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November 19, 2008

PEI Component
Prevention and Early Intervention Branch
California Department of Mental Health
1600 9th Street, Room 150
Sacramento, CA 95814

Dear Assistant Deputy Director:

The County of San Diego, Health and Human Services Agency (HHSA), Behavioral Health Services (BHS) is submitting the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) component of the Three-Year Program and Expenditure Plan. This document outlines new programs for our PEI plan. This request is in response to DMH Information Notices No: 07-19, The Mental Health Services Act (MHSA) Prevention and Early Intervention Component – Proposed Three-Year Program and Expenditure Plan Guidelines, Fiscal Years 2007-08 and 2008-09 (Revised August 7, 2008) and No: 08-27, Increased Level of Funding for Community Program Planning Activities and Funding Augmentation to the Mental Health Services Act Prevention and Early Intervention Planning Estimates (Fiscal Year 2008-09).

The PEI plan was made available for public review and comment for a 30-day period (pursuant to Welfare and Institutions Code §5848[a]) via presentation at our Mental Health Board, posting electronically on our community access website, and e-mail distribution to Council and Board participants.

The attached documents meet all requirements of the PEI Component Guidelines as described in DMH Information Notice No: 07-19 (revised) and No: 08-27.

We request your review and approval of our MHSA PEI Plan. We appreciate your consideration of this request.

Submitted by,


ALFREDO AGUIRRE, LCSW
Deputy Director
Mental Health Services


PHILIP A. HANGER, PH.D.
MHSA Coordinator
Mental Health Services

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

Form No. 1

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

County Name: San Diego

Date: 11/19/2008

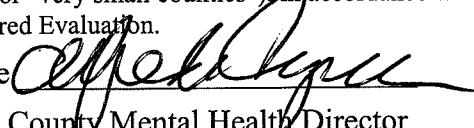
COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):

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AUTHORIZING SIGNATURE

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

Signature


County Mental Health Director

11/19/2008
Date

Executed at San Diego, California

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

County: San Diego

Date: 11/03/08

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

Dr. Philip Hanger, Assistant Deputy Director (ADD) in Mental Health Services (MHS), is the MHSA Coordinator for the County of San Diego. Dr. Hanger led our County's PEI Planning Team, assisted by Sarah Brichler (Administrative Analyst III), a full-time staff dedicated to the MHSA planning process. Additional participation in the overall planning process included Alfredo Aguirre (MHS Deputy Director), Piedad Garcia (MHS Assistant Deputy Director, Ethnic Services Manager, State Diversity Committee Member, & CiMH Multicultural Development Center Committee Member), Henry Tarke (MHS Assistant Deputy Director), Liza Cabigas (Behavioral Health Services, Assistant Deputy Director, Financial Management Unit), Candace Milow (BHS Quality Assurance Director), as well as two Temporary Expert Professional staff who had extensive experience in project management and County programming, Kelly Henwood and Ged Bulat. Representatives from our Adult and Children consumer liaison groups were contributing members on this PEI Planning Team as well. The Team met weekly to review the status of the PEI Planning Process.

b. Coordination and management of the Community Program Planning Process

Members of the PEI Planning Team formed the core of staff providing coordination and management for the Community Planning Process. In addition, the Planning Team utilized a taskforce of 10 County staff that assisted in event coordination and PEI workplan development. Significant in-kind assistance was also received from stakeholders within the community - including consumers, contractor/providers, and experts – who helped disseminate information, direct community members to appropriate community locations, and serve as presenters and facilitators at the community planning forums. The role of County staff was to identify and retain subject matter content experts, develop/disseminate appropriate announcements through media or direct community contacts (e.g., fliers that were distributed in consumer clubhouses), secure venue space in adequate locations based on targeted community densities and transportation needs, set up forum and focus group venues, manage and distribute materials presented, and collect community input/questions.

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

As described in the “Lessons Learned” section to follow, the County of San Diego utilized community input from the CSS Planning process, data from the Gap Analysis, and ongoing community input through our sustained Stakeholder-led Councils (Children’s System of Care Council, Adult System of Care Council, Older Adult System of Care Council, Housing Council, and Mental Health Board). From this community-based input, San Diego County developed eight focus areas: Native American Communities, Veterans and their Families, Co-Occurring Disorders, School Age and Early Childhood, Community and Domestic Violence, First Break of Psychosis, Rural Community Issues (East County, North Inland, Mountain Regions), and Older Adult Issues.

A September 2007 “Kickoff Forum,” co-facilitated by the Director of Behavioral Health Services and the Mental Health Services Deputy Director, introduced these eight PEI areas of focus and the PEI planning process to the larger community. The MHSA Planning Team and MHS staff then organized eight community-based forums throughout the county for the purpose of soliciting stakeholder input within each of the focus areas. These community forums, each of which was facilitated by a lead member from the PEI Planning Team or staff support team, took place from November 2007 through March 2008.

During the same time the “Kickoff Forum” and the community forums were taking place, Dr. Hanger and members of the PEI Planning Team attended numerous existing community-based stakeholder meetings as part of the outreach campaign to present and outline the PEI planning process, guidelines and timeline and engage community members in the planning process. Between July 2007 and April 2008 the MHSA Planning Team members and support staff participated in over 60 stakeholder meetings across six regions within San Diego County covering a variety of cultural and ethnic communities and age-ranges. These stakeholder meetings included our ongoing Mental Health Councils, the constituency of which includes consumers, family/caregivers, providers, community experts, public agencies (City and County), education representatives, as well as open membership from local stakeholders. These Councils are chaired by members of the stakeholder community – not by Mental Health staff. Additional ongoing community meetings included community commissions (e.g., Children Youth and Family Commission, Domestic Violence Commission), which are similarly comprised of consumers, professionals, providers (public and private), interested community members, and designees from political offices. Finally, thirty focus groups were convened specifically to obtain further stakeholder input from the immigrant, African Refugee, African American, Asian/Pacific Islander and LGBTQ communities, as well as other unserved and underserved populations. To ensure stakeholder input was also received from those with serious mental illness and serious emotional disturbances, focus groups were also facilitated in client clubhouses and an adult day health center..

Separate from these public meetings, community and stakeholder input was solicited and received in a variety of formats including phone messages, website submissions (the County maintains an ongoing website, www.sandiego.networkofcare.org, which includes a section dedicated to disseminating information related to our MHSA planning process), e-mail and mail (PEI Community Input Forms, memos, letters, and full proposals). The information received was compiled for public review in a more “consumable” PEI Community Input Summary document. All summary documents incorporating community input were posted on the County of San Diego’s Behavioral Health Network of Care website for public information and review. In addition, these summary documents were sent to all members in our continually expanding e-mail distribution list of consumers, professionals, agencies, and other interested parties.

All community/stakeholder input received to date, as well as summary documents prepared by the PEI Planning Staff, were also presented in an open, public session of our April 2008 Mental Health Board. The Mental Health Board serves as the initial cross-threading work group, as they are a non-conflict body of existing consumers and other stakeholders. Given the “contracting” nature of our County’s mental health services, the issue of “conflict” had been previously resolved during the CSS planning process by our County’s requiring the absence of fiscal conflict as a condition of cross-threading membership.

Following additional community input received during the public comment period, the April 2008 Mental Health Board provided a ranking of key community needs and priority populations. These rankings were taken up further by 10 workgroups consisting of a County Mental Health Chief, Regional Program Coordinator, or Assistant Deputy Director as lead, pertinent inter-Agency County staff, non-conflict community experts, and non-conflict consumers and stakeholders. (During the stakeholder input process, community members had recommended separating School Age and Early Childhood Services into two separate focus tracts for further detailed planning. Additionally, in the majority of the forum and focus groups, input was received recommending that the County address universal (“primary”) prevention needs of suicide risk and stigma and discrimination, as well as targeted (“secondary”) prevention for focus populations, within a separate work group. Thus, eight focus issues became 10 priority focus area workgroups.) These workgroups scrutinized community input, relative data, and Mental Health Board rankings, as well as holding intensive meetings to develop PEI plans.

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.

During the eight community forums, the county made certain to issue targeted invitations to both unserved and underserved communities. Additionally, forum venues explicitly took into consideration how best to reach representatives and family members from these communities as well as how to ensure the necessary

access for their participation. For example, the Native American Forum was held in a location geographically central to all the tribes in San Diego County (a location chosen by consensus of planning members from the Native American community) while the Rural Forum was held in five rural settings, simultaneously linked by teleconferencing equipment.

Existing consumer and family liaison agencies, whose members attended PEI Planning Meetings, also played key roles in creating additional opportunities for including representatives and family members of unserved and underserved populations in the participation process. Between February and March, 2008 approximately 30 focus groups coordinated in partnership with community-based agencies were facilitated by these consumer and family liaisons, community members and County staff. Each focus group consisted of 6 to 15 participants and included consumers and family members. Smaller than community forums, these focus groups were specifically designed to foster a welcoming, inclusive environment for individuals from unserved and underserved communities, and to provide intentional, targeted opportunities for their input to be included in the planning process. In total, approximately 250 community members participated in focus groups representing a diverse group of individuals from a variety of unserved and underserved communities including, but not limited to, youth, LGBTQ, and various ethnic and cultural communities e.g., Latino, Asian/Pacific Islander, Eastern European, African-American, Refugee and Immigrants (see Section 2.b. for a fuller explanation of how two liaison agencies, Family & Youth Roundtable and Partners in Care, facilitated both representatives' and family members' involvement through targeted focus groups as well as attachment, "List of Focus Groups & Forums" detailing the diversity of the these focus groups).

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 MHSA Coordinator and members of the PEI Planning Team maintained ongoing review of feedback obtained via existing community meetings, planned forums, and independent communications. Using this information, the focus groups were crafted relative to community members' geographic location, age, gender, ethnicity and language. Several focus groups were held in Spanish, and translator services were made available to community participants when requested.

Examples of Stakeholder participation:

Consumer and Family Liaisons: The County of San Diego utilized the expertise of two consumer advocacy liaison groups under contract from MHSA CSS program funds - Family & Youth Roundtable and Partners in Care. They were responsible for organizing and hosting smaller focus groups to ensure that family and potential consumer level input was included in the process and to maximize involvement with consumers, family members, and representatives of underserved and under-represented ethnic and cultural communities. These two consumer and client/family

liaison groups played an important role in MHSA PEI planning by assisting in the collection of input from consumers and their families on issues related to PEI and mental health services.

The Family and Youth Roundtable is an independent, family and youth led organization that works to promote authentic partnerships and achieve excellence in public child-family serving agencies by amplifying the voice of families and youth. The County felt it important to involve them in the planning process due to their unique position serving as a bridge between the needs of consumers, the public, and community agencies that provide services.

