals Experiencing Onset of Serious Psychiatric Illness and Trauma-Exposed
- Addresses key issues of Onset of Psychosis, Depression, Suicide, Alcohol and other Drugs, PTSD and Other Anxiety
- Combines the top ranked and rated strategies for Onset of Psychiatric Illness, Children and Youth in Stressed Families and Trauma-Exposed.
- Activities will be in natural settings, including but not limited to, Primary Care settings, schools, in-home, etc.
- “Primary Care Settings” can include Community Health Care Clinics and Primary Care Clinics that are community-based or county-operated. Some of those clinics are Federally Qualified Health Centers (FQHC). Sacramento County is currently exploring the feasibility of have a Primary Care Clinic become a full FQHC in order to provide integrated and coordinated physical and behavioral health care.
- The Selective activities came from the top-ranked strategies **“Building Life Skills with Peers, Professionals and Para-professionals and “Holistic Health and Wellness Care”**.
- These activities are those being considered to address with PEI funding. While we will not be able to fund all of them, we will do our best to implement as many as possible based on cost analysis and leveraging opportunities.

Ages Served	0-5	6-15	16-25	26-59	60+
<b>Universal Activities</b>	<ul style="list-style-type: none"> <li>• Developmental screens in Primary Care settings</li> </ul>	<ul style="list-style-type: none"> <li>• Risk Assessment for new parents</li> <li>• Mental Health screens in Primary and school settings</li> <li>• Screening and assessment for psychosis, depression, suicide, PTSD, substance abuse in Primary Care settings and Schools</li> </ul>	<ul style="list-style-type: none"> <li>• Risk Assessment for new parents</li> <li>• Mental Health screens in Primary and school settings</li> <li>• Screening and assessment for psychosis, depression, suicide, PTSD, substance abuse in Primary Care settings and Schools</li> </ul>	<ul style="list-style-type: none"> <li>• Mental Health screens in Primary and school settings</li> <li>• Screening and assessment for psychosis, depression, suicide, PTSD, substance abuse in Primary Care settings and Schools</li> </ul>	<ul style="list-style-type: none"> <li>• Mental Health screens in Primary Care settings</li> <li>• Screening and assessment for depression, suicide, PTSD, substance abuse in Primary Care settings</li> <li>• In-home support services</li> </ul>

# Mental Health Services Act PEI Draft Proposed Projects

Ages Served	0-5	6-15	16-25	26-59	60+
<b>Selective Activities</b>			<ul style="list-style-type: none"> <li>• Trauma support groups for non-English speaking people</li> <li>• Community-based peer mentor and peer companion support programs</li> <li>• Culturally appropriate trauma support groups – age, gender, background appropriate</li> <li>• Peer counseling specific to age/culture and type of trauma</li> <li>• Peer support with professional oversight</li> <li>• LGBTQI resource center</li> <li>• Teach health and wellness e.g., exercise, proper nutrition, basic health care, Tai Chi, Yoga, and other alternative health practices</li> <li>• Healthy eating information classes that are culturally sensitive</li> </ul>	<ul style="list-style-type: none"> <li>• Trauma support groups for non-English speaking people</li> <li>• Community-based peer mentor and peer companion support programs</li> <li>• Culturally appropriate trauma support groups – age, gender, background appropriate</li> <li>• Peer counseling specific to age/culture and type of trauma</li> <li>• Peer support with professional oversight</li> <li>• LGBTQI resource center</li> <li>• Teach health and wellness e.g., exercise, proper nutrition, basic health care, Tai Chi, Yoga, and other alternative health practices</li> <li>• Healthy eating information classes that are culturally sensitive</li> <li>• Helper service to assist with routine tasks</li> </ul>	<ul style="list-style-type: none"> <li>• Trauma support groups for non-English speaking people</li> <li>• Community-based peer mentor and peer companion support programs</li> <li>• Culturally appropriate trauma support groups – age, gender, background appropriate</li> <li>• Peer counseling specific to age/culture and type of trauma</li> <li>• Peer support with professional oversight</li> <li>• LGBTQI resource center</li> <li>• Teach health and wellness, e.g., Tai Chi, exercise, proper nutrition, basic health care</li> <li>• Healthy eating information classes that are culturally sensitive</li> <li>• Helper service to assist with routine tasks</li> </ul>
<b>Early Intervention Activities</b>			<ul style="list-style-type: none"> <li>• Treatment for Onset of Psychosis (Early Intervention)</li> <li>• Short-term interventions/treatment for trauma and onset</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment for Onset of Psychosis (Early Intervention)</li> <li>• Short-term interventions/treatment for trauma and onset</li> </ul>	<ul style="list-style-type: none"> <li>• Short-term interventions for trauma and onset</li> </ul>

**MENTAL HEALTH SERVICES ACT  
Prevention and Early Intervention  
Proposed Projects**

**Strengthening Families Project (\$1,640,000)**

- KCMHN: At Risk Children, Youth and Young Adults
- PP: Children and Youth in Stressed Families

<b>Program 1 \$300,000</b>	<b>Program 2 \$400,000</b>	<b>Program 3 \$240,000</b>	<b>Program 4 \$250,000</b>	<b>Program 5 \$300,000</b>	<b>Program 6 \$150,000</b>
<b>Early Childhood Consultation</b>	<b>In-Home Support Services for Foster Children</b>	<b>Social Skills</b>	<b>School-Based Violence Prevention</b>	<b>Building Life Skills for Teens and TAY</b>	<b>Family Conflict Management</b>

**Integrated Health and Wellness Project (\$2,315,000)**

- KCMHN: At Risk Children, Youth and Young Adults; Psycho-Social Impact of Trauma; Suicide Risk
- PP: Individuals Experiencing Onset of Serious Psychiatric Illness; Trauma-Exposed (All ages)

<b>Program 1 \$89,000</b>	<b>Program 2 \$1,036,000</b>	<b>Program 3 \$590,000</b>	<b>Program 4 \$600,000</b>
<b>Screening and Assessment</b>	<b>Peer Support and Treatment</b>	<b>Assessment and Treatment of Onset of Psychosis</b>	<b>Senior Navigator: Targeting Isolation and Depression in Older Adults</b>

<b>Strengthening Families Project</b>			
<b>Program 1 - Early Childhood Consultation</b>			
<b>Targeted Ages</b>	<b>Number to be Served Estimate</b>	<b>Settings</b>	<b>Budget Estimate</b>
<b>0-5</b>	<b>450</b>	<b>Pre-Schools Child Care Centers</b>	<b>\$300,000</b>
<p><b>Program Description</b>                      The Early Childhood Consultation Program will be expanded by increasing the number of mental health clinicians able to provide behavioral consultations to early childcare and education providers. Currently, the Division of Mental Health partners with Sacramento County Office of Education and Child Action to form a Consultation Team. The Consultation Team is part of the Quality Child Care Collaborative, a partnership of community agencies and educational and governmental institutions funded by the First 5 Sacramento Commission.</p> <p>The Consultation Team consists of experts in child development, mental health, family support, developmental disabilities and other special needs. The purpose of consultation is to provide childcare providers working in childcare centers, family childcare homes and family, friend, and neighbor caregivers with information, strategies, and resources to be able to provide quality childcare programs to young children. Mental Health clinicians assist childcare providers in addressing questions or concerns about caring for children with a variety of behavioral concerns.</p> <p><b>Specific Services</b></p> <ul style="list-style-type: none"> <li>• Observation of children in the classroom, on the playground and, when requested, in the home</li> <li>• Consultation to providers to share their assessment of the child care environment and/or a specific child they have observed</li> <li>• Training for providers and their staff in a variety of areas, including child development and behavior management</li> <li>• Provide specific strategies to teachers and providers that will assist in working with challenging children</li> <li>• Make referrals or linkages to other needed services as appropriate</li> <li>• Participate in parent/teacher meetings to communicate information to both parent and teacher in order to assist in coordination of consistent adult responses</li> </ul> <p><b>Outcomes</b></p> <ul style="list-style-type: none"> <li>• Help children learn to manage challenging behaviors</li> <li>• Create a successful learning/enriching environment for children</li> <li>• Increase the number of childcare providers able to work with children that present with challenging behaviors</li> <li>• Decrease the number of children removed from childcare programs</li> <li>• More successful preschool placements with strengthened relationships between teachers, children and families</li> </ul>			

<b>Strengthening Families Project</b>			
<b>Program 2 - In-Home Support Services for Foster Children</b>			
<b>Targeted Ages</b>	<b>Number to be Served Estimate</b>	<b>Settings</b>	<b>Budget Estimate</b>
<b>0-5</b>	<b>240</b>	<b>In-Home</b>	<b>\$400,000</b>
<p><b>Program Description</b>                      Children between the ages of zero and five are at the highest risk of child abuse and neglect. Nationally, one-third of all children entering foster care are zero to three years of age and 15 percent of those are babies under age one. In Sacramento County in 2008, 1,247 children under age 5 entered the foster care system.</p> <p>Children are removed from their parents and placed in out-of-home care because a court has determined that it is not safe for them to live at home. However, children who are removed from home, particularly those who are very young, are exposed to a new danger – the emotional and developmental harm that can result from separation. Children at different stages in life react differently to separation from a parent, based primarily on their ability to understand the reasons for separation and the range and maturity of their coping strategies. The younger the child and the longer the period of uncertainty and separation from the primary caregiver, the greater the risk of harm to the child.</p> <p><b>Specific Services</b>                      A developmental specialist will provide culturally competent in-home visits with the child and the foster parent in order to:</p> <ul style="list-style-type: none"> <li>• Assess the needs of the child</li> <li>• Provide the foster parent with child development information</li> <li>• Make appropriate linkages to other needed services the child may qualify for, such as speech and language or occupational therapy services.</li> <li>• Assist with transition back to the home or to permanent placement</li> <li>• When appropriate, work with the biological parent related to the welfare of their child.</li> </ul> <p><b>Outcomes</b></p> <ul style="list-style-type: none"> <li>• Increase resiliency and protective factors</li> <li>• Decrease trauma and attachment disruption in children</li> <li>• Increase in appropriate services for children to prevent further long term developmental problems</li> <li>• Increase in young children experiencing successful placements with less disruption</li> </ul>			