Partners in Care is a program of Labor Community Services that acts as the adult and older adult client liaison to County Mental Health Services. Their role is to advance meaningful client partnership through establishment of the client liaison function. Partners in Care provided education and outreach to underserved and under-represented Latino populations through a "Prevention & Recovery" forum in Spanish and a Spanish/English forum on Relational & Community Violence. Outreach was conducted through print media, advertising, mass emailing using a comprehensive email list, face-to-face contacts (individuals and groups), and stakeholder meetings held at clubhouses for those suffering from mental illness and emotional disturbances.

The groups used various training materials including *Principles of Outreach and Engagement to Underserved Communities* by Dr. Sergio Aguilar-Gaxiola, MD, PhD, UC Davis Center for Reducing Health Disparities and the Department of Mental Health. The County also developed a set of guiding questions for focus groups in order to facilitate and encourage dialogue. Facilitators were asked to attend an orientation and received tips on conducting focus groups.

LGBTQ (Lesbian, Gay, Bisexual, Transgender & Questioning): Planning efforts included a partnership with the San Diego LGBT (Lesbian, Gay, Bisexual and Transgender) Community Center - The Center. The Center's mission is to enhance and sustain the health and well-being of the lesbian, gay, bisexual, transgender and HIV communities by providing activities, programs, and services that create community, empower community members, provide essential resources, advocate for civil and human rights, and embrace, promote and support our cultural diversity. The Center was instrumental in assisting with two separate focus groups. One group focused on Transition Age Youth at the Hillcrest Youth Center; the second involved an existing support group for transgender individuals and their families. The LGBT Community Center staff also participated in the Community and Domestic Violence Forum.

Native Americans: San Diego has 17 federally-recognized Indian tribes, one of the highest concentrations of Native Americans in the nation. The first Native American community forum was held on February 26, 2008, and provided a unique opportunity to engage the community in an inclusive and collaborative decision making process. At the request of the Native American community, a total of three forums were held. This group evolved into a smaller workgroup that developed the Native American

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PEI programs. This workgroup was made up of members from the Native Community health clinic providers and represented all 17 of the San Diego County tribes including urban Native Americans. Consistent with community needs and norms, the health services providers have formed a collaborative that will serve as a consortium for the ongoing delivery of PEI services to American Indians/Alaskan Natives.

Asian/Pacific Islanders: Three separate focus groups were held to receive community input from the Asian/Pacific Islander community. One of these meetings was a parent group held in partnership with the Union of Pan Asian Communities (UPAC), a local agency focusing on the general well being and education of the Asian/Pacific Islander and other ethnic communities of San Diego County. Another focus group was conducted by the Family & Youth Roundtable with a group of Vietnamese women who work and patronize a nail salon in Mira Mesa, a community with one of the highest percentages of Asian/Pacific Islanders in the County. The third focus group was conducted by Partners in Care with a group of older Filipino adults who reside in an assisted living facility in the southern region of San Diego.

African Americans: While African Americans were well represented in the various community forums, two specific focus groups were held to increase the level of input from this under-represented and underserved community. One group included parents and caregivers of young people. The second group included ex-offenders being served in a job training program. Both of these focus groups were conducted in partnership with faith-based organizations including Metro United Methodist Urban Ministries.

Refugees and Immigrants: San Diego has a wide range of refugee and immigrant populations from a variety of ethnic groups from countries in geographic regions such as Eastern Europe, the Middle East, Africa and Asia. Although representatives of refugees and immigrants attended the larger community forums, three specific focus groups were held to gain additional input from these underserved communities. The focus groups were developed and conducted in partnership with local agencies that advocate for or provide services to refugees and immigrants, including services to victims of domestic violence and war trauma. The partnering agencies were License to Freedom, Survivors of Torture, and the San Diego Refugee Forum.

Rural Communities: San Diego County is a large geographic area that includes many small communities located in relatively isolated areas. To encourage rural community participation, a Rural Communities forum was held simultaneously at five sites around the county via web-based teleconferencing. The sites were located in the offices of member organizations of the Council of Community Clinics, providers of primary care services, in the communities of Julian, Warner Springs, Campo, Alpine and Escondido.

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

Adults with serious mental illness (SMI) and/or children and youth with serious emotional disturbance (SED) were specifically invited to participate in the various community forums, as well as the targeted focus groups. To help facilitate attendance, Partners in Care held several of the focus groups at consumer clubhouse locations throughout the County that were geographically convenient for consumers. These clubhouses are important sites for socialization, and educational, vocational/avocational, and support activities.

Membership within the Children's System of Care Council, Adult System of Care Council, and Older Adults System of Care Council includes consumers and their families. It was through these existing council meetings that considerable community input was received during the planning of our PEI projects.

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

a. Participation of stakeholders as defined in Title 9, California Code of Regulations (CCR), Chapter 14, Article 2, Section 3200.270, including, but not limited to:

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

As indicated earlier, separate focus groups were held and specific outreach was conducted to involve consumers and their families. In addition, membership in each of the Councils (referenced above) includes consumers and families. All community forums were held as open meetings, with transportation assistance provided on request and targeted outreach (e.g., fliers to consumer clubhouses and community clinics) inviting consumer and family participation. At each community forum, we requested "sign in" information allowing us to confirm the participation of consumers and families. Based on feedback from our consumer/family liaisons, focus groups were crafted to be smaller assemblages (10-15 attendees, relative to the larger forums, where attendance was over 100 in some cases), as it was advised that consumers and family members may be more willing to share input in a smaller, less intimidating setting.

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

Public and private mental health and alcohol and drug partners are included in the membership of our established Councils (referenced above). Prevention and Early Intervention planning input was solicited between July 2007 and September 2008 at the County's established monthly Hospital Partners meeting, with membership representing psychiatric inpatient facilities throughout the region. Child Welfare Services (CWS) is represented in our Children's System of Care Council, and separate PEI Planning meetings were held with key CWS staff. MHS also maintained ongoing communication to receive suggestions from the CWS staff and leadership team during the PEI Planning process.

- **Educators and/or representatives of education**

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Representatives from the County's educational system are standing members on the Children's System of Care Council – one of the primary community input/feedback venues utilized during the PEI planning process. In addition, the MHSA Coordinator, Dr. Hanger, responded to several invitations from the County's Office of Education to provide information on the PEI guidelines and obtain input/feedback from executive and line (teachers) level staff within education.

- **Representatives of Law Enforcement**

Since the Community Services & Support component was implemented, San Diego County has maintained a regular, monthly meeting with law enforcement representatives through a "Public Safety Group/MHSA Meeting," for the purpose of solicitation of input and feedback on our planning and implementation process. Representation at this ongoing meeting includes staff from local law enforcement (multiple city police departments), County Sheriff, Probation (Adult & Juvenile), the Public Defender's Office, and City and County District Attorney offices.

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

Juvenile Court Judge Susan Huguenor brought together a group of representatives with investment in the juvenile justice system, including Child Welfare Services, Juvenile Probation, the Public Defender and District Attorney offices, and Mental Health Services for the purpose of coordinating input and feedback related to the PEI planning process.

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

Members of the MHSA PEI Planning Team participated in weekly conference calls coordinated by OAC/DMH. These staff also attended numerous trainings offered by CiMH, DMH, and the CMHDA related to PEI planning – the most recent included the PEI Roundtables in University City this past summer. At the PEI Roundtable meeting, consumer/family liaison representatives were in attendance as well. The MHSA Coordinator also participated in regular "Regional Face-to-Face" meetings held in Van Nuys by DMH.

Each County staff and community member who was involved in facilitating the community forums or focus groups was given a facilitation training that included an overview of PEI and the County's planning process and timelines (see attachment, "Facilitation Guide"). This document was used to ensure that members were clear on the State guidelines for PEI as well as to provide information on how to facilitate the inclusive participation of all attendees during these sessions. The PEI Planning Team also held weekly internal meetings to support staff development in the community planning process.

The MHSA Coordinator, Dr. Hanger, provided education and training to consumers, family members, and public and private providers through multiple existing meetings (councils, Mental Health Board, commissions, etc.) and several established community collaboratives (e.g., Chula Vista Community Collaborative, East Region

Collaborative) between July 2007 and December 2007. The content of these presentations helped to improve awareness of the PEI guidelines, including key community needs and priority populations, as well as differentiating PEI services from existing mental health services (e.g., CSS). Emphasis was also made to encourage community members to participate in upcoming forums, focus groups, existing councils, commissions and board meetings, or to submit input through a range of communication modalities (e.g., e-mail, telephone, mail, website submissions).

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 our Community Services and Supports (CSS) planning process, it became apparent that the diversity and extensiveness of community input led to a diffusion of the community voice, expanding in too many different directions. In response to this, MHSA planning staff utilized community input in a number of forums and venues to more clearly identify key priority areas from the stakeholders – these eventually became the 10 focus areas selected in San Diego County. The sources of community input used to develop these priorities included the CSS “Parking Lot,” the CSS gap analysis, and ongoing community input at councils and the Mental Health Board.

CSS Parking Lot: At the conclusion of the community input process associated with the CSS portion of the MHSA, a list of input was developed including services and needs that were either ranked below the level of those chosen for funding with CSS dollars, or were determined to be more appropriate for other, future components of the MHSA.

Gap Analysis: This data driven analysis, part of our CSS planning process, provided a compass directing San Diego County to the underserved and unserved populations within our region. It was determined that these populations, already experiencing disparities in access to mental health care, should be given priority in developing PEI services.

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.

Attendance at meetings: A separate focus group, held by our consumer/family liaison partners, Family & Youth Roundtable and Partners in Care, included Transition Age Youth consumers. Our “sign in” data from each of the community forums reflected attendance by a variety of priority population members, in particular at the Veterans and their Families Forum, Older Adult Forum, Rural Communities Forum, and Native American Communities Forum.

Community Input Data: A review of the sources of community input in our data set indicated the priority populations were thoroughly represented, as we have received responses from advocates, providers, family members and council members.

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

a. The date of the public hearing.

San Diego's Public Hearing was scheduled on October 2, 2008 at the Mental Health Board meeting.

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 document was presented to the community in final draft format beginning on August 1. Throughout the months of August and September (referred in our County as "Informal" and "Formal" 30 Day Public Review periods, respectively) our PEI Plan was distributed in hard-copy at numerous venues, including regular public meetings and councils, posted on our Network of Care web site, posted at the County's Clerk of the Board, and numerous e-mail distribution listings were utilized. The attached table (*County of San Diego PEI Public Comments*) reflects the time-table of community input, the content of that input, and, when applicable, the responses made to our PEI plan based on those comments received. Following the Public Hearing, San Diego County continued to allow and incorporate community input via public venues, as indicated in the above reference table.