<b>Strengthening Families Project</b>			
<b>Program 3 - Social Skills Program</b>			
<b>Targeted Ages</b>	<b>Number to be Served Estimate</b>	<b>Settings</b>	<b>Budget Estimate</b>
<b>6-12 and their parents</b>	<b>400 children (small groups) 1000 (entire classrooms) 200 - 500 Parents</b>	<b>Resource Centers Cultural Community Organizations Faith-Based Organizations Schools Primary Care Clinics</b>	<b>\$240,000</b>
<p><b>Program Description</b>                      During the PEI Community Planning Process, participants recommended social skills building groups as a PEI Universal Strategy for children and youth. Groups in the Social Skills Program will focus on stressors and issues that participants were most concerned about – stress reduction, anger management, and violence prevention – as well as other relevant topics.</p> <p>The Social Skills Program will target children ages 6 to 12 and their parents. Effective social skills programs are universal strategies that can assist children in recognizing and managing emotions, developing caring and concern for others, establishing positive relationships, making responsible decisions, and handling challenging situations constructively and ethically. Arenas where children gather and interact with others are natural training grounds for the development of good social skills. Furthermore, programs that contain a parent education component supports and enhances social skill development for children.</p> <p>Two Trained Facilitators will conduct children’s groups; One Trained Facilitator and One Peer Parent or Parent Advocate will conduct parent groups; One full-time facilitator will conduct 10 children groups and 10 parent groups per quarter year. Stipends may be offered to Peer Parent/Advocate. Staffing shall reflect the ethnic, cultural and racial diversity of the individuals and families being served.</p> <p><b>Specific Services</b></p> <ul style="list-style-type: none"> <li>• Social Skills Groups for 8 to12 children and/or entire classroom, depending on selected curriculum. Sessions will be time limited (8-12 sessions) with 40 groups offered annually</li> <li>• Social Skills Group Activities for children will address the following topics; emotional awareness and empathy, conflict management skills, problem solving skills, basic interaction and “getting-along” skills, making friends</li> <li>• Parent Groups are offered simultaneously; 40 groups offered annually                      Parent Education Activities will address the following topics; problem solving skills, limit setting, anger management, non-violent discipline, communication skills</li> </ul> <p><b>Outcomes</b></p> <ul style="list-style-type: none"> <li>• Increase teachers knowledge and ability to encourage and praise children in the classroom</li> <li>• Increase children’s self-esteem</li> <li>• Promote children’s social skills</li> <li>• Decrease students inappropriate behaviors in the classroom</li> <li>• Teach children how to build and maintain positive relationships</li> <li>• Increase parent involvement in children’s development</li> </ul>			

<b>Strengthening Families Project</b>			
<b>Program 4 - School-Based Violence Prevention</b>			
<b>Targeted Ages</b>	<b>Number to be Served Estimate</b>	<b>Settings</b>	<b>Budget Estimate</b>
<b>13-18</b>	<b>600 Youth/TAY (small groups) 1200 (entire classrooms)</b>	<b>Secondary Schools</b>	<b>\$250,000</b>
<p><b>Program Description</b>                      During the PEI Community Planning Process, participants recommended violence prevention as a Universal Strategy for youth and TAY. A school-based violence prevention program would focus on issues that participants were most concerned about – teaching about violence prevention, stress reduction, and supports for those witnessing violence – as well as other relevant topics.</p> <p>The School-Based Violence Prevention program will target schools in high-risk, high-need areas with children/youth ages 13 to 18 years old. School- Based Violence Prevention programs are universal strategies that reduce or prevent violent and aggressive behavior among children and youth and are administered at a school-based setting. These programs teach all students, regardless of individual risk, in a given school or grade level about the problem of violence, its prevention and about one or more of the following topics or skills intended to reduce aggression or violent behavior: emotional self-awareness, emotional control, self-esteem, positive social skills, social problem solving, conflict resolution, or team work. This program may be developed and facilitated by a community-based mental health organization or a Sacramento school and will be delivered by trained facilitators who are diverse and reflective of the students being served.</p> <p>Two Trained Facilitators will co-facilitate youth groups and other program components. The facilitators will conduct 15 groups per quarter year.</p> <p><b>Specific Services</b></p> <ul style="list-style-type: none"> <li>• Social Skills Groups for 8 to12 children and/or entire classroom, depending on selected curriculum. Sessions will be time limited (8-12 sessions) with 60 groups offered annually. Groups will be implemented no later than the middle of the school year, which will create opportunities for students to discuss, practice and reinforce skills during the academic school year.</li> <li>• Program will utilize age-appropriate activities that may include a combination of the following classroom or group approaches:                             <ul style="list-style-type: none"> <li>○ social skills building</li> <li>○ problem solving skills</li> <li>○ conflict resolution techniques</li> <li>○ information about specific types of violence and the problem of violence</li> <li>○ teaching violence resistance skills by discussion accompanied by role playing, modeling, skill practice, feedback and reinforcement</li> </ul> </li> <li>• Other program components will include:                             <ul style="list-style-type: none"> <li>○ Peer Mediation</li> <li>○ Youth mentoring and teaching young children</li> <li>○ Youth engaging in developing an antiviolence campaign</li> </ul> </li> </ul> <p><b>Outcomes</b></p> <ul style="list-style-type: none"> <li>• Decrease violence in schools, including gang violence, bullying and dating abuse</li> <li>• Increase students knowledge of the causes of violence</li> <li>• Increase the use of peer mediation to resolve conflict</li> <li>• Teach students problem solving skills, anger management and impulse control</li> <li>• Increase students social skills and emotional awareness</li> </ul>			

<b>Strengthening Families Project</b>			
<b>Program 5 - Building Life Skills for Teens and TAY</b>			
<b>Targeted Ages</b>	<b>Number to be Served Estimate</b>	<b>Settings</b>	<b>Budget Estimate</b>
<b>13-25</b>	<b>Prevention:</b> <b>150 Individuals/25 Families</b> <b>Early Intervention:</b> <b>50 Individuals/10 Families</b>	<b>Health Clinics</b> <b>Schools</b> <b>Colleges</b> <b>Community Centers</b> <b>Homeless Youth Centers</b>	<b>\$300,000</b>
<p><b>Program Description</b>                      Prevention and Early Intervention services for teens and Transitional Age Youth (TAY) were consistently a top-ranked strategic direction during the community planning process meetings. Many of the specific strategies suggested by participants were combined to create the Building Life Skills for Teens and TAY Program. This program would fund staff time in existing programs or settings that offer services to teens and TAY to provide universal screenings for risk factors; provide skill building groups, classes and/or workshops to address life skills needed to become independent and productive members of the community; and brief case management services to link to community services. The providing programs would also be expected to provide targeted outreach and engagement efforts to high-risk teens and TAY including, but not limited to: LGBTQI youth; teens and TAY with substance use concerns; youth in the foster care system; underserved racial, cultural and ethnic populations; and homeless teens and TAY. Staffing will reflect the ethnic, cultural and racial diversity of the individuals and families being served.</p> <p><b>Specific Services</b></p> <ul style="list-style-type: none"> <li>• Help teens and TAY establish and maintain health and wellness services, including linkage to primary healthcare provider, crisis prevention and intervention strategies</li> <li>• Provide education and support for building and maintaining healthy relationships</li> <li>• Provide conflict resolution, anger management and communication skills training</li> <li>• Provide adult life skills training and mentoring (for example elders mentoring youth and young adults)</li> <li>• Provide educational assistance, vocational training and employment linkage</li> <li>• Expand understanding of community resources and supports</li> <li>• Assist with and provide education about benefits acquisition and maintenance</li> </ul> <p><b>Outcomes</b></p> <ul style="list-style-type: none"> <li>• Increase self determination and self sufficiency</li> <li>• Increase meaningful social relationships</li> <li>• Decrease school drop-out rates</li> <li>• Decrease suicide risk</li> <li>• Increase problem solving and coping skills</li> <li>• Increase youths knowledge of available resources</li> <li>• Increase a coordinated network of comprehensive and culturally competent services for youth</li> <li>• Decrease feelings of hopelessness, anxiety, anger and depression</li> <li>• Decrease substance use/abuse</li> <li>• Decrease in juvenile justice involvement</li> </ul>			

<b>Strengthening Families Project</b>			
<b>Program 6 - Family Conflict Management</b>			
<b>Targeted Ages</b>	<b>Number to be Served Estimate</b>	<b>Settings</b>	<b>Budget Estimate</b>
<b>Across All Ages</b>	<b>300 family members</b>	<b>Resource Centers</b> <b>Cultural Community Organizations</b> <b>Faith-Based Organizations</b> <b>Schools</b> <b>Primary Care Clinics</b>	<b>\$150,000</b>
<p><b>Program Description</b>                      Individuals that participated in the planning process prioritized Family Violence Prevention and Intervention as a strategy targeting whole families. The Family Conflict Management Program will focus on issues that participants were most concerned about: teaching about violence prevention, anger management and stress reduction, and supports for those family members who may be in environments of abuse. The Family Conflict Management Program utilizes a multi-level approach, and universal and selective strategies, in assisting families in managing conflict and developing peer and community support. Outreach and engagement approaches, psycho-educational groups for family conflict management and violence prevention, and peer support are components of this program. This program may be developed and implemented in two at-risk communities by a community-based organization that has knowledge and experience in working with at-risk families. One Trained Facilitator will conduct psycho-educational groups and peer leadership training. The facilitator will conduct 15 groups per quarter year and 2 leadership trainings per year. One Outreach Specialist will plan and coordinate on-going outreach efforts, support groups and peer/mentoring activities. Staffing will reflect the ethnic, cultural and racial diversity of the families being served.</p> <p><b>Specific Services</b></p> <ul style="list-style-type: none"> <li>• On-going outreach and engagement strategies (a universal strategy) to ensure participation of the following: residents of at-risk communities; unserved and underserved racial, cultural and ethnic communities; boys; men; batterers; and parents/caregivers and youth in the community who can be leaders/mentors or have the potential to lead/mentor others in their community.</li> <li>• Facilitated multi-family, multi-session/time-limited psycho-educational support groups (universal strategy) which focus on issues related to conflict management and violence prevention, that include but are not limited to: providing information about specific forms of violence; the problem and cycle of violence; violence resistance skills; empathy; problem solving; anger management; coping with stress; communication skills; and identifying emotions and pre-violence stressors</li> <li>• Efforts designed to “spin off” groups into continuing support groups and to build community capacity through peer facilitation will be core component of the program</li> <li>• Peer parent/caregiver and youth leadership/coach component (selective strategy): Leadership and facilitation skills training will be provided to identified leaders/coaches so that they can co-lead support groups, provide guidance and support for other parents/caregivers or youth in “stressed families” or environments of abuse.</li> <li>• Provide linkages to a network of supportive services and supports.</li> </ul> <p><b>Outcomes</b></p> <ul style="list-style-type: none"> <li>• Decrease family violence</li> <li>• Increase knowledge of available resources</li> <li>• Increase knowledge of non-violent conflict resolution</li> <li>• Increase the knowledge and use of problem solving skills, anger management and coping with stress</li> </ul>			

<b>Integrated Health and Wellness Project</b>			
<b>Program 1 - Screening and Assessment</b>			
<b>Targeted Ages</b>	<b>Number to be Served Estimate</b>	<b>Settings</b>	<b>Budget Estimate</b>
<b>Across All Ages</b>	<b>10,000</b>	<b>Community Health Clinics</b>	<b>\$89,000</b>
<p><b>Program Description</b></p> <p>In the PEI Community Planning Process, screening and assessment was consistently identified as a priority for Sacramento County and primary care settings were mentioned as key places to reach large numbers of community members, including those in unserved and underserved populations. The Screening and Assessment Program will take place in up to eight primary care settings, which can include Community Health Care Clinics and Primary Care Clinics that are community or county-operated. The selected clinics will participate in a program to screen and/or assess for general depression, maternal depression, suicide risk, Post Traumatic Stress Disorder, substance abuse, and/or onset of serious psychiatric illness.</p> <p>Protocols will be developed and screening tools will be selected to be used with clients in participating clinics as part of their primary care visit. If concerns are identified, referrals will be made to other services. Clinics selected to participate in this program will also be eligible to implement the Peer Support and Treatment Program which is Program 2 in the Integrated Health and Wellness Project.</p> <p><b>Specific Services</b></p> <ul style="list-style-type: none"> <li>• Existing staff in primary care settings will be trained to administer the screening tools selected as part of this program</li> <li>• Written preventative information will be provided to each patient</li> <li>• When appropriate, patient will be referred to on-site clinician, peer support group or activities designed to reduce and manage stress, such as yoga, Tai Chi or other alternative health practices</li> </ul> <p><b>Outcomes</b></p> <ul style="list-style-type: none"> <li>• Appropriate and early identification of mental health and substance abuse issues</li> <li>• More appropriate and timely mental health services</li> <li>• Increased culturally competent and linguistically appropriate services</li> <li>• Increased number of referrals to peer led support groups</li> <li>• Increased number of referrals to treatment groups</li> <li>• Decrease in utilization of high cost services (i.e. emergency rooms, hospitals and jails)</li> <li>• Increase awareness and recognition of mental health issues amongst primary care providers</li> <li>• Stigma reduction amongst older adults and other cultural groups</li> </ul>			

Integrated Health and Wellness Project			
Program 2 - Peer Support and Treatment			
Targeted Ages	Number to be Served Estimate	Settings	Budget Estimate
Across All Ages	3,000	Community Health Clinics Community-Based Organizations	\$1,036,000
<p><b>Program Description</b> Peer Support and Treatment Groups will be offered at each primary care setting that participates in the Screening and Assessment Program. Based on the identified needs of the individuals, peer support groups will be formed to provide a range of services to group members, including psycho-educational information on a variety of topics. Peer support groups will be run by individuals that share common concerns or who are members of the community served by the clinics. Increased language capacity by peers providing services will be targeted. Each clinic site will have a FTE clinician to address clinical treatment through both individual and group sessions.</p> <p>The psycho-social impact of trauma was identified as a key community mental health need. Practitioners will be trained in Trauma Focused - Cognitive Based Therapy and/or other culturally appropriate treatment modalities to address the impact of trauma. Opportunities will be developed for shared clinical expertise and support among participating clinics. Each clinic will work with a coordinator to develop agreed upon protocol and best practices.</p> <p><b>Specific Services</b></p> <ul style="list-style-type: none"> <li>• Clinical referral for individuals screened by primary care professional</li> <li>• Referral to peer run support groups</li> <li>• Health and wellness activities, such as Tai Chi, Yoga and other alternative health practices, will be available at clinic locations or at locations that are well-known in the targeted community to support overall physical and emotional wellness</li> <li>• Group referrals may also come from the Strengthening Families and Suicide Prevention Projects</li> </ul> <p><b>Outcomes</b></p> <ul style="list-style-type: none"> <li>• Increase identification of mental health concerns</li> <li>• Increase linkage to services</li> <li>• Improve mental wellness</li> <li>• Increase social supports for at-risk individuals, including families and older adults</li> <li>• Decrease the negative impacts of trauma</li> <li>• Stigma reduction</li> </ul>			

Integrated Health and Wellness Project			
Program 3 - Assessment and Treatment of Onset of Psychosis			
Targeted Ages	Number to be Served Estimate	Settings	Budget Estimate
12-25	50	Community Health Clinics	\$590,000
<p><b>Program Description</b>                      The onset of psychosis was rated as a high priority during the PEI community planning process. This was especially true for youth and young adults. The public mental health system has primarily excluded individuals who have not been previously “diagnosed” with a major mental illness – instead of being proactive, the system has been reactive – frequently resulting in high cost services across various systems. Early detection and intervention of psychotic disorders is critical to mitigating the effects of the illness and the personal maladaptive functioning that often accompanies these types of disorders. The goal of the program is to detect and intervene early enough in the onset of the illness to promote healthy, productive and empowered individuals in managing what otherwise may be a debilitating condition. The program will work with the individual and family/primary support persons in developing culturally competent treatment and services plans, illness management, and when indicated, to provide advocacy and support to the individual with his/her external needs, such as education and employment.</p> <p><b>Specific Services</b></p> <ul style="list-style-type: none"> <li>• Comprehensive psychiatric, medical, and psychosocial assessments</li> <li>• Multi-disciplinary staffing – psychiatrist, behavioral health professionals, peer and family advocates, support specialist</li> <li>• Medication treatment and management</li> <li>• Individualized treatment and service planning</li> <li>• Individual, family and group therapy</li> <li>• Family and peer advocates providing support, hope, education and advocacy</li> <li>• Client and family education</li> <li>• Skill development</li> <li>• Supported education and employment</li> <li>• Outreach and education about identification of early signs and symptoms to staff working in primary care settings</li> </ul> <p><b>Outcomes</b></p> <ul style="list-style-type: none"> <li>• Reduced symptoms associated with early onset of psychosis</li> <li>• Reduced hospitalizations</li> <li>• Increased school and/or work success</li> <li>• Educate individual and/or family around illness/symptom management</li> <li>• Earlier recognition and identification of psychosis</li> <li>• Reduced utilization of high cost services (i.e. emergency rooms, hospitals and jails)</li> <li>• Reduced incidence of mental disorders, particularly psychotic disorders</li> <li>• Improved methods for identifying, assessing and treating psychotic disorders prior to onset</li> </ul>			

Integrated Health and Wellness Project			
Program 4 - Senior Navigator Program: Targeting Isolation and Depression in Older Adults			
Targeted Ages	Number to be Served Estimate	Settings	Budget Estimate
60+	180	In-Home	\$600,000
<p><b>Program Description</b>                      During the Community Support and Services (CSS) planning process, older adults were identified as one of Sacramento’s most underserved age groups. This continues to be true and the importance of addressing the needs of older adults has been discussed in subsequent MHSA planning processes, including WET, PEI and during the development of the Suicide Prevention Project. The propensity for isolation and depression places this population as high-risk for suicide, trauma and untreated medical conditions. The community singled out in-home support services as a strategic preventative intervention to assist and support this population to access health and social support services. The program is modeled after the highly regarded and successful program, <i>Promotores</i>, whereby health education services are provided by community members to community members. The Senior Navigator program seeks to work in collaboration and partnership with primary care settings, and to employ seniors, whenever possible, as Senior Navigators. Referrals will primarily come from the primary care settings whereby the individual has been assessed as at risk for depression and/or isolation. Referrals may come from other community agencies; however, the primary referral source will be community health care centers. Working with clinic staff and community resources, the Senior Navigator role is to ensure follow-up with recommended services and assist with improving health and wellness. The Senior Navigators will reflect the ethnic, cultural and racial diversity of the community of the older adults being served. Bilingual fluency will be a requirement reflecting Sacramento’s threshold languages.</p> <p><b>Specific Services</b></p> <ul style="list-style-type: none"> <li>• Frequent in-home support services</li> <li>• Transportation to recommended services from community health care providers</li> <li>• Collaboration with healthcare providers</li> <li>• Service coordination</li> <li>• Liaison to community services for older adults</li> <li>• Peer support services</li> <li>• Peer advocacy</li> <li>• Peer education</li> </ul> <p><b>Outcomes</b></p> <ul style="list-style-type: none"> <li>• Improved social and emotional wellness</li> <li>• Reduced isolation</li> <li>• Increased social interaction</li> <li>• Improved knowledge and access to community resources</li> <li>• Decreased incidence of suicide and attempts</li> <li>• Decreased utilization of high cost services (i.e. emergency rooms and hospitals)</li> <li>• Increased collaboration between primary care settings and mental health providers</li> </ul>			