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

San Diego County voluntarily participated in a 30-day informal review period in order to gain feedback from the community and key stakeholders on our PEI plans prior to the formal review period. This informal review was publicly announced and provided many comments that were incorporated into the formal 30-day review draft. We also incorporated suggestions for collaborations and partnerships with various organizations to improve linkages for a number of programs into the formal draft plans. We received extensive input from the educational community that improved the structure and widened the breadth of the school-based programs.

Internally, San Diego County made substantial changes to our PEI plans in order to increase and enhance collaborations and partnerships amongst the projects and with other agencies throughout the County. For example, each workplan contains language promoting a linkage between the County-contracted referral agency, 2-1-1, and the future provider of each program. This will improve the capacity of referrals available to clients and ensure that accurate information is available for 2-1-1. In addition, PEI workplans that address the issue of suicide prevention will be required to send a program representative to the County's Interagency Suicide Prevention Meeting, chaired by Alfredo Aguirre, MHS Deputy Director. This will ensure that suicide prevention planning is inclusive and that goals are consistently implemented throughout the County.

In order to present recommendations for substantive changes, the attached table (*County of San Diego PEI Public Comments*) was created to summarize our community feedback and the resulting response to the PEI workplans.

The Veteran's culture is unique and many have issues with confidentiality.

- The importance of confidentiality is embedded in the plan language and the eventual contractor must have knowledge of the military culture. There will be a confidential hotline for individuals to access for resources and support. In addition, a peer-to-peer format for certain services will build trust and maintain confidentiality. Language to highlight the importance of confidentiality was added to the plan.

Will community outreach be a part of the domestic violence plans?

- The provider of these plan services will be tasked with creating collaborations and partnerships with a variety of community based services and organizations. The Community Violence Response Team (part of DV03) will also be working directly in the community to provide outreach, assessment, and supportive services. The plan was adjusted to broaden the arena of outreach for the provider.

RFP's should be written so that data will be collected to measure the success of each intervention in securing the continuing care of each consumer.

- Each program has identified intended outcomes with goals to measure program implementation and effectiveness. Specifically, the First Break Plan (FB01) will undergo extensive evaluation as the Local Evaluation Project and successes from this plan will be applied to other PEI projects.

In the school based plans, we recommend the use of evidence-based prevention programs, staff capacity building, evaluation of effectiveness, and parent education.

- The School Age Plan (SA01) involves two parts to meet these concerns: 1) Positive Behavioral Supports is an evidence-based practice that involves different levels of the school community and parents in education and evaluation of a school-wide transformation and 2) Community Outreach Specialists will provide support and education to parents. The Positive Parenting Program (EC01) also employs evidence based programs for prevention and parent education, which may be expanded to include presenting curriculum for school staff.

Regarding the Positive Parenting Program (EC01), to reach the broadest number of children and youth, the County must work with school districts. Not all children go to preschool or to day care (i.e., Head Start/Early Head Start). They all come to school.

- Currently, this plan targets 15 Head Start (HS) Centers annually. The contract will specify that a percentage/number of HS Centers served be located at a school.

Recommend the use of Parent Child Interaction Therapy (PCIT), an empirically-based treatment model with both the parent/caregiver and child.

- This model is present in the Domestic Violence Plans and other plans have been written to allow more flexibility for the use of additional evidence-based practices such as PCIT.

Consider "following" clients from EPU to jail – those that are screened and released to booking, but still meet the Quadrant III criteria.

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- This element has been incorporated into the Bridges to Recovery Plan (CO01).

Suicide prevention is extremely important for Native Americans due to the fact that suicidal ideation is rarely discussed or heard from those in contemplation. Bringing elders into the Native American programs is also very important.

- The Native American Plan (NA01) is comprised of several different components, of which two are specifically designed to address suicide prevention and integration of elders as “navigators” for their communities.

There could be a linkage between Domestic and Community Violence Plans (DV02 & DV03) through a referral system from CPS and law enforcement.

- This suggestion has been incorporated into the language of these two plans.

Suggested an increase in staffing for the scope of services provided in the First Break Plan (FB01) to include an employment specialist, nurse, psychiatrist, and the addition of an occupational therapist.

- Due to budget constraints, clients served in intensive program have been decreased in order to adequately provide services outlined in the program. However, staff increases have been made based on key stakeholder recommendations.

When providing outreach in schools and communities, will there be a mechanism in place for providing referrals to non-government organizations or programs?

- Language was added to all workplans referencing linkage with the County-contracted ‘211’ program, which provides referrals for many different services provided by a wide range of organizations. All County and contracted services are responsible for providing appropriate referrals to anyone seeking services beyond the scope of the program.

Will there be a Public Service Announcement (PSA) for family members or parents who did not recognize their child's mental illness and who feel guilty and at a loss? These individuals need information on where they can go for services, support, etc.

- PSAs and other media and information sharing outlets are currently a part of the Primary and Secondary Prevention Plan (PS01) to address stigma, discrimination, suicide, and services available. The Warm Line Plans (PS02 & PS03) are designed to create support, information and referral lines specifically for youth and parents.

There is a requirement that the program manager be a licensed mental health professional and a certified drug and alcohol counselor in the Co-Occurring Plan (CO02). These licenses/certifications will limit the number of potential candidates.

- This suggestion has resulted in a change to the program requirements allowing an experienced individual without a license to fill the Program Manager position.

d. The estimated number of participants.

We have received input from many sources during our formal 30-day review period. Each of our stakeholder-led councils provided a formal document reviewing each PEI plan. We also received numerous comments from our MHSA toll-free line and email address. In all, we have collected input from over 150 individuals presented either independently or collectively to our County MHSA team.

County of San Diego Mental Health Services Act (Prop 63)
Prevention and Early Intervention (PEI) Community Forums and Focus Groups

Updated 9/19/08

Overview

The County of San Diego's Mental Health Services has conducted an extensive community input process to identify mental health needs and priority populations as part of Proposition 63 Prevention & Early Intervention (PEI) planning. Input has been solicited in a variety of ways including: 1) Community Forums, 2) Focus Groups, 3) Community Input Forms, and 4) Key Informant Interviews.

The themes from this community input process can be found on the San Diego Network of Care website at: http://sandiego.networkofcare.org/mh/home/mhsa_prevention.cfm. For more information or questions, please contact MHSProp63.HHSA@sdcounty.ca.gov.

Community Forums

A series of Community Forums have taken place over the last five months. The Community Forums were large group public meetings, consisting of 40 to 150 participants that included many professional stakeholders and advocates working in the field. The ten (10) Community Forums that took place were:

<u>Community Forum Topic</u>	<u>Date</u>
Kick Off Event	September 27, 2008
Older Adults	November 28, 2007
First Break of Mental Illness/Transition Age Youth	January 23, 2008
Early Childhood/Education Based Services	January 28, 2008
Individuals Exposed to Domestic and Community Violence	February 20, 2008
Veterans and their Families	February 21, 2008
Native American Communities	February 26, 2008 & March 27, 2008
Co-Occurring Conditions (Mental Health & Substance Abuse)	February 27, 2008
Rural Communities	March 4, 2008

Focus Groups

In addition, small Focus Groups are being facilitated by community agencies, in order to obtain input from underserved and underrepresented individuals. These focus groups consist of 6 to 15 participants and were inclusive of many consumer level stakeholders and their families. Approximately 250 people participated in Focus Groups. The following is a list of the Focus Groups conducted.

Attachment – List of Focus Groups & Forums

<u>Prevention and Early Intervention (PEI) Focus Groups</u>		
Focus Area/Population	Date	Location
Older Adults/Philipino	February 13, 2008	National City - Summercrest Apartments
Older Adults/English speaking	February 21, 2008	Escondido Library
Older Adults/Adult Day Health Center Clients	February 22, 2008	San Marcos - Americare
Older Adults/Latinos/Adult Day Health Center Clients	February 26, 2008	San Marcos - Americare
Family Care Givers of Alzheimer's Association	February 27, 2008	San Marcos - Americare
Adult/MH Service Consumers	February 6, 2008	San Diego - Southeast Friendship Clubhouse
Adult/MH Service Consumers	February 21, 2008	Escondido - Mental Health Systems
Adult/Latino/MH Service Consumers	February 19, 2008	San Diego - Central - Casa Del Sol
Adult/MH Service Consumers	February 11, 2008	San Diego - Central - Meeting Place
Adult/Immigrants & Refugees	February 14, 2008	San Diego - Central - Survivors of Torture
Transition Aged Youth Consumers	February 22, 2008	San Diego - Catalyst
Adult/Offenders	February 29, 2008	San Diego - Central - Metro United Methodist Urban Ministries
Family Members/Asian/Pacific Islander	February 28, 2008.	San Diego - Central - UPAC
Adult/Transgender and Family Members	February 28, 2008.	San Diego - Central - The GLBTQ Center
Youth/GLBTQ	February 25, 2008	San Diego - Central - The GLBTQ Center
Family Members/Caregivers/Latino	February 28, 2008.	Escondido - Rady Children's Hospital Outpatient Psychiatry
Family Members/Male Domestic Violence Perpetrators	February 20, 2008	San Diego - Central
Adults/Female Domestic Violence Perpetrators	February 29, 2008	San Diego - Central
Adults/Eastern European Immigrants/Victims of Domestic Violence	March 3, 2008	East County - El Cajon
Youth/Homeless	March 6, 2008	South County - Chula Vista
Youth/Teen Parents	March 4, 2008	North County - Central
Family Support/Caregivers/African American	March 4, 2008	San Diego - Southeastern
Family Support/Caregivers/Asian/Pacific Islander	March 1, 2008	San Diego - North Central
Adults/Domestic Violence Victims/Refugee and Immigrants	March 7, 2008	East County - License to Freedom
Adults/Offenders/Drug & Alcohol Relapse	March 11, 2008	San Diego - Central - Second Chance/Strive
Adults/Veterans	March 5, 2008	San Diego - North Central - Veteran's Hospital/Veteran's Consumer and Family Council
Adults/Veterans	March 11, 2008	San Diego - Mental Health America Advocacy
Refugee Forum	March 18, 2008	San Diego - Mid-City - Multicultural Community Storefront

Facilitating Groups
Tips for Facilitating Discussion at MHSA PEI Focus Groups

Conducting a Focus Group

- The facilitator should arrive before the participants and arrange the room so all participants can view one another. U-shaped seating or everyone at the same table is best.
- As participants arrive, the facilitator should set the tone for a comfortable, enjoyable discussion by welcoming them.
- Inform the participants that what they say will be recorded accurately and that their comments will be compiled into a report for the County staff
- Set the tone: participants should feel good about the session
- Make sure that every participant is heard.
- Get full answers
- Monitor the time closely
- Keep the discussion on track
- Make sure to thank all the participant for their time and input

Questions for MHSA Planning Groups

The below questions will serve as a guide for these groups.

A. Introduce yourself, and ask everyone present to introduce themselves too. Thank them for their time and help with the Mental Health Services Act, Prevention and Intervention planning.

B. Introduce the Act. One good way to start is to ask if anyone knows about the Act, and let them explain it to the others. Be sure these key items are included:

- Proposition 63 was passed by voters in 2004 to provide funds for mental health services. Prevention and Early Intervention is one of five components of MHSA.
- The State will fund San Diego County Prevention and Early Intervention dollars for 8 target areas:
 - Veterans and their families
 - Individuals exposed to Community/Domestic Violence
 - Rural East, North Inland and Mountain Communities
 - Native American Communities
 - Children, Youth & Families
 - First Break of Mental Illness
 - Co-occurring Adults, Youth, Older Adults
 - Peer Counseling for Older Adults

- The County of San Diego is now collecting input, opinions and ideas about what mental health clients, youth and families need. This discussion group is part of that input collection.

Explain that you're going to ask several questions, and that you'd like to hear from everyone if possible. Explain that their comments will be shared anonymously --without their names – as part of the MHSA planning. Participants can talk much like they would in a group session, being respectful of each other, allowing everyone a chance to speak, and without being judgmental of each others' opinions.

C. Ask participants to address the following questions:

- a. What are the needs of the community?
- b. Tell me about who in the community needs extra help to be self sufficient.
- c. What kind of services would help them?
- d. Where do people in the community go for help?
- e. When you first realized you needed help, what services do you wish were in place?

Discuss the 8 target population (each participant will have a handout listing them). Ask which of the target areas are important to the participants.

Keep in mind that these questions can be customized for children/youth and families, for adults, for older adults and for ethnic communities such as Latinos and Asian Pacific Islanders of all age groups.

D. Logistics After the Session

- Someone should be taking good notes (no names!) about the issues being discussed. These notes, along with the sign-in sheet, should be turned into Liz within two days after the session.
- If you've co-facilitated this session, spend a few minutes together immediately after the session to "debrief" and talk about what worked well, what didn't, things you might want to do differently in the next session, and any follow-up that might be needed for any of the participants.

MHSA PEI COMMUNITY FEEDBACK - INFORMAL 30-DAY PUBLIC REVIEW

Date Received	Community Partner	Input/Suggestions <i>(Red input/suggestion items have been addressed in the Formal PEI Plan for 30-Day Review)</i>
8/1/08	Cultural Competence Resource Team Meeting Submitted by Piedad Garcia	<u>Native American</u> - MHSA PEI funds are time limited and so part of the consortium's responsibility needs to be addressing the long term sustainability of these programs. This should be put on the agenda for ongoing long term pursuit. The consortium also needs to be addressed in the work plan. There needs to be something in the work plan that addresses a monthly meeting to ensure that whatever is being done is being coordinated and carried out. The COTR should participate as well as the cultural broker that is being hired by Mental Health America. Quarterly meetings with the consortium should be considered with the MHS administration to include Alfredo, Piedad and the COTR. One of the issues about sustainability is not only funding and resources but how you maintain the relationships that have been established. <u>0-5</u> - within the Latino community there are intergenerational and linguistic issues between children and parents that would have to be addressed in a culturally sensitive manner. This needs to be reflected in the work plan and the SOW, that services will be provided in English and in Spanish as appropriate and that the staffing will be reflective of that community and in the event that there is difficulty in hiring someone to fill this requirement that interpreters would be made available. The same thing would be with the military community. The person hired to fill this position needs to be reflective of that culture. We need to elaborate more on that piece as to the staffing team hired within that community. <u>Youth Warm Line</u> - Comment was also made that the technology should be now because the kids are using the internet and email more then telephones. <u>VMRGF</u> - The group identified outreach and education to the veteran population, the culture of this population and the issues that they have with confidentiality.
8/11/08	Deborah A. Williams LCSW, LMHP Department Head Social Work	Caring for the wounded warriors and all Active Duty Service members and their families is a privilege for all of the Social Workers at the Naval Medical Center San Diego. We cover inpatient to outpatient care and find one area that is desperately needed for our AD members suffering with stress related issues and PTSD is to involve the whole family. In Social Work we have found the best practice for these service are to suggest that they are provided in the home. Home services in the form of home behavioral care would cut through the stigma of patients having to make a mental health appointment or come into a "hospital" system for care. Hope that you could consider home health behavioral services for military beneficiaries with PTSD and other behavioral problems under the new Prop 63 funding.
8/12/08	Ellen Schmeding, MFT Assistant Deputy Director HHSA AIS	I do not see the issue of senior suicide called out in the attached proposal and believe that statistics showing the rate of suicide in seniors needs to be included as well as a specific focused campaign targeting seniors as well. (Older Adults are one of the priority populations being considered for the PS01 focused media campaign.)
8/12/08	Kay DiFrancesca	<u>Older Adult Communities</u>: Is it possible and logical to include older adults with Parkinson's Disease in the Salud Program? There is a high incidence of severe depression in patients who have Parkinson's, although I do not know the incidence of Parkinson's disease in the Latino community. <u>Children and youth in stressed families and domestic violence</u>: I know we are targeting south county but is it feasible to partner with the Family Justice Center? (I think they serve South County too.) At this point the Family Justice Center does not serve the children in families with domestic violence but they are aware that there is a huge impact on these children and that in order to stop the intergenerational cycle of abuse, the children need to be targeted. If an educational curriculum could be developed for this population, we could use this curriculum over and over. The children of self-referred battered women could be an ideal group upon which to develop a curriculum that could then be used with other children in domestic violence situations. If we do this, we might help a lot of children learn not be become a victim or victimizer. Also, I think that self referred women would be more open to accepting help than people identified by CPS.
8/16/08	Dr. A D Krems	The veterans section on prevention highlights several more acute problems than I appreciated. The vet coverage of the county, adjunct to all that the VA system offers and delivers here could contribute much in planning. Training is required, of course. Who, of staff, is directing this effort? Collaborations are still in order and could be quite productive, cost-free, between staff, councils, Board, all professional societies, all academia, civic groups, advocates, service groups, agencies and all levels of gov't units involved in all phases of prevention. The PEI project summary covers comprehensive issues, not what I would expect for Primary, Secondary, or Tertiary Prevention. Early Intervention may be implied, but it is not well covered in the plan.
8/18/08	Childrens System of Care Council	Wanted to see more prevention. Many kids don't go to daycare or pre-school. Schools have access to all children. Teachers have good insight into early emotional problems with the children. More focus in this area. Population in bottom 3rd of triangle is the largest population. Universal preventive programs for everyone. Schools could have possibly been more involved with offering in-kind services. SD Unified sees opportunity to work together in prevention. Nothing proposed for 4-12th grade. Addressing drop-out, expulsion rates. Teach them to build resiliency for bottom 3rd. They have insight into whats going on with younger or older children Blend resource, hedge funds, build on existing resources; parent liaison to identify children. Would like to have the focus age group of each plan. DV plans - Siblings and family focus; community also has to have outreach. DV02 – course material should be printed in other languages or layout plan to print other threshold languages. Wants to see the partnerships paved. Gang – multi-cultural storefront collaboration suggestion; what specific ethnic and cultural populations. Coalition for Abused Refugee and Immigrant Women.
8/19/08	Dixie Galapon	DV02 – South Region Trauma Exposed Services: In this proposed project, the course material is only in English and Spanish. I would like to propose that the material be translated into all the County threshold languages (Vietnamese, Tagalog, Arabic – in addition to English and Spanish) at the very least. In addition, I would like to propose other collaborators for this project. As such, I would propose collaboration with one or more of the following: San Diego Domestic Violence Council, San Diego Family Justice Center and/or the Coalition for Abused and Refugee Immigrant Women (CARI♀). FB01 – Individuals Experiencing Onset of Serious Psychiatric Illness: In this proposed project, it is not clear how all the County Threshold languages will be included. The project does a good job of identifying some basic milestones for the project. However, it would be more significant if the project (or proposer) could identify milestones for the identified Priority Populations, and also milestones for particular unserved/underserved groups. Again, in order for the System of Care to truly continue transformation, it would be necessary to pay attention to the needs of these groups.