# Consumer Speaks Conference

## WELCOME AND INTRODUCTIONS:

**Andrea Hillerman-Crook**, Consumer Advocate Liaison  
Mental Health Association, Sacramento Chapter

## OPENING REMARKS:

**Susan Gallagher**, Executive Director  
Mental Health Association, Sacramento Chapter

**Pat Mangan**, Human Services Division Manager  
Sacramento County, DHHS, Mental Health

## CONFERENCE HIGHLIGHTS:

**Mental Health Services Act (MHSA)-Next Chapter**  
Mental Health Services Prevention and Early Intervention (PEI)  
Learn the elements and how you can get involved

## FEATURED SPEAKER:

**Stephen Pocklington**, Executive Director  
Copeland Center for Wellness and Recovery  
“Create Recovery in Our Community”

## Oak Park Community Center

3415 Martin Luther King Boulevard, Sacramento, CA 95817

**October 28, 2008 @ 9:30 a.m. - 5:00 p.m.**

**Registration @ 9:30 - 10:00 a.m.**

**5.0 Continuing Education Hours will be offered for  
MFT's and/or LCSW's**

Board of Behavioral Sciences (BBS) Continuing Education Provider Number (PCE 3653)

*Course meets the qualifications for 5.0 hours of continuing education credit for MFTs and/or LCSWs as required by the California Board of Behavioral Sciences.*

**Lunch, Conference and CE Hours Free of Charge**

**Community Information Booths, Awards Ceremony, Raffle, Prizes**

**No Pre-Registration - Please Come Join Us!**

**Questions? Call Andrea Hillerman-Crook at (916) 875-4710**

If you need to arrange for an interpreter or a reasonable accommodation, please call Mary Drain at (916) 875-4639 - One Week Prior to the Event!

Sacramento County PEI Plan Amendment

Rachael Beutler, Training Coordinator: (916) 875-0847  
Mental Health Division, Quality Management Services

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**California's Mental Health Services Act, Prevention and Early Intervention Component:  
Collaborative Partnerships in Sacramento County**

**Friday, February 13, 2009 • 9:00 a.m. – 4:00 p.m.  
Sacramento County Office of Education • Mather Room**

**Meeting Summary**

**Desired Outcomes**

- 1) To provide recommendations for the role of schools in planning and implementing Prevention and Early Intervention Mental Health Services in Sacramento County for children and youth ages 0-18.
- 2) Establish a foundation for countywide collaboration to better serve children and youth ages 0-18.

**Welcome and Introductions**

David Gordon, Sacramento County Superintendent of Schools, welcomed all participants and thanked them for attending. Mr. Gordon explained that the purpose of the meeting is to bring together education stakeholders, mental health professionals, and other system partners to discuss the Mental Health Services Act (MHSA) and the opportunities the Prevention and Early Intervention (PEI) component holds for students.

The Sacramento County Department of Health and Human Services (DHHS), Mental Health Division and the Sacramento County Office of Education co-sponsored the day's meeting as part of community planning efforts to explore how schools can play a role in implementing PEI services for students aged 0-18. Mr. Gordon emphasized the importance of working together towards a common goal and using different approaches that can prevent more serious problems.

Mr. Gordon introduced Lisa Bertaccini, Chief, Child and Family Mental Health, Sacramento County Department of Health & Human Services. Ms. Bertaccini expressed DHHS's excitement to be part of the day's meeting. She explained that DHHS wants to work collaboratively toward positive outcomes, opportunities and the idea of doing something different

Lead facilitator Deb Marois, CSUS Center for Collaborative Policy, reviewed the agenda and ground rules for participation. She explained that the group will work together to:

- Exchange relevant information, ideas, and terminology to establish a common understanding of prevention and early intervention across professional disciplines.
- Identify current conditions, practices and opportunities related to school-based mental health efforts in Sacramento County.



## California's Mental Health Services Act, Prevention and Early Intervention Component: Collaborative Partnerships in Sacramento County

- Develop a common vision and desired results for the role of schools in creating a comprehensive countywide system of prevention and early intervention for the mental health of children from birth through age 18.
- Recommend priorities for key community mental health needs and priority populations most in need of prevention and early intervention services.
- Identify key supports schools need to promote student mental health.
- Explore establishing a process for ongoing collaboration among meeting participants, linking how to respond to additional opportunities such as the state administered prevention and early intervention projects.

Ms. Marois led the group through a warm-up activity where each participant introduced themselves and described one thing that contributes to the healthy deployment of young people. Participants mentioned various components including:



*Relationships:* the importance of positive adult relationships; a supportive community connection; parents that advocate a healthy lifestyle and model positive behavior; and formal and informal mentors that reflect the diversity of the community.

*Emotional:* a sense of belonging, emotional and physical safety; feeling valued; feeling of connection rather than isolation; and knowledge that they are heard and supported.

*Education:* success in academics to boost self-esteem; opportunities to pursue a passionate activity; access to extracurricular activities; educators that take an interest in students' social and emotional needs; and knowledge of life skills and healthy coping skills.

## California's Mental Health Services Act Prevention & Early Intervention Component: State & Local Implementation

Michelle Callejas, MHSA Program Manager, Division of Mental Health, Sacramento County DHHS, presented a PowerPoint overview of the MHSA and the PEI approach. The presentation explained the need for mental health system reform. She outlined components of the new approach, such as focusing on wellness, recovery, resilience and the whole person; assuring client/family-driven approaches, and community participation. Ms. Callejas contrasted this with previous approaches characterized by fragmentation and a "fail first" model that focused on symptoms and accepting long-term disability.

## California's Mental Health Services Act, Prevention and Early Intervention Component: Collaborative Partnerships in Sacramento County

The new approach strives to eliminate the negative outcomes that result from untreated mental illness, reduce disparities and improve access to care. Based on the Institute of Medicine's Spectrum adopted by the California Department of Mental Health (DMH), she defined prevention as both universal and selective services and programs that occur prior to a mental health diagnosis which are designed to prevent mental illness from occurring or from becoming more severe and disabling. She also described early intervention services, which are intended to address a condition early and are comprised of services and programs that are relatively low in intensity and short in duration (one year or less). One of the primary goals is to support well-being in major life domains and avoid the need for more extensive mental health services in the future. This may include individual screenings for confirmation of potential mental health needs. Ms. Callejas mentioned that the PEI funds cannot be used for filling the gaps in treatment and recovery services for those who have been diagnosed with serious mental illness or serious emotional disturbances.



Ms. Callejas explained that DMH has directed each county to develop a work plan in order to receive the MHSAs funding for PEI. DMH has identified five different community mental health needs and six priority populations but gives counties the flexibility to decide what to address. However, 51% of the funding must address the needs of individuals 0-25 years of age.

Ms. Callejas explained that the allocation of funding to all the counties is sustainable. The State is looking to the counties to give back some of their funding to help implement three statewide projects: Suicide Prevention; Stigma and Discrimination, and the Student Mental Health Initiative. For the Student Mental Health Initiative, twenty grants will be awarded to counties throughout the State, approximately \$350,000 per year for four fiscal years. DHHS Mental Health Division is currently undertaking a community planning effort to decide priority needs and populations. This process includes outreach and engagement; data gathering and analysis including focus groups with underserved groups; strategy and project development; public review and hearings; and lastly the submission to DMH.

### Question and Answer

Following the presentation, participants asked clarifying questions about statewide mental health initiatives, the local planning process in Sacramento County and funding for the PEI component.

California’s Mental Health Services Act, Prevention and Early Intervention Component:  
Collaborative Partnerships in Sacramento County

What will the student mental health initiative look like?

Ms. Callejas responded that the RFP has not been released. This initiative came about after the Virginia Tech tragedy to get mental health assistance into schools and to build the infrastructure to support it. Though this is one-time finding, much can be done and there are programs and services that can be implemented but do not cost a lot of money.

When will the synthesis from the forums be available to view?

DHHS is working on an ambitious timeline and anticipates that all the data and information will be gathered and synthesized by April. After that, the department will work on preparing the report and managing expectations.

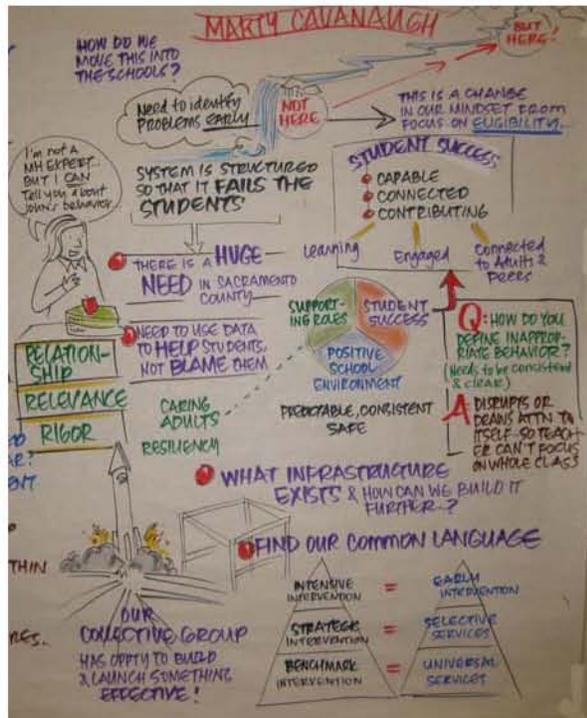
Will PEI funding increase every year? Will money from previous years be folded back in?

The funding has gone up from the last year because the 1% tax on incomes over 1 million dollars yielded more revenue than was initially projected. Prior year funding will be folded back in if it is not used. However, if the funding is not used within three fiscal years the State will take it back.