MHSA PEI COMMUNITY FEEDBACK - INFORMAL 30-DAY PUBLIC REVIEW

Date Received	Community Partner	Input/Suggestions <i>(Red input/suggestion items have been addressed in the Formal PEI Plan for 30-Day Review)</i>
8/21/08	Dr. A D Krems	In August of 2008, all data for 2007 should be in the document. The processes are detailed. The same should be included for a battery of quality indicators reflective of the level of state of art care delivered to the clients/patients and their families.
8/26/08	Patricia Rickon	I would like to mention that the Sudanese in San Diego really suffer from emotional trauma. Virtually all women have suffered torture. They all have great anxiety about meeting the obvious and expressed needs for food, medication and education of the relatives not fortunate enough to make it here. They are under tremendous economic pressure to pay their utility bills on minimum wage jobs in a timely manner. This has been the status for the 15 years I have been working with the community. The community attitude toward mental health is that it is an embarrassment and a great weakness to have mental health issues, and to admit you need help for it is unthinkable! Everyone bears the trauma alone. There is much we can do to help them. We have some ideas to improve parent child relationships. Strong healthy families need parents who are emotionally strong and healthy too.
8/27/08	Sumali Tuchrello, M.A. Project Coordinator Santee Solutions Coalition	In the response by public, quoted comments <u>I – K on pages 146-7</u> of the work plan focus specifically on prevention activities to be conducted throughout the community, our coalition is strongly in support of these comments which clearly request the county to provide more community-based programming to individuals who are not currently involved with treatment systems. In the 2008 Partnership Attitude Tracking Study put out by the Partnership for A Drug-Free America, nationwide 51% of middle school parents feel they lack the proper tools to prevent ATOD use with their children. Additionally, this study showed that only 1 in 3 parents feel they are extremely prepared to get their child the proposer assistance (through intervention or treatment) to address a drug problem each year. We would encourage the county to develop this plan further to include more prevention efforts though community education programming, school and home based pre-screenings, and linking the non-treatment involved community with local resources and information portals regarding alcohol and substance abuse issues San Diego youth currently face. Again, we applaud the efforts of the current work plan to provide information, education, and support to individuals currently connected to treatment systems, however we would like the work plan to also address the needs of the currently non-involved county residents to prevent them from becoming part of the 12,000 client base County of San Diego, Alcohol & Drug Services currently serves (A second workplan was developed for school-aged children, gatekeepers and families. The focus is on suicide prevention education at all levels, as well as early intervention for youth and TAY identified as being at-risk for mental illness.)
8/28/08	Ruth Covell, MD Chair Older Adult System of Care Council	SALUD: Change language to state “may include but not limited to problem solving therapy such as Impact , must be evidence based or promising practice;” Gatekeeper Project/ Home Delivered Meals: Change language to state “may include but not limited to a depression management technique program such as PEARLS, must be evidence based or promising practice,” REACHing Out: Most family caregivers, who will benefit from this program, are adults, not older adults, Recommend requesting Adults to contribute financially toward this program (75% of funding is now from Adults) Lifelong Learning: Original funding allowed for 1 FTE – current funding allows for .5 FTE yet the workload is that of 1 FTE, Recommend funding at a level for 1 FTE (Adjusted to 1.0 FTE in current plan); Recommend looking at Adults and Children for additional funding as some classes are geared for adult caregivers, grandparents raising grandchildren; EMASS: Original work plan allowed funding for 4.5 FTEs as there are 4 distinct populations, current funding allows for 3.5 FTEs, Recommend to increase funding to allow for 4.5 FTE – one position per culture (Increased to 5.0 FTE in current plan);Recommend looking at programs like “Breaking Barriers” to see where cost savings might occur; Native Americans: Recommend determining how many Older Adults are within the Native American community; Recommend that services provided are culturally and medically appropriate; Co-occurring Mental Health/AOD Programs: Budget information provided on spreadsheet was inaccurate (Budget corrected in current plan); Recommend providing accurate information on amount to be funded by Older Adults for this program; Rural Communities: Recommend obtaining the number of older adults to be served; Recommend looking at home-based technology (e.g. that being tested with UCSD); Recommend determining how transportation will be provided for follow up services at clinic; Veterans: Families of returning vets that will be served could include OA; Recommend looking at way to assist getting older vets into needed treatment through other funding; Universal Proposals: Recommend looking at OA PEI needs and targeting OA specifically as a population due to high incidence of suicide and stigma (Older Adults is one of the specialty populations being considered for the PS01 focused media campaign) Co-occurring Bridge to Recovery: Recommend that teams engage OA at all Central Region hospitals, including Mercy, UCSD where OA are more likely to be seen; Budget information provided on spreadsheet was inaccurate; Recommend providing accurate information on amount to be funded by Older Adults for this program (Budget adjusted in current plan).
9/3/08	Renee Trudeau	Looking over the plans for spending income from prop 63 I am extremely perplexed over the \$1.2 million dollar allocation specifically for Native Americans. The tribes are to be considered sovereign nations thereby exempt from taxation and government requirements of the individual citizens living outside of the reservations. In addition to being a sovereign nation, we have been told many times that our support of Indian Gaming is the ticket to Indian self-sufficiency. This is over a million dollars that could be spent in a more qualified area of our mental health needs. Welfare programs are necessary and available for those in need, but either our tribes are misleading with their statements about the self-sufficiency benefits of casinos in our communities, or once again our tax dollars are being wasted! Expenditures such as these should be paid for from casino profits rather than by tax dollars set aside for mental health programs.
9/4/08	Debbie Andersen	I believe that Native Americans should be paying for the following services out of the income they receive from gaming and should not come from American Taxpayers. Please allow these natives to be self-reliant in all areas of life.
9/5/08	Commission on Children, Youth, and Families (Meeting Minutes)	Family & Youth Roundtable has been actively gathering information and feedback from youth and their families. Three top themes that emerged are: Youth would like mental health services/education at school but separate from school personnel and in a discreet manner; Have a discreet peer to peer chat or phone line Start County-wide training for teachers to help recognize and deal with youth that may have mental health issues. There is no funding allocated or new projects planned in East County other than one rural regions project[added to SA01]. Funds in the South Region are limited to children in the CWS system but more services are needed for youth and parents prior to CWS involvement including addressing the stigma around mental health in the Latino populations . Judge Huguenor mentioned that the plan also did not reflect a proposal submitted by the Commission that had been worked on by Kim Broderick and others. That plan was school based hoping to catch children earlier to keep them out of the juvenile court system. Barbara Ryan mentioned that the programs proposed for the most part not that broad-based prevention. It is her understanding that the prevention part of these funds confirmed by Senator Steinberg was to reach a very broad population of adults and kids.

MHSA PEI COMMUNITY FEEDBACK - INFORMAL 30-DAY PUBLIC REVIEW

Date Received	Community Partner	Input/Suggestions <i>(Red input/suggestion items have been addressed in the Formal PEI Plan for 30-Day Review)</i>
9/8/08	Claudia Gray Senior Director East County SELPA-SDCOE	The following are key messages from the education community in response to the PEI draft proposal: The draft proposal appears to provide little in the way of actual prevention and more treatment. To reach the broadest number of children and youth, CMH must work with the school districts. Not all children go to preschool or to day care. They all come to school. The school districts do not come to the table empty handed. There are already existing programs to be expanded upon and some prevention dollars to begin support programs. Educators are not intending to become mental health providers. Our students deserve mental health support from the professionals in that field. Contracting with private vendors would be an integral part of most plans. This is a perfect time to create a stronger partnership with education while making the most of the limited funds and reaching the most children and families. Dr. Philip Hangar met with several education groups throughout the year to hear suggestions and ideas about how education could be involved. In partnership, forty-two independent school districts submitted a consensus statement in regard to PEI funding. Educators identified a number of universal strategies which could be used in schools to support PEI goals. These strategies included: 1) the use of evidence-based prevention programs; 2) staff capacity building; 3) prevention orientation; 4) expanding parent education services; 5) leveraging community services, maximizing collaborations and 6) evaluation of effectiveness. Research and practice clearly demonstrates the effectiveness of school based, with community collaboration works for children and families.
9/19/08	Rachel Humphreys, MA Executive Director La Cuna, Inc.	La Cuna proposes the augmentation of current services, and the development of new services, to provide Prevention and Early Intervention evidenced-based services to young foster children (0-5). These very young children are in need of foster family agency services that can provide assessment of infant and toddler mental health needs, and ensure a high degree of continuity of care that is culturally and linguistically appropriate. The Foster Family Agency Enhanced Mental Health Services (FFAEMHS) are designed to provide family centered, integrated, multidisciplinary mental health services to 0-5 year old children in foster care. Parent Child Interaction Therapy (PCIT) is an empirically-based treatment model with highly specified, step by step, live coached sessions with both the parent/caregiver and child. Thank you for considering the ways we can make dramatic changes to the mental health and well-being of San Diego's Latino foster children.

MHSA PEI COMMUNITY FEEDBACK - FORMAL 30-DAY PUBLIC REVIEW

Date Received	Community Partner	Input/Suggestions <i>(Red input/suggestion items have been addressed in the Final PEI Plan)</i>
9/22/08	Shirley Bard Older Adult Council	I am also very disturbed about not getting a corrected copy of last month's PREVENTION AND INTERVENTION PLAN that we were asked to approve. It was acknowledged by the presenter during the August meeting, that there were numerous errors. In addition, there were significant changes voted on during the meeting. A month has passed, yet we were not provided the final copy. In addition, the references made in the August minutes to last meetings' Prevention and Intervention Advance Input Before The Formal 30 day Review" were incomplete and additions/corrections were not included. If the final copy of the plan is just passed through to Sacramento without the council seeing it, isn't that the same as the council not approving? And does that not defeat the stakeholders approval at every level requirement? I will be more specific in my own 30 day input that will be submitting soon.
9/22/08	Partners in Care MHSA PEI Plan Input Forum	Primary Care - Educate primary health care providers about the fact that people with psychiatric disabilities have short term memory loss and need to be given written instructions; Physical complaints of mental health clients who disclose their disabilities are often viewed as psychosomatic and not worked up thoroughly. Providers need to be educated about the side effects of medications and how they can manifest as physical illness Child Protective Services – Clients expressed concerns about CPS breaking up families and "criminalizing parents" who are struggling with life issues. They felt that PEI Programs should be the "gatekeepers" for CPS and be the ones who determine when children are at risk and refer the families to treatment and CPS. Clients felt that CPS should be the "last line of defense;" Parental Guidance – clients felt that parents were "afraid of the child and the school" because of the risk of the child calling CPS or telling on parents in school. Education of parents and teachers needs to take place and proper referrals to treatment need to be made Home Start Programs – clients support efforts to work with parents of children in Home Start Programs that teach parenting and disciplining skills and assist with transportation; Children Traumatized on School Buses - clients cited incidents where children were hurt while on the bus.
9/23/08	Kristin Gist Senior Director, Developmental Services Rady Children's Hospital San Diego	South Region Point of Engagement: Clarify whether the purpose of this work plan is to: 1) Develop an assessment center for children and families ; 2) Provide treatment for children and families, or 3) Both develop an assessment center and provide treatment; If the goal is provide both services (as outlined in #3), should both the assessment and treatment services receive equal priority or will one be emphasized more heavily than the other?; What is the Healthy Start program? We would encourage any potential RFP to allow enough flexibility for an agency to implement a service model that will truly fit the target population. A skilled therapist, or therapists with less experience who are well supported by reflective supervision, can make a significant difference with this age group. Likewise Parent Child Psychotherapy, Parent-Child Attunement Therapy (PCAT), Parent-Child Interaction Therapy (PCIT), and Safe Care are not mentioned as possibilities, but are all evidence-based practices that strengthen the relationship from birth to 8 yrs (each targets a different age group) This work plan presents a unique domain (e.g., mental health/behavior). Any proposed treatment model should include strategies to also address speech and language development, which is so closely tied to behavior, as well sensory regulation, sensory processing, and even motor skills development. Estimated Budget: The estimated budget looks relatively low compared to the potential scope of work. Please confirm that the budget figure outlined in the work plan is accurate (\$340,400). The % breakdown of funds for each target group (children and youth vs. transitional age youth) is not consistent with where true prevention efforts should be targeted (young children under age 6). The age breakdown for this work plan should mirror the age breakdown for funding for the South Region Trauma Exposed Services work plan. South Region Trauma Exposed Services: One of the evidence-based practices outlined in the work plan is "resiliency training", however it is not clear what this means exactly. To our knowledge there is not an evidence-based treatment that is called resiliency training. This model must include flexibility to use relationship-based therapy with the dyad that is not yet evidence based, as there are few to no models (maybe only Alicia Lieberman's Child Parent Psychotherapy) working with infants and toddlers, who have experienced the loss of a primary relationship, together with their caregiver. Such work will increase the likelihood that a child will become bonded with his/ her caregiver which can result in a lasting relationship and long term placement. Further, it is not clear if the target of these services will be children and their biological caregivers and/or foster parents. It is important that this work plan includes specialized training and support for foster parents/relative caregivers around emotional development and disrupted attachments as well as provides support for the biological parent as he/she seeks reunification following the disruption caused by the separation.