Universal Perspective on School-Based Mental Health in Sacramento County

Martin Cavanaugh, Deputy Superintendent Sacramento County Office of Education, reviewed the supportive evidence that mental health problems in school-aged children are real and escalating. He cited Sacramento County data that shows a high number of students scoring below basic levels, dropping out of high school and experiencing juvenile arrest. Relative to these statistics, he emphasized the connection between student success and school-based

mental health efforts. To succeed academically and in life, students need to be capable, connected, and contributing. Mr. Cavanaugh reminded participants that positive behavior supports and effective instructional strategies are necessary for all students. He gave an overview of the factors that contribute to a positive school environment and school culture including social climate, quick response to prevention, effective intervention, progress monitoring and active use of data for decision making. The presentation also outlined a series of evidence-based practices and interventions that work to support students’ mental health. He mentioned the importance of school based intervention as evidence has shown teachers at the second grade level can predict with great



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**California’s Mental Health Services Act, Prevention and Early Intervention Component:  
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accuracy those students that will drop out of high school.

Next, Mr. Cavanaugh explained that prevention is the infrastructure to support intervention. Data, instructional support, family support, youth development, resiliency factors, informed teachers, services and neighborhoods are components of prevention. Schools currently have varying degrees of these components in place. The Response To Intervention (RTI) model is a common approach used in schools to provide support services to students that begins with benchmark intervention, moving next to strategic intervention, and lastly to intense intervention. He explained that the education perspective sees RTI as more than academics; traditionally the model was organized in terms of rigor, relevance and lastly relationship. The new RTI model would begin with relationship, then relevance and finally rigor. Mr. Cavanaugh emphasized the similarities between the education and mental health approaches, despite differences in language.

At the conclusion of this presentation, participants discussed how “indicators of disengagement” and “inappropriate conduct” are defined. There was some concern that inconsistent definitions could result in some students being inappropriately labeled. Mr. Cavanaugh explained that school districts try to establish consistency in behavioral models as well as in the definitions. “Inappropriate conduct” is defined as behavior that disrupts or draws attention to itself in the classroom; it is behavior that is taking away from the teacher’s ability to keep the attention of the classroom.

**What is Prevention and Early Intervention? Establishing a Common Understanding of Definitions**

Ms. Marois explained that the two presentations set the context for the day, enabling the group to begin establishing some shared meaning. Participants shared their impressions of key themes and insights that had developed so far, such as:

- People have worked in silos for so long that it is positive to see a collaborative approach to leveraging resources rather than a territoriality approach.
- Partnering offers more opportunities to collectively think of and identify good programs.
- It is good to see adults take some responsibility for the poor tests scores because children are reliant on adult guidance.
- Universal compliance will be crucial, not just in terms of early intervention but ensuring that everyone is involved and that whole community change will be possible.
- There is a need to start working with the family far earlier than kindergarten.

Next, the group identified some initial concerns including:

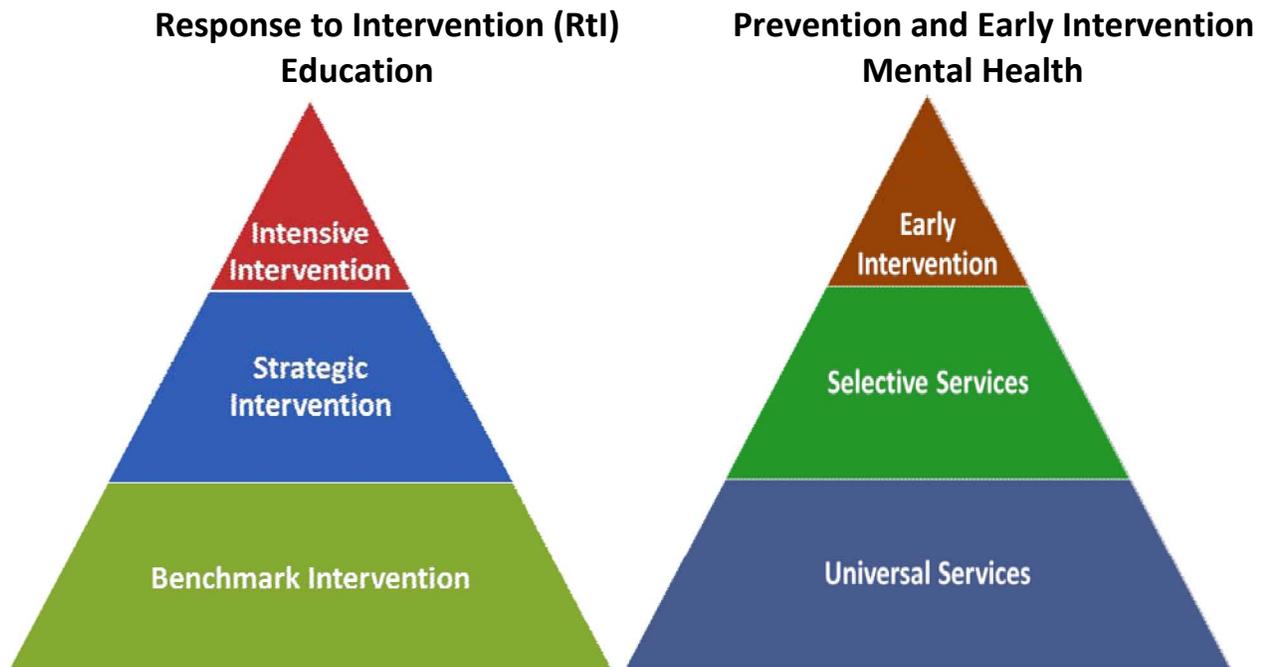
- The current State budget crisis and how Proposition 63 (MHSA) funding may be impacted. For example, some wondered whether the programs and approaches being discussed will be implemented or if the funding be reallocated.
- The need to focus on high school aged students with programs to prevent suicide and incarceration.

## California's Mental Health Services Act, Prevention and Early Intervention Component: Collaborative Partnerships in Sacramento County

- Prioritizing homeless families because evidence has shown that once a person has been homeless, post-traumatic stress disorder (PTSD) can develop and this affects students in the schools.
- High school students who do not receive support from parents could become parents who do not provide support; it is a cyclical situation and should be addressed.
- Workgroups need to be efficient in how they use the initial Proposition 63 funding.
- Make sure that the approach is culturally competent in terms of outreach and considers the cultural perceptions of mental health.

Participants also discussed the side-by-side education and mental health models of prevention and intervention language and stages.

### How We Define the Language of "Prevention" and "Intervention"



- The pyramids seem identical except for the words which can be changed. If the group can all work at the same table with the same student using the same plan, then that student will be successful.
- Sacramento City Unified School District (SCUSD) has instituted the RTI framework and is excited that everyone is now speaking the same language. Having a common meaning and language will deliver a powerful message.
- Child Protective Services has recently put more of an emphasis on ensuring that kids who are put into the foster care system will be able to remain at their same school in familiar surroundings.

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**California’s Mental Health Services Act, Prevention and Early Intervention Component:  
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- The Folsom-Cordova Unified School District (FCUSD) has instituted an “every child by name” program, which is an approach where school personnel come together as a group to review every child on a quarterly basis. The group looks at academic performance, home life stability, and participation in other programs.
- Wendy Greene, Child and Family Mental Health, asked for clarification on the different stages of the RTI model. Mr. Cavanaugh explained that the “benchmark intervention” stage includes all students who get in behavioral trouble or need any extra academic help. This action addresses behavior both socially and emotional. At the benchmark stage, the student is not in danger of failing or anything serious and the entire classroom is benefitting from the action. The second stage is “strategic intervention” where if action is not taken the student will advance to the higher level on the pyramid. Students at this stage may need more resources than are available in the classroom. By the “intensive intervention” stage, the student is behind relative to grade level and most likely requires an intervention that occurs outside of the classroom.
- Ms. Greene explained that even with the clarification, the alignment of the pyramids does not match. She sees the benchmark stage as comparable to early intervention and not prevention; when a child has signs of a problem that is a point of intervention.
- It is important to note that students do not stay at one stagnant point.

The group then reviewed the elements of prevention infrastructure which Mr. Cavanaugh presented and offered suggestions to enhance the framework. These suggestions included the following additions as core elements of prevention:

- “Positive Peer Support”
- “Inform” aspect to ensure that all parties are informed, e.g., “Informed Parents and Informed Students”
- “School Attendance Support” after data because poor attendance is an indicator before poor test scores.
- “Staff Development” because staff are not taught about risk factors and if they were trained, they could help intervene. This should include mental health mentoring in schools.
- “Administration” including principals, and staff on board for mental health support.
- “Foundational Principles” to guide the work including values and diversity awareness, particularly for students being left behind.
- “Coordination of the Elements” – otherwise it is just back to the old system. There has to be a point that coordinates all the elements and makes sure that everyone is on the same page. It should not be assumed that one person would take this on but rather view it as a sphere of responsibility.

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**California's Mental Health Services Act, Prevention and Early Intervention Component:  
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- "Outreach to Faith-Based Organizations" as a support for students and families.
- Health elements such as mind, body, spirit and nutritional focuses.



- "Cultural Centers" as part of the neighborhood element; this includes interaction with elders of the community.
- "Having Basic Needs Met," which is especially important during the recession and economic crisis.
- "Student Buy-In"

Participants suggested a few changes, including:

- "Youth Development" to "Individual Development"
- "Neighborhood" to "Community"

The group offered several other suggestions to strengthen a preventive approach such as:

- Be sure to include parents in the programs.
- Mandate that questions about suicide be included on the CA Youth Risk Behavior Survey, a common data collection tool.
- Data collection should not just occur at one point; instead it should feed back into the process to help drive success.
- Be sure to include the rural communities that do not have access to services. Keep in mind that the infrastructure may not be in place.

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- Specifically emphasize the adult/student relationship and need for connection with adults.
- Look at this from the youth perspective; they look at things more holistically.