MHSA PEI COMMUNITY FEEDBACK - FORMAL 30-DAY PUBLIC REVIEW

Date Received	Community Partner	Input/Suggestions (Red input/suggestion items have been addressed in the Final PEI Plan)
9/23/08 (resent on 10/21/2008)	Dr. Charles Daleo Program Manager Health Services Unit Student Support Services	Our proposal identified a number of universal strategies which could be used in schools to support MHSA goals. These strategies include 1) the use of evidenced-based prevention programs, 2) staff capacity building, 3) prevention orientation, 4) expanding parent education services, 5) leveraging community services, maximizing collaboration 6) and evaluation of effectiveness. We have attached a copy of our initial input once again for your review. We are very willing to work with you to craft a portion of your plan that acknowledges and allows public schools access to much more reasonable resources than the current plan. See plan located here: S:\BHS\Enterprise\MHSA DOCUMENTS\PEI Comm. Input and Plan Development\PEI Plan Development\PEI Plan Write Up\FeedbackonPlans\PEI\San Diego Schools PEI Input 10-21-08.doc
9/25/08	Lori Futterman Shannon Jaccard Liz Kruidenier Bettie Reinhardt Adult MH SOC Council	<u>Media Campaign</u> - focus too large for size of budget, used mixture of media outlets (PSAs may not be best, suggest movie theaters, college events/publications, YouTube, local publications, DVDs), need to target more specific at-risk populations like TAY and OAs; <u>Suicide Prevention and Stigma Reduction</u> - should be separate campaigns, consider a partnership with NAMI SD to maximize use of funds, no use of behavioral measurements, expansion to groups outside of TEEN/TAY, salaries low for clinicians, may need support programs for clinicians working these lines, some programs already in existence, instead of duplication add specifics like more depth, hours, & funding; Outcomes need to be determined by instruments that measure outcomes; <u>Crisis Lines</u> – may not be necessary given the abundance of such lines, perhaps funds could be spent on expanding/supporting other lines, such as NAMI SD HELP
9/26/08	Kristin Gist Senior Director Developmental Services	<u>South Region Point of Engagement</u> – The partnership between the “provider” and First 5 will be very important in determining the developmental and social-emotional screening protocol for children 0-5. It is essential that all screening and referral efforts be coordinated. <u>Positive Parenting Program (Triple P)</u> – We would encourage any potential RFP to allow enough flexibility for an agency to implement a service model that will truly fit the target population; interventions targeting the parent-child relationship will likely also be needed for a sub-set of families; support around developing or strengthening the primary relationship may at times be better provided through one-on-one therapy than through a didactic module; While it could be argued that Head Start and Early Head Start sites serve an at-risk population of families, there are many children and families with needs in other settings (e.g., community-based child care, military-based child development centers, and those who are receiving no services at all).
9/26/08	Cynthia Jackson, Ph.D (sent by Robyn East) Executive Assistant Heritage Clinic	<u>QA02</u> - Individual outcomes include:(3rd bullet point) reduction and/or elimination of depressive or other symptoms; <u>QA04</u> - Staff Care Manager: A bi-lingual and bi-cultural Masters level or above clinician, (page 6) first line in need of which may include early intervention services will be provided . . .and Coping Skills Training (CST) or others, and short term over <u>QA05</u> - PEI Project Description: (First paragraph) Chronic Care Model developed by Stanford University, and IMPACT Problem Solving Therapy or other evidence based, promising, or best practices. Services/Staff: (First bullet) solution oriented counseling utilizing Problem Solving Therapy or other evidence based, promising, or best practices – In Primary Care (PST-PC).
9/29/08	Richard Hayes Professor of Gerontology	I am requesting that consumers, ex-patients and their families must be well represented in planning, implementation and delivery of services. Minimum standard should be as follows: Planning 50% plus one, Implementation 50% plus one, and Delivery of Services 50% plus one. There must be a voluntary treatment option for those who do not want inpatient treatment.
9/29/08	Partners in Care MHSA PEI Plan Input Forum	Possible funding issue (3,800 vs 5800) which can lead to underfunded programs and overloaded case managers; Cultural brokers as a bridge between accessing programs for vets, native americans. etc.; There may be barriers to accessing services for the unserved/underserved groups that are being reached out; Will need very specific/clear points of entry to ensure access to services; There should be something in the RFP's and the contracts about cultural competence for the specific ethnic and cultural groups being targeted in the new programs Some of your identified programs have names attached to it (e.g. "Salud", "CPS", "Wheels on Meals", are these contractors that have been identified to be funded or are they "models". How will the collaboratives formed?
10/1/08	Richard Hayes Professor of Gerontology	There are no checks and balances; no representation or involvement of diverse client, youth, or family representatives; consumers, families, and ex-state hospital consumers must be involved at every level (51%); the PEI Plan is heavy on demographics and programs goals and weak in other areas; there is not a comprehensive plan to identify and enlist the unserved/underserved; hot meal delivery is just a start; there is no mandated requirement that contractor organizations, boards of directors include client members; disappointed in the dual-diagnosis programs and services for older adults.
10/1/08	Public Safety Group	<u>VF01</u> – consider referrals can come from jail and/or probation – as additional gatekeepers – also refer the COTR to connect with the “Returning Veterans Legal Task Force” <u>DV02</u> – consider allowing referrals from probation for kids in the South region <u>CO01</u> – consider “following” clients from EPU to jail – those that are screened and released to booking, but still meet the Quadrant III criteria – essentially following up with them upon release from jail if within a reasonable time frame – may also allow engagement of the services to take place while client is in jail <u>PS01</u> – can these funds be used to train law enforcement on Prevention concepts (i.e., risk factors, early indicators of mental illness) and/or educate them on the specific new services available within the community.
10/1/08	Diana Alvarez Family Wellness Unit Coordinator La Maestra Community Health Centers	It is very disappointing to see that those funds are not designated to central areas in San Diego. In the past year through the CSS funding given to the Council of Community Clinics we were able to integrate Primary Care and Mental Health Services. The Impact program that has been a great success given the level of mental health crisis that our uninsured clients have endured. In its current form, the distribution of funds for programs for prevention and early intervention to clinics only in the rural east area demonstrates to our community that the MHSA is failing to achieve its purpose overall. It is my sincere hope that the commission re-evaluates the decision to exclude community clinics in the central area of San Diego for this funding. Our population has a high need to access such services and as a community clinic this can only happen with the PEI funding. We strongly advocate that these funds reach our under-served families.
10/2/08	Child Welfare Services	Consider expanding the <u>PS03 Family to Family Warm Line</u> to include capacity to respond to distressed, but not crisis calls that come to the CWS Hotline – these are typically from family members that are not calling to report abuse/neglect, but they have questions about navigating the delinquency system, and it would be expected that Family members would have some experience with the CWS system, and can be provided FAQs for assistance.
10/2/08	Housing Council	<u>EC01</u> – MAC / Housing is available for this population <u>QA02</u> – can the PEI program assist the community awareness of how food stamps can be used to provide Meals on Wheels benefits

MHSA PEI COMMUNITY FEEDBACK - FORMAL 30-DAY PUBLIC REVIEW

Date Received	Community Partner	Input/Suggestions <i>(Red input/suggestion items have been addressed in the Final PEI Plan)</i>
10/2/08	Dr. A D Krems Mental Health Board Member	Dr. Krems expressed dissappointed in the narrowness of vision in estimating who can be served in each of these plans; Also mentioned the fact that there was no mention of linkages or collaborations for the programs
10/2/08	Eric Revere Mental Health Board Member	Asked if there will be tools in the new MIS to measure all of these outcomes, specifically those regarding stigma reduction in the public media campaigns since we are devoting so much money to this program.
10/2/08	Dale Parent Mental Health Board Member	Asked why the County cannot track these outcomes given all the money posted for these programs. Believes it would be prudent to measure thse outcomes.
10/2/08	Judith Shaplin Mountain Health and Community Services	Regarding the PEI plan in rural communities - the continuum of care is poor in this area for issues related to drugs/alcohol and domestic violence, these issues are cyclical and passed down to the next generation within families, glad to hear about plans to work with schools, however people need to be found and they will not work to find providers, many are bound by extreme geographical constraints, transportation is non-existent, providers need to be able to go to homes and see how they operate in order to change the dynamics of the family
10/2/08	Joe Balfur San Diego American Indian Health	It is difficult to get to community members, but this PEI plan is seen as a unique opportunity to have many different operations within the Native American community come together in a consortium through coordination and linkage, this is a wonderful opportunity
10/2/08	Dr. Hector Torres	I see students falling through the cracks due to mental health issues and the inability to read, it will be helpful to work with other tribes to provide inter/intra referrals for clients, bringing elders into these programs is very important, suicide prevention is also extremely important especially due to the fact that suicidal ideation is rarely discussed/heard from those in contemplation, it is imperative that there is a program to reaches individuals in rural areas.
10/3/08	Rene Santiago, South Region Deputy Director Lynn Sharpe-Underwood Executive Director Commission on Gang Prevention and Intervention	After reviewing all of the programs the County is framing for Mental Health funding through Prop 63 funds, it was clear that there could be a linkage between DVO2 and DVO3. Would you please consider adding the language that a referral can be made from not only CPS (DVO2) but also from law enforcement who may be called to a scene of gang violence that impacts siblings and community youth - neighbor children (DVO3).
10/6/08	Ray DiCiccio, MSW CASBIRT Project Director	Bridge to Recovery - project is innovative and builds on previous successful work in the use SBIRT. The specificity in the budget with regard to classification and certification of staff may restrict the contractor's ability to hire appropriately trained/experienced staff. Licensed mental health professionals often don't have the management experience or education needed to serve as a Project Manager. Managers with MSW, MPH or MPA with administrative education and experience managing programs are often more able to provide leadership/management needed to make the program successful. They are often better equipped to design ongoing evaluation, make program adjustments and collaborate with County regarding service integration. Licensure as a mental health professional may be an appropriate expectation for a Counselor Supervisor or some similar position. The description of work in the draft could benefit from more innovative proposals. The proposed program seems very detailed and appears to leave little if any room for the contractor to develop or utilize alternative, complimentary approaches and staffing requirements to achieve the desired outcomes.
10/8/08	Dr. William McFarlane Portland Identification and Early Referral (PIER) Program	EB01 - suggested an increase in staffing for the scope of services provided including an employment specialist, nurse, psychiatrist, and the addition of an occupational therapist
10/12/08	Richard Hayes Professor of Gerontology	I have reported the following concerns about the San Diego prevention and intervention program prop 63. 1) Implementation Clinical Care Committee was disbanded by administrative actions of Alfredo & Piedad; 2) Implementation Committee was mandated to provide oversight for all Prop. 63 programs within the OA SOC; 3) Systems Development committee was not empowered by Alfredo, Piedad, or the exec. committee to provide consumer "oversight;" 4) O.A.A. by-laws were not changed; 5) Council did not secure a 2/3 vote in order to legally disband the Implementation committee; 6) 72 hour notice was not given that Implementation Committee would be disbanded - unless someone objected; 7) Dr. Ruth Covell refused to recognize a request by Dr. Abe Krems that a topic be added to the agenda; 8) Dr. Krems was not informed of a grievance process thru which he could find remedy; 9) Exec. Committee did not offer to hold a closed meeting to discuss the grievance; 10) Dr. Hanger now states that only the Mental Health Board provides oversight of all prop 63 programs; 11) The whole issue will be referred to Sacramento for clarification - real conflict of interest; 12) Under 1090, the term contract is interpreted to include the negotiations, discussions, reasoning, planning, and give and take that go beforehand in the making of a decision on a contract. Chapman vs. superior court 130 cal app. 4261 (2005); Note: There is a grievance process available through the area plan on aging.
10/13/08	Marty Member Children's SOC Council	EC01 - There should be more explicit language in these plans to include services to the very young (0-7 yrs); Use of Triple P is good but very prescriptive; the workplan should include language that allows providers to use other evidence based practices
10/13/08	Shirley Culver Member Children's SOC Council	EC01 - The County supported the use of the Incredible Years program in its other services; this should also be included in these workplans for young children in order to be consistent with other programs; this may be confusing and could challenge coordination efforts.