*Identifying Current Prevention and Early Intervention Activities, Partnerships and Unmet Needs*

Ms. Marois reminded the group that planning takes patience and encouraged them to resist the urge to jump immediately into developing actions. Instead, the day's discussion is intended to identify a long-term vision and current PEI activities, partnerships and unmet needs that already occur in schools. This information will provide the group with a common understanding of current reality and a foundation to build effective strategies. Following lunchtime table discussions, each small group reported one current partnership and one unmet need (see Appendix A for entire group reports). Highlights included the following:

Partnerships

- MH and the school boards
- Early mental health program
- Varies from district to district; collaboration would be more effective if it included all the stakeholders such as the Student Attendance Review Boards (SARBs).
- Healthy Start program
- White House Counseling within the San Juan Unified School District (SJUSD) and similar services in the Elk Grove Unified School District
- Universal study team process that could provide a foundation or model for universal programs
- Sacramento City Unified School District (SCUSD) Home Visiting Program where teachers visit families with hard-to-reach parents
- SCUSD collaborates with Bayside Church to offer mentoring and tutoring without a religious component
- SB 65 programs and drop-out prevention programs
- BEST Behavior Training
- 36/32 program on IEPs to help those students who have been suggested as having mental health problems.

Unmet Needs

- Common roles and responsibilities
- On-site anger management skills
- Outstation mental health sites that collaborate with the Healthy Start program
- Healthy Start Program is only in 19 of the schools in the SCUSD.
- Clinicians in the school to provide support and providing more consultation for staff and families on mental health.
- Student Study Teams, which are multi disciplinary teams that come together when a student seems to be at-risk but before they are at early intervention level. The team

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includes parents, specialists and sometimes a social worker and they work together to develop an early intervention plan.

- Peer programs and peer advisors.
- Getting all the programs to work together
- Mental health professionals in schools to do training.

**Vision 2019: Schools as Prevention and Early Intervention Partners to Support Student Success**

Ms. Marois introduced the next item on the agenda and explained that it is helpful to decide what direction to go in before beginning the journey. Ideally, implementation activities begin with the end in mind so the group was asked to consider desired results to achieve over the next ten years. Ms. Marois led the group in imagining a future celebration where Sacramento County has made tremendous progress in transforming systems to support student success with schools as key partners in the effort. Participants were asked to brainstorm descriptions of this preferred future and its greatest accomplishments, based upon the following:

Ten years have passed and all the things you imagined have come true. Sacramento County has achieved success in transforming the mental health system. Schools are now integrated as key partners in prevention and early intervention efforts.

- Ideally what does this world look like?
- What accomplishments are you most proud of?
- What outcomes have been achieved for students, for the school system, for the mental health system?
- What is different now - for students, families, teachers, schools, mental health, health providers, administrations, etc.?

Group members each shared components of what student success could look like with regard to the role of schools as prevention and early intervention partners. Graphic facilitator Emily Shepard captured these elements in a visual recording. Common elements of this vision focused on a holistic approach to health; the changing role of teachers and mental health service providers; coordination of services; increased access to services; culturally competent and stigma-free access to mental health support; preparation for students planning to enter college or the workforce; open campuses that include multi-generational participation and mentors; enhanced data collection and student tracking methods that allow for earlier intervention; and policy change to prioritize prevention. Specifically, individuals offered the following ideas:

Holistic Health/Relationships

- MH is something that everyone has and positive MH is universal. Services are delivered regardless of funding and culture.
- MH is nonexistent; instead there is a holistic care model where the whole person is cared for at one time.



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- The next generation is not here talking about the same things that we are talking about
- A clearinghouse of volunteers in every district to match mentors with the schools that need the support.
- Parents could have more time at home to raise their children and then work less.
- People would choose life.
- Changing role for MH professional; less time on therapy and more time education and facilitating an emotionally health environment.
- At the celebration of implementation, all of the child services will stand together.
- MH starts with physical health and a lot of people are not aware of this nor do they have access. In this vision doctors would recommend exercise such as yoga, address nutrition and provide holistic health access.

**Collaboration & Service Delivery**

- System navigators so that no one gets lost.
- Mechanism to help share responsibility and anyone can ask for help.
- Individual plans for every student – not just the troubled children – that are asset-based and encompasses their strengths.
- School sites are open 24 hours a day, 7 days a week to be used as meeting space and infrastructure to build communities.
- Multiple methods/mediums of access.
- Develop a computer system to track early warning signs, such as attendance records, to help identify at-risk students.
- Students with behavior problems that exhaust the schools are referred to Student Attendance Review Board (SARB). The SARB should include a MH representative to link the student to the resources of the community.
- Student start internship type training as young as 3<sup>rd</sup> grade to build relevant learning.
- Services should all be available at the school and there would be no stigma associated with accessing those services.
- There needs to be an accountability system in place.
- Universal access to MH services for all kids and reps at each site.
- Coordination of care. Example: if a student from one district moves to another district, staff at the new district would know the child's history immediately so that there is no need to reinvent the wheel.
- Alcohol, drug and other substance abuse services are centralized; stakeholders can access these in one place such as a youth center.
- Seamless integration of work so that one cannot tell a teacher from a MH provider or a probation officer.
- Schools will serve as the hub for services.
- As a system, make sure that it is a relevant and responsive approach rather than a cookie cutter.
- Partnerships will make this dream happen.
- Not to forget First Five and the programs for children 0-5 years old.

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Policy Change

- Decision making authority will be given to those closest to the person needing the services.
- CA will be ranked #1 in funding for education.
- Prevention would no longer be seen as discretionary and instead mandatory because in a budget crisis, prevention is the first thing to be cut.
- Policy work done in the districts with SCOE as the spearhead. SCOE should create a task force including the school board and superintendents to create policy around social and emotional student functions, including funding to implement programs with data collection mechanism to track progress.
- Program needs to begin immediately if this will be achieved.

After hearing everyone's input to the 2019 Vision, some group members offered the following reflections:

- It is too bad that the group has known about this need for a long time and only now are they coming together to address it as a collaborative effort. There is nothing stopping this group from being a model for the nation.
- Schools will play significant roles in the future as service-oriented centers.
- There is movement toward looking at this as a holistic system where everything works together. Currently, there are impediments for students seeking services.
- A lot of the expertise will be out of the workforce by 2019 and that should be noted.

Others described breakthroughs that will be necessary for this vision to be achieved such as:

- Every person that works with youth recognizes that mental well-being is part of their job.
- Support from private industry will be needed. Regardless of who you are, there is a place for you in the workforce – even those who are disabled.
- Immediate need: all those involved take structured time to meet to overcome barriers and make time for communication.
- Staffs need to see this as more than just a job and see themselves as civil and public servants.
- Acceptance of the concept that prevention is important and a good use of funding.
- SCOE needs to help the group to stay together for this charge.
- Reform stressed system so that staffs are not compelled to refer students to others but instead have the time to take responsibility themselves.
- Tap into the existing infrastructure and involve pre-school and pre-K teachers in the communication lines.
- Public health campaign to create a more general awareness of MH.

**Identifying Current Trends, Assets, Opportunities and Challenges**

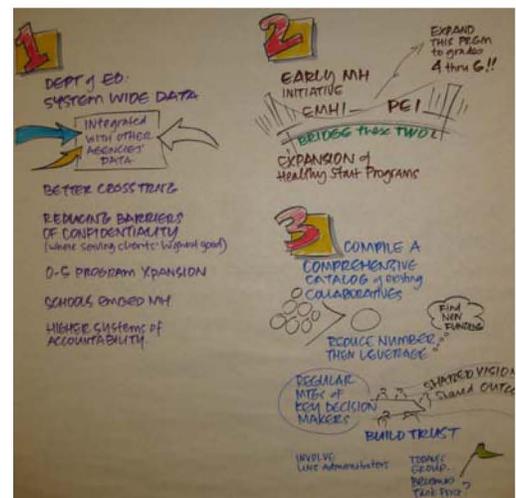
Participants divided into small discussion groups that explored a series of questions about current conditions related to prevention and early intervention services and programs in

## California's Mental Health Services Act, Prevention and Early Intervention Component: Collaborative Partnerships in Sacramento County

schools. After the initial discussion, participants had the opportunity to rotate to a new small group.

### 3-5 Year Trends, Changes & Innovations Predicted to Impact School-Based Mental Health

- CA School Information Services (CSIS), CA Longitudinal Pupil Achievement Data System (CALPADS), California Longitudinal Teacher Integrated Data Education System (CALTIDE)
- New data systems and integrated data efforts
- Expanding youth and family mentors
- More evidence-based practice
- Basic cross-training (MH and education)
- Reduce barriers of confidentiality between agencies
- Mitigate financial and economic needs of families
- Crisis counseling
- Exercising categorical flexibility
- Negative and positive impacts
- Universal (New National Health Care Systems) with unintended consequences i.e. staffing, limited resources, etc.
- Birth – 5 program expansion – increase relationships
- 0-16 highest impact
- School based mental health could shift to more prevention
- Preschool expansion in Early Start/statewide initiative
- Schools embed MH social workers and set aside dollars to conduct long-term social emotional work
- Higher accountability (RTI)
- Transition specialists
- Every student has an individual learning plan



### Existing Resources and Upcoming Opportunities to Leverage to Transform School-Based Mental Health

#### Existing Resources

- Early Mental Health Initiative via PEI – expansion of services in grades 4-6 (currently k-3)
- Community-based mental health agencies serving selected schools
- SARB exists – but need more models – maintain and existing support improvement
- Support services that once existed need to return
- Healthy Start programs still in operation and should be expanded
- Comprehensive Student Support (CSS) which is part of SB 65
- Nell Soto Home Visit program
- McKinney-Vento homeless assistance services

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- Foster youth services
- Family agencies, i.e. La Familia, Birth and Beyond, St. Johns (Rancho Cordova)
- Using existing structures to partner for providing support services, i.e. back to school night (make mental health specific to talk about services)
- Youth coalitions – as advocates for sharing information
- Expanding mental health coalition partners with EMHI and inquiring of natural partners and avoiding duplication

**Upcoming Opportunities**

- Collaboration with university/college internships (school social work degree program)
- Early Mental Health Initiative – sponsored trainings and conferences extending invitations to services providers for attending

**Strategies to Enable Schools, Mental Health and Other Partners to Collaborate Effectively**

*\* In priority order*

- Matrix of existing collaborative; both county and neighborhood
- Simplify/collapse existing collaboratives
- Build upon existing collaboratives to seek funding, coordination to provide needed services
- Regular meetings of key decision makers for shared vision, resources, data, and outcomes
- Strengthen relationships to build trust
- Involve district/school administrators
- Today's group serve as a PEI Task Force
- Use SARBS (all existing groups and mental health)

**Support School Systems Need to Reduce the Risk of Suicide for Students**

- Training on three levels:
  - o Staff – warning signs
  - o Parents – where to go, what are resources
  - o Students – problem solving, coping skills
- Develop a safety net so parents and teachers become part of the safety net
- Peer mentor training/ peer mentor program trained in warning signs and making referrals
- All schools need a risk assessment tool to be able to assess risk
- Need a policy/procedure that is standardized and used by everyone
- All staff in suicide awareness would be trained in the risk assessment tool
- Research existing tools
- Jason Foundation is a resource connecting school systems with mental health and CBOs doing work and survivor groups
- Include in training sensitivity awareness or how behavior can impact others, ex: bullying
- Investigate existing programs that change school culture such as, Challenge Day or Safe School Ambassadors

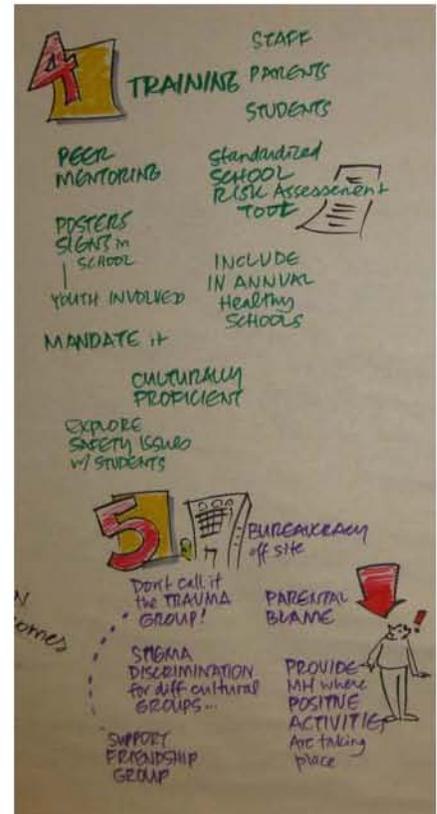
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- Resource: Living Works
- Distribute prevention posters and signs around the campus in bathrooms and hallways
- Use email to access resource information
- Confidentiality kiosk on computer
- Use teens to design a specific campaign
- Kathleen Snyder is a CDE trainer on suicide
- Make sure school district is included in the comprehensive safe school plan done annually
- Encourage or mandate schools to use CA Healthy Kids survey section on suicide risk
- Explore issues of safety with kids. What and how would they feel safer?
- Consider cultural, ethnic differences and things to know

### How Stigma and Discrimination Looks in School Populations

- Reluctance to assess services
- Misinformation
- Fear
- Denial
- Lack of trust and respect
- Prejudgment
- Primary language barriers
- Bullying
- Misconceptions
- Stereotypes
- Previous stigma and discrimination
- Cultural barriers
- Shame and embarrassment
- Age and gender
- Avoidance
- Isolation
- Poverty
- Learned helplessness
- Off-site services lead to stigma and other problems
- "Zero tolerance" feeds into this disparity in suspensions
- Fear of association
- Parental blame
- Stigma toward those in 26.5 County Mental Health placement or special education
- Stigma and discrimination by our language
- Traditional, bureaucratic way of delivering services (embed in settings where there are positive activities taking place)
- Labeling of kids receiving services – avoidance by others
- 50 minute session – groups less stigmatizing and more effective

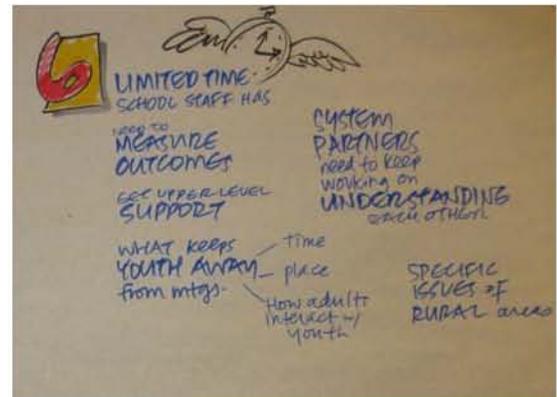


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- Being left out – isolated – avoidance by others
- Solution: include mental health staff “wellness staff” at open houses, etc.
- Normalize
- Cultural explanations of mental illness
- Breaking cultural taboos in seeking help

### Challenges to Implementing School-Based PEI in Sacramento Communities/County

- The limited time school staff have to devote to training and staff development
- Us/Them mentality such as “not my job” or “I don’t have kids with problems”
- Seeing school personnel as problem and not a partner
- The need to teach to the standards and accountability measures
- How to measure outcomes?
- No teeth in CA Healthy Kids Survey (in terms of mandated components)
- Upper level leadership (Board’s Cabinet) needed to support this across the partner systems
- Form follows policy
- Losing institutional memory over next few years
- Beware of negative views such as “we tried that before” – maybe the time just was not right



### Barriers that keep youth away from the table

- Transportation
- Need to build youth and adult partnerships
- Lack of patience in adults
- Adults knowing how to work with youth as leaders
- Do we believe, really, that youth should be involved?

### General challenges

- The institutional setting itself is a barrier
- Openness and acceptance related to data, the validity of data, and trusting the data
- Continued struggle for systems to understand each other which often results in expectations not being met
- How do we decide which processes and programs to build upon? Prioritizing, how do existing and new strategies fit?
- How many collaboratives already in place? How do we bridge them? Get “right” people at table and the “right” timing?
- Issues of rural areas – bridging to urban and suburban

### Recommended Priorities

Now that the group has considered their vision for the future along with current resources and needs, Ms. Marois asked participants to begin focusing on priorities. As discussed in the

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morning presentation, the State requires each county to identify priority mental health needs and populations in their plan. She explained that the Sacramento County Mental Health Division is collecting information from many different stakeholder groups and that this is an opportunity to provide recommendations to inform the local PEI planning process. Based on the feedback of this group, SCOE will assemble a detailed report for the Sacramento County Mental Health Division. Each participant received colored dots to vote on each of the three categories. Results are summarized below:

**PEI Key Community Mental Health Needs**

- Disparities in access to mental health services (2 Votes)
- Psycho-social impact of trauma (3 Votes)
- **At-risk children, youth and young adults (30 Votes)**
- Stigma and discrimination (2 Votes)
- Suicide risk (1 Vote)

**PEI Priority Populations**

- Underserved cultural populations (4 Votes)
- Individuals experiencing early onset of serious psychiatric illness (0 Votes)
- **Children/youth in stressed families (17 Votes)**
- Trauma-exposed (3 Votes)
- Children/youth at risk of school failure (10 Votes)
- Children/youth at risk of juvenile justice involvement (3 Votes)

**PEI Priority Age Groups**

- Ages 0-5 (3 Votes)
- **Elementary School Age (27 Votes)**
- Middle School Age (2 Votes)
- High School Age (4 Votes)

After reviewing the highest priorities according to the dot vote count, Ms. Marois opened the discussion for comment. One participant noted that efforts need to start where the problem begins and that youth need to be involved in planning. Another group member pointed out that underserved populations should not be considered as a separate group. Rather, underserved populations should be considered within each priority population.

**Wrap Up and Next Steps**

Joyce Wright, Assistant Superintendent, SCOE thanked the group for coming to the table and participating. She explained that SCOE's next step is to develop a detailed report based on the group's work for Sacramento County's Mental Health Division. The input and ideas heard today will be part of the data collection for the local PEI planning process. Ms. Wright mentioned that she would like to have participants of this meeting become a workgroup to stay part of the

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process. Lastly, Ms. Wright thanked Ms. Callejas and County MH for the opportunity to have this meeting and to enlist this input.

Ms. Callejas explained that Sacramento County's Mental Health Division will take the report from today's meeting and merge it with the input they receive from other stakeholders. These reports and data collection mechanisms will aid in the decision for allocation of funding. She also hoped that further participation by the group will be possible.

**For More Information**

California Department of Mental Health, Mental Health Services Act  
[http://www.dmh.ca.gov/Prop\\_63/MHSA/default.asp](http://www.dmh.ca.gov/Prop_63/MHSA/default.asp)

Sacramento County Office of Education  
[www.scoe.net](http://www.scoe.net)

Sacramento County Mental Health Division  
<http://www.sacdhhs.com/default.asp?woid=men>

CSUS Center for Collaborative Policy  
<http://www.csus.edu/ccp/>

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**California's Mental Health Services Act, Prevention and Early Intervention Component:  
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**PARTICIPANTS**

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Kathleen Snyder, Intern, Suicide Prevention, California Department of Education  
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Gaye Lauritzen, Categorical Services Specialist, Center USD  
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Paul Teuber, Student Support & Health Services, Elk Grove USD  
Bill Tollestrup, Director, Special Education, Elk Grove USD  
Linda Burkholder, Director, Family Support Services Office, Folsom Cordova USD  
Annette Lazzarotto, Outreach Consultant, Galt Joint UESD  
Janet Munoz, Prevention Specialist, Galt Joint UESD  
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Mary Conklin, Counselor, Galt High School, Galt Joint UHSD  
Colleen Hurley, Director of Special Education, Galt Joint UHSD  
Gayle Martin, Counselor, EMHI Program, Natomas USD  
Tim Shironaka, Principal, Discovery High Continuation, Natomas USD  
Amreek Singh, Homeless Liaison, Natomas USD  
Barbara Kronick, Director, Integrated Support Services, Sacramento City USD  
Lawrence Shweky, Coordinator, Integrated Support Services, Sacramento City USD  
Shelton Yip, Administrator, SCUSD SELPA, Sacramento City USD  
Nancy Marshall, Program Manager, Family Support, Sacramento County DHHS  
Lisa Bertaccini, Chief, Child and Family Mental Health, Sacramento County DMH  
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Wendy Greene, Program Manager, Division of CFSU, Sacramento County DMH  
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John Reilly, Supervisor Probation Officer, Juvenile Field, Sacramento County DMH  
Anne-Marie Rucker, Program Planner, DHHS Child & Family, Sacramento County DMH  
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Kathryn Skrabo, Program Planner, MHSA, DHHS, C&FMH, Sacramento County DMH  
Gay Teurman, Program Coordinator, Division of CFSU, Sacramento County DMH  
Lori Vallone, Juvenile Drug Court Coordinator, Sacramento County DMH  
Dawn Williams, Program Planner, Sacramento County DMH  
Uma Zykofsky, Program Manager, Sacramento County DMH