MHSA PEI COMMUNITY FEEDBACK - FORMAL 30-DAY PUBLIC REVIEW

Date Received	Community Partner	Input/Suggestions <i>(Red input/suggestion items have been addressed in the Final PEI Plan)</i>
10/13/08	Paula Maness, Ph.D. Southern Indian Health Council	There are limited services in the East suburban area; the plans were well presented but they do not include services for the family member who is currently suffering from trauma; it is a struggle to provide services to the Campo population in need; it is difficult for families to get to the city for services; it is difficult for family practioners to reach all those who need mental health services
10/15/08	Richard Hayes Professor of Gerontology OASOC Council Member	<u>PEI Statewide Projects</u> - there is a clear emphasis on children and youth, but suicide prevention is different for OA's, do we have a guarantee that people developing programs have a geriatric focus/expertise at the state level? <u>Rural</u> - County could do a beter job with 10% more manpower in rural east area.
10/15/08	Mary Jo O'Brian Partners in Care	<u>Rural</u> - plan initially stated 5800 contacts, but presentation states 3800, is that correct?
10/15/08	Jennifer Bransford-Koons Aging & Independent	Is there a break down of the dollar amounts for each age group?
10/15/08	Carol Neidenberg CCHEA	Rural - will thes services be replicated for those patients who also get screened/assessed for Medi-Cal purposes? Clients are already screened for mental health concerns. Seems duplicative
10/15/08	Ken Dellefield OASOC Council Member	<u>CO01</u> - Could this program be a successful model for the prodromal older adult dementia population? It seems that the model could easily be transferred for prevention purposes. <u>PS01</u> - suicide hotlines seem like a good approach, but is there any definitive research that indicates its success rate or effectiveness? Why was this approach chosen?
10/15/08	Older Adult Council PEI Review Committee J. Hayes, D. Downing, H. Cohen, R. Velasquez, S. Jaccard, & V. Criado	<u>NA01</u> - the number of older adults to be served needs to be addressed as "at a minimum, xxx number of older adults will be served," a clarification is needed for number of months of program (6 months vs. 12 months, pg. 15 of 21) stated in budget <u>CO01</u> - budget and number to be served need to be accurate , same as above plan, language needs to include outreach to Mercy, UCSD, and other Central region ER units <u>CO02</u> - budget and number to be served need to be accurate , same as above plan <u>Rural</u> - budget and number to be served need to be accurate , same as above plan, the use of home-based technology needs to be clarified <u>PS01</u> - need for older adult specific issues to be addressed by plan; stigma, agism, and suicide among older adults; ensure that the OA PEI Committee will be a part of the development process for this program plan
10/16/08	Richard Hayes Professor of Gerontology OASOC Council Member	For five years members of the OA council have asked administration not to come to them for a vote on programs, without a 72 hour notice. The brown act applies to San Diego mental Health board. Dr. Ruth Covell that if we managed the PEI programs we would only be funded for two years. The suggestion was made by Ruth Covell and Dr. hanger that we should permit Sacramento to manage the PEI programs with the guarantee of untended funding. nobody wants their water cut off. However the fact remains that the 72 hour notice was not given and in my opinion the vote taken was illegal and non binding. Despite statements that PEI programs is not prop 63 money -- the front page of 3 year plan clearly states that all this is MHSA money. I honestly feel that someone has been trying to manipulate me. Can we somehow transfer oversight responsibility for prop 63 from the older adult council to DMH or to mental health director association. prop 63 requires consumer participation at all levels. Collaboration is much more than the telephone conversation between Dr. hanger and the department of mental health. Both I and other members of the council would like to help you with future reports and research.
10/21/08	Dr. Gloria G. Harris Adult Council Member Fee-for-Service Providers Representative	DV/SA Plans - when going into schools and communities, is there some mechanism in place so that there will be referrals to someone in Kaiser or other hospitals that are not County related for these individuals?
10/21/08	Elene Bratton Adult Council Member San Diego County Sheriff	PS Plans - Where is there a PSA for family members or parents who did not recognize their child's mental illness and who feel guilty and at a loss? These individuals need information on where they can go for services, support, etc.
10/21/08	Dixie Galapon, Samantha Hua, Gabriela Bervecos, Betsy Knight, & Chesley Blevins Adult Council Members PEI DV Plan Reviewers	<u>DV01</u> - Plan sounds like intervention at times; does this only involve families under CWS?; recommend mobile counselor to go to DV shelters to do screenings; what happens if a South Bay family is living in a DV shelter outside of South Bay?; recommend close collaboration with DV Shelter & Supports Committee under DV Council; need to identify cultural/language supports for Filipino families in South Bay; recommend screenings be conducted at ERs; group likes how it's a universal screen of all families; need specifics on protocols for law enforcement referrals; should have budgeted staff to meet County threshold languages at minimum <u>DV02</u> - Some of the interventions, such as "baby massage" may not appeal to males; need to think of more gender-neutral and/or culturally appropriate interventions; unclear when DV01 stops and when DV02 starts; need to specify if all kids at Polinsky will be served, or only South Bay kids; need to identify what will be provided for dads <u>DV03</u> - Group likes the broad scope of this project; need to specify if North Central Region is included because of presence of gangs in Mira Mesa and Linda Vista; kids are bussed in from other regions, so need to be specific how to address this; unsure if license-eligible clinicians are required for this type of project; applicants for this project should be a consortium of providers so there are no "turf wars" -- and to be role models for community; great primary prevention project; consider building in some type of peer mentoring aspect in this program; recommend linkage with Teen Recovery Centers, Juvenile Diversion programs, Planned Parenthood; this project appears to be heavily system-based - Need to consider how to incorporate community voice

MHSA PEI COMMUNITY FEEDBACK - FORMAL 30-DAY PUBLIC REVIEW

Date Received	Community Partner	Input/Suggestions <i>(Red input/suggestion items have been addressed in the Final PEI Plan)</i>
10/21/08	Bettie Reinhardt Adult Council Member Executive Director NAMI SD	<u>Rural Communities</u> – selected contractor(s) should have flexibility regarding the staffing pattern; how will liaison refer patients to mental health system if services are either unavailable/impacted in rural areas?; the public awareness activities that community liaisons develop appear to be a program or multiple programs in and of themselves; how does this component fit with the SBIR model for clinic patients?; development of a website is described in the outcomes, but that is not mentioned in program description or budget; para-professional and community outreach specialists are mentioned but not described; can peer specialists and parent partners be utilized?; Page 61, first paragraph reads “ Primary care physicians shall demonstrate increased acceptance of..... ” more realistic to say, “A culture will be developed that will help primary care physicians accept...” States that mobile outreach comprised of advance practice nurse and consumer or family member; the nurse’s specialty could be mental health or public health.
10/21/08	Peggy Beers (and staff) Mental Health America Adult Council	<u>NA Plan</u> - Indian Country in San Diego County is so large and wide spread, that we think it would be difficult for one clinician to cover all of Indian Country and to satisfactorily fulfill the PEI objectives. Recommendation: Hire two part-time clinicians, one for North County and one for South County, or add more money to the budget for two full-time PEI Project coordinators. Replace Spiritual Advisor with Youth Counselor or Cultural Mentor. Spiritual Advisor is too vague and that Cultural Mentor or Youth Counselor titles relate more to the community we will be targeting. Replace Elder Navigator services with Elder Outreach Services. Elder Navigator sounds science fictional and takes away from the importance of an Elders role in our communities. As well as additional outside services, some community consumers may not feel comfortable using Consortium services, due to confidentiality phobias. Will the UYC also be a place for American Indian Youth to enjoy themselves as well as nurture our Youth in a stimulating learning environment, which is both academically challenging and culturally enriching, and that will encourage our Youth to become productive, self-reliant members of society?
10/21/08	Dr. Diego Rogers CRF CCISC Group Adult Council Member	<u>Co-Occurring</u> - the CCISC group praises the plans. We only have one concern: There is a requirement that the program manager be a licensed mental health professional and a certified drug and alcohol counselor. We feel that mandate these 2 licenses/certifications will significantly limited the number of potential candidates. Instead, we propose adding the following to the existing language “and/or possess the necessary education and training that demonstrates dual diagnosis capability.”
10/21/08	Mary Jo O'Brian Partners in Care MCI Committee	<u>PS01</u> - should use college campuses for outreach; need to educate professors/educators; individuals with mental health needs may need more time for assignments and written instructions; physical effects of illness are real and not just psychosomatic; need education for public transportation workers and housing specialists; many times the compatability of roommates is not considered in placements.

MHSA PEI COMMUNITY FEEDBACK - RECEIVED AFTER 30-DAY PUBLIC REVIEW

Date Received	Community Partner	Input/Suggestions
10/22/08	Robert Bornt, MFT Executive Director Farm Hands, Inc.	<u>Veterans:</u> Dept of Defense is funding/mandating PTSD screening. Many of OIF/OEF veterans may have a PTSD diagnosis. They need to have a diagnosis pre-discharge or it is virtually impossible to get after discharge. The percentage of disability is up to the VA to determine. These individuals MUST NOT be excluded from participation in County Mental Health programs. Using the term mental illness in association with PTSD with this population is unwarranted and will erode trust and create a greater divide between veteran and service communities. And, you may find opposition by veteran groups to what may be viewed as exclusion and/or separation of government funded services. Most are very capable of moving forward with their lives and research is showing that difficulties in receiving social and agency support creates an increase in stress and can actually excite symptoms of PTSD not otherwise presenting. If we can provide effective and efficient service to all returning at-risk veterans we may find a wealth of advantage and we must have a system of referral in place for those who intervention does not assist. Lastly, the plan needs to consider the potential for the OIF/OEF veteran to be using some degree of prescribed medication. This is the first-line of treatment by both the DoD doctors and the VA psychiatrists. To be on a medication they may have had to get a diagnosis. And again, these individuals must not be disqualified without clearer guidelines of tolerance. Thanks for the opportunity to speak for those who have informed me and often do not have a voice due to their career situation.
10/27/08	East Region Collaborative Network	On behalf of ECRN, we are writing to express our deepest concern that the voices of East County residents participating in the planning process did not result in any dedicated PEI services for the urban ares of the East Region we represent (El Cajon, La Mesa, Lakeside, Lemon Grove, Santee and Spring Valley). we understand that a key to success for PEI is education and destigmatization and believe that our schools are a crucial point of engagement for a whole family approach to mental health prevention and early intervention. Therefore, we are respectfully requesting your assistance with action on two issues: 1) We join others in the education community in asking for a larger share of resources to be included in the current plan before it gets sent ot the State DMH and MHSOAC for approval. Specifically, we ar erequesting dedicated funding for school-based (K-12) East Region pgrams such as the evidence based programs listed above (Project PEACE & SHIELD) and recommended by us and others during the input process; 2) If additional funding becomes available through generalized PEI expansion dollars, we are requesting that the priority for this funding be identification of additional school sites including the East REgion of San Diego County for PEI school-based programs. We will be in attendance at the upcoming November 6th MHB meeting to further emphasize our disappointment and request action.
11/6/08	Barbara Ryan	The PEI plans have too much intervention and not enough prevention.

PEI PROJECT SUMMARY

Form No. 3

**PEI Project Name: Primary & Secondary Prevention – Outreach & Education;
Media Campaigns & Targeted Populations**

County: San Diego

Date: 11/19/08

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

PEI PROJECT SUMMARY

Form No. 3

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

The County of San Diego utilized community input from the CSS Planning process, data from the Gap Analysis, and ongoing community input through the System of Care Councils to develop the 10 Project areas for PEI. As described in Form 2, the community input and data analysis for San Diego's PEI Plan included a number of forums, focus groups, and other venues to clearly identify key priority areas for programming. The following workplan provides the specific input and data gathered for the development of this Project for Primary and Secondary Prevention.

Input related to primary and secondary prevention was received at all of the PEI community forums. That information included:

- Need for a youth focused, culturally competent, engaging, media campaign to reduce stigma and increase awareness including: health relationships, signs of depression, risk for suicide, and psychiatric breaks;
- Reduce stigma, thereby increasing access to mental health services, through public education;
- Public education – community notices – rural community newspapers/fliers, churches, post offices, stores, markets, fire stations, schools, etc.;
- Educate/train existing community organizations to recognize service needs and help veterans and families access services;
- Educate/train Native American community members to identify high-risk individuals and assist them in accessing services;
- Education and training to reduce stigma – campaign about trauma and consequences of violence (especially on children);
- Mitigate fear, secrecy, and stigma associated with domestic violence;
- Services should include community organizing and education before there is a need for crisis intervention;
- Public awareness to reduce stigma, trauma, suicide, and co-occurring disorders;
- Education to parents and community members on identifying at-risk behaviors in youth and helping them access services; and
- Public campaign to educate people about trauma, normal aging, passive suicide, and prescription medication misuse.

PEI PROJECT SUMMARY

Form No. 3

Additional Analysis – Suicide Prevention

According to the report "Suicide in San Diego County: 1995-2004," issued by Community Health Improvement Partners (CHIP), suicide now ranks first among causes of non-natural death in San Diego County, exceeding deaths by motor vehicle crashes, homicide, drug overdose, and other non-natural causes. From 1995 through 2004, suicide took the lives of 3,331 San Diegans, claiming about one person each day and outnumbering homicides (1,416) by 2.35 to 1. The report also emphasized that the devastating impact of suicidal behavior reaches far beyond those who actually take their own life. It is believed that for every suicide, there are six "survivors" – persons who suffer lasting emotional trauma when someone close to them dies as a result of suicide. Moreover, for every one completed suicide, there are an estimated 8 to 25 attempted suicides.

According to data from the Centers for Disease Control and Prevention (CDC), the age-adjusted suicide rate has been consistently higher in San Diego County than in the state of California. In 2002, suicide rates per 100,000 population were as follows:

- United States: 10.9
- California: 9.5
- San Diego County: 10.9

The CDC, in its *Healthy People 2010* report, has set a target of 5.0 suicides per 100,000 population. This indicates our county, our state, and the nation as a whole must gear up to make a significant impact on the problem of suicide.

The CHIP report also discussed suicide among various race and ethnicities. The suicide rate among Whites in San Diego County is nearly double all other races combined, with White males having the highest suicide rate of any race/gender combination. Both genders were at increased risk in the White population compared with other racial/ethnic groups, and males were substantially more at risk of committing suicide among all groups.

PEI PROJECT SUMMARY

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Table 1.4: Suicides by Race/Ethnicity and Gender

Race/ Ethnicity	Male		Female		Total	
	Number	Rate [†]	Number	Rate	Number	Rate
White	2010	25.44	650	8.43	2660	17.04
Black	114	13.84	24	3.29	138	8.88
Hispanic	240	6.52	49	1.35	289	3.96
Asian/Other	141	8.51	59	3.33	200	5.83
Unknown	3	**	1	**	4	**
Total	2508	17.84	783	5.66	3291	11.80

[†] Rate per 100,000

Source: County of San Diego Health and Human Services Agency, Emergency Medical Services, Medical Examiner Database, 1995 – 2004

Additional Analysis – Stigma and Discrimination

"Stigmatization of people with mental disorders is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. Stigma leads the (public) to avoid people with mental disorders. It reduces access to resources and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care. Stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society" (U.S. Surgeon General Dr. David Satcher).

"Overall approaches to stigma reduction involve programs of advocacy, public education, and contact with persons with mental illness through schools and other societal institution...One in five Americans struggles with a mental illness in any given year, fewer than half receive the right kind of treatment. Those who fail to get good care are held back by enduring stigma, a fragmented system of mental health care delivery, and financial strains. Mental illness is as real as heart disease; patients can benefit from new treatments and medications and can recover. New drugs and therapies have

PEI PROJECT SUMMARY

Form No. 3

vastly improved the outlook for the five million or so people with the most severe mental illnesses. People should expect to do better than they've ever done in the past" (U.S. Surgeon General Dr. David Satcher).

The Federal Action Agenda states, "Every man, woman, and child with or at risk for mental disorders deserves a life in the community, with meaningful employment, interpersonal relationships, and community participation." However, stigma and discrimination often stand in the way of opportunities for individuals with mental illness. They have a substantial impact on access to mental health services as well as support for funding for public mental health services. Stigma and discrimination have such an impact on those living with mental illness, that the Substance Abuse and Mental Health Services Administration (SAMHSA) recently facilitated a three-year Elimination of Barriers Initiative. The initiative gave consumers an opportunity to voice their concerns and needs related to these areas, and approaches to address discrimination and stigma were tested in eight States across the Country.

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

This proposed project is a two-pronged approach to increase public awareness and understanding of mental illness through media-based outreach and education campaigns and provide outreach and education to targeted underserved and unserved populations.

Primary Prevention, Media-Based Outreach, and Education

These programs will enhance and expand upon the state DMH plans on stigma reduction and suicide prevention. The County of San Diego Mental Health Services will work closely with the County of San Diego's Health and Human Services Agency's (HHSA) Office of Media and Public Affairs (OMPA) to identify an organization to assist in developing and implementing comprehensive campaigns. The programs will use existing stigma reduction and suicide prevention curricula and coordinate with local strategies to provide the following:

1. Stigma Reduction – A variety of projects have been implemented around the country dealing with the issue of stigma and discrimination. This program will utilize strategies and directions from a number of these sources,

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including *Developing a Stigma Reduction Initiative* (Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA), 2006); *What a Difference a Friend Makes* (SAMHSA, 2006); and *Youth Champions for Hope* (United Advocates for Children and Families, 2007). These strategies will be modified to address the unique characteristics of San Diego County and specific target populations.

The selected strategies will be integrated in the media campaign targeting stigma reduction:

- o Work with OMPA to engage an advertising/media firm to develop a community education media plan around stigma reduction;
- o Conduct a general advertising campaign in English and threshold languages (Arabic, Spanish, and Vietnamese);
- o Create printed materials to include flyers, posters, brochures, fact sheets, and cards;
- o Hold a news conference kicking off the campaign;
- o Run TV/radio/print ads in threshold languages, on County Network Television (CNT) & network stations; and
- o Write ongoing opinion pieces, Mental Health Provider Alerts, and Letters to the Editor during campaign.

2. Suicide Prevention – Suicide is defined as the intentional taking of one's own life. The broader term of suicidal behavior also includes self-inflicted, potentially injurious behaviors (Silverman et al., 2007). This program will build upon the California Strategic Plan on Suicide Prevention (2008) by the California Department of Mental Health.

The selected strategies will be integrated in the media campaign targeting suicide prevention:

- o Work with OMPA to engage an advertising/media firm to develop a community education media plan around suicide risk and prevention;
- o Conduct a general advertising campaign in English and threshold languages;
- o Create printed materials to include flyers, posters, brochures, fact sheets and cards;
- o Hold a news conference kicking off the campaign;
- o Run TV/radio/print ads in threshold languages, on CNT, and network stations; and
- o Write ongoing opinion pieces, Mental Health Provider Alerts, and Letters to the Editor during the campaign.

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The selected strategies will be used to build upon the existing San Diego County Interagency Suicide Meeting, which will include Public Health, Regional Health Promotion, Aging and Independence Services, Epidemiology, Behavioral Health and community partners

- o Develop a suicide prevention action plan,
- o Develop a supplemental survey for suicide prevention training and technical assistance needs,
- o Expand suicide prevention training via the MHSA Workforce Education and Training component,
- o Enhance reporting systems to improve the consistency and accuracy of data about suicide deaths, and
- o Establish capacity for suicide death reviews and provide regular reports to the Office of Suicide Prevention and the local mental