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**California's Mental Health Services Act, Prevention and Early Intervention Component:  
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Marty Cavanaugh, Deputy Superintendent, Sacramento County Office of Education  
Dave Gordon, Superintendent, Sacramento County Office of Education  
Karen George, Teacher, Project TEACH, Sacramento County Office of Education  
Judy Holsinger, SELPA Director, Sacramento County Office of Education  
Trish Kennedy, Foster Youth Director, Sacramento County Office of Education  
Cheryl Raney, Director, Prevention & Student Services, Sacramento County Office of Education  
Pamela Robinson, Director, Prevention & Student Services, Sacramento County Office of Ed.  
Joe Taylor, Administrator, Child Welfare & Attendance, Sacramento County Office of Education  
Joyce Wright, Assistant Superintendent, ISS, Sacramento County Office of Education  
Linda Bessire, Director, Pupil Personnel Services, San Juan Unified School District  
Patricia George, Program Manager, White House Counseling Center, San Juan USD  
Margaret Jones, Program Specialist, Foster Youth Services, San Juan Unified School District  
Janet Balcom, Assistant Superintendent, Twin Rivers Unified School District  
Jane Claar, Coordinator, CWA, Twin Rivers Unified School District  
Rudy Puente, Director of Student Services, Twin Rivers Unified School District

**Lead Facilitator** – Deb Marois, CSUS Center for Collaborative Policy

**Graphic Facilitator** – Emily Shepard

**Note Taker** – Charlotte Chorneau, CSUS Center for Collaborative Policy

## **APPENDIX A**

### **What is Prevention and Early Intervention? Identifying Current PEI Activities, Partnerships and Unmet Needs**

**Group A: Janet Balcom, Patricia George, Rudy Puente, Linda Bessire, Jane Claar**

#### **What specific PEI activities are schools already doing?**

- Early Mental Health Initiative (EMHI)
- Student Attendance Review Board (SARB)
- AB 1802 – Student Assistance Program
- SB 65 CSS Outreach Consultant
- Parenting Project
- Mentoring/Solutions
- Home Visit Program (Nell Soto)
- Positive Behavior Support (PBS) – BEST and RTI

#### **What partnerships/collaborations are currently in place?**

- CPS
- Stanford Settlement
- The Effort
- Mentoring Solutions

#### **What unmet PEI needs currently exist for students, families and the education system?**

- EMHI at all sites
- Outreach support (SB65)
- Collaboration with probation needed
- Not all activities at all schools within districts (PBS, Home Visit, EMHI, Parenting, SB 65)
- Community service learning needed
- Mentoring

**Group B: Nancy Marshall, Cheryl Raney, Barbara Kronick, Patrick Mangan, Gay Teurman, Karen George**

#### **What specific PEI activities are schools already doing?**

- School psychologist
- Mentoring
- Classes and individual (FCUSD)
- Making room for individual counselors for outside agencies
- 19 schools in SCUSD have collaboratives with Healthy Start with MH counselors, social workers, parent coordinators.
- Student study teams in all schools (sometimes under another name i.e. Student Success Team)

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**What partnerships/collaborations are currently in place?**

- Family support collaborative
- Birth and Beyond

**What unmet PEI needs currently exist for students, families and the education system?**

- Lack of services reaching down to birth – 5 years.
- Not all programs are in all schools
- Unequal access and capacity

**Group C: Margaret Jones, Pam Gressot, Anthony Madariaga, Kathryn Skrabo, Lawrence Shweky, Trish Kennedy**

**What specific PEI activities are schools already doing?**

- Collaboration with Healthy Start
- White House Counseling Center

**What partnerships/collaborations are currently in place?**

- County mental health clinicians at schools
- Mental health education for staff at some schools

**What unmet PEI needs currently exist for students, families and the education system?**

- Consultations to support understanding of identified issue and resources available
- Crisis intervention for families in need of emergency support

**Group D: Shelton Yip, Verronda Moore, Stephanie Ramos, Joyce Wright**

**What specific PEI activities are schools already doing?**

- Home Visitation Program – teachers visit families
- Healthy Start – resource center for families and schools
- Early Detection and Intervention for Prevention of Psychosis Program (EDIPPP) – partnership with UC Davis

**What partnerships/collaborations are currently in place?**

- Early Detection and Intervention for Prevention of Psychosis Program (EDIPPP)
- Faith based – Bayside Church
- School based mental health
- MH and SCUSD collaboration for the Mental Health Advisory Committee
- SARB
- AB3632 – MH and schools – 26.5 County Mental Health Placement

**What unmet PEI needs currently exist for students, families and the education system?**

- More peer programs
- On-site peer may help with conflict resolution (“peer advisors”)
- Collaboration training

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**Group E: Dawn Williams, Anne-Marie Rucker, Wendy Greene, Myel Jenkins, Jane Ann LeBlanc, Diane Lampe**

**What specific PEI activities are schools already doing?**

- Out-stationed MH staff at two schools through Healthy Start
- The Effort counseling services at one high school
- Counselors in training (getting their hours; not paid) at some school sites
- Integrated services department
- Violence prevention
- Character and asset development
- Conflict meditation
- Safe Schools Ambassadors
- Breaking down walls

**What partnerships/collaborations are currently in place?**

- Healthy Start – school-based or regional
- Mental health and schools
- The Effort counseling
- Federal and state grants for prevention

**What unmet PEI needs currently exist for students, families and the education system?**

- Gaps
- Training for staff, teachers and families on how to access resources.

**Group F: Wendy Greene, Uma Zykofsky, Dave Schroeder, Michelle Callejas**

\* There is a need to clarify definition of primary prevention and early intervention

**What specific PEI activities are schools already doing?**

- Early Mental Health Initiative (EMHI)
- Student Study Team
- Parent teacher conferences and back to school nights.
- Socialization skills group
- PTAs and PTSOs

**What partnerships/collaborations are currently in place?**

- Student Attendance Review Board (SARB) which MH does not see as early intervention.
- SCUSD Mental Health Advisory Board
- MHSA taskforces and stakeholder groups
- EDIP

**What unmet PEI needs currently exist for students, families and the education system?**

- Common definitions and understanding of the problem, roles and responsibilities.
- Training for teachers on identification of early signs of distress.
- Proactive strategies for supporting children and families before challenges occur.
- Building connections between elements of prevention.

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**California’s Mental Health Services Act, Prevention and Early Intervention Component:  
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**Group G: Lori Vallone, Tim Shironaka, Paul Teuber, Gayle Martin, Amreek Singh**

**What specific PEI activities are schools already doing?**

- Youth alcohol and drug treatment services
- DMH –PEI Early Mental Health Initiative – primary intervention program
- Children’s Art Bereavement – Sutter Hospital
- PBS

**What partnerships/collaborations are currently in place?**

- Children’s Art Bereavement group –Sutter Hospital
- Terkensha – access team
- Terkensha, primary intervention program (EMHI)
- Sac State internship program
- Stanford Settlement
- Visions Unlimited
- Smile Keepers

**What unmet PEI needs currently exist for students, families and the education system?**

- Mental health for undocumented citizens, the homeless
- Parenting support
- Mentoring
- On site anger management/social skills programs throughout schools

**Group H: Alyson Collier, Gaye Lauritzen, JoAnn Johnson, John Reilly**

**What specific PEI activities are schools already doing?**

- Early Detection Intervention for Prevention of Psychosis (EDIP)
- Sacramento City - specific tools to indentify
- Student Study Teams
- “Every 15 Minutes” teams

**What partnerships/collaborations are currently in place?**

- SARB Teams
- Truancy sweeps
- School-based county mental health

**What unmet PEI needs currently exist for students, families and the education system?**

- Youth development
- Suicide prevention
- Literacy education model (to educate families on health/wellness needs of families)
- Staff development

**Group I: Kathleen Snyder, David Kopperud, Linda Burkholder, Joe Taylor, Pamela Robinson**

**What specific PEI activities are schools already doing?**

- SARB process starts with a comprehensive school attendance improvement plan.
- Most districts are doing the parental truancy notifications.

**California's Mental Health Services Act, Prevention and Early Intervention Component:  
Collaborative Partnerships in Sacramento County**

- Student Study Teams

**What partnerships/collaborations are currently in place?**

- SARB is currently in place- varies from district to district how deep the collaboration is – many SARBs lack key representatives.

**What unmet PEI needs currently exist for students, families and the education system?**

- SARBs would be more effective with county mental health representatives. Few SARBs currently include a county mental health representative – even though that is a recommended practice.

**Group J: Colleen Hurley, Janet Munoz, Annette Lazzarotto, Kuljeet Nijjar, Robert Nacario, Mary Conklin**

**What specific PEI activities are schools already doing?**

- Positive behavior strategies
- Jump start kindergarten
- Outreach consultants – run groups at elementary
- Parent project – strengthening families

**What partnerships/collaborations are currently in place?**

- After School Education and Safety (ASES) program 21<sup>st</sup> Century Grant
- After school tutoring
- Partnership with Boys and Girls Club
- Strategies for change

**What unmet PEI needs currently exist for students, families and the education system?**

- Parent resource counseling services
- Trained social worker in the home
- Having a mental personnel person train teachers and work with top at-risk students.
- Gang intervention
- Access to rural community
- Suicide prevention
- Family treatment

# **End of PEI Plan Amendment Attachments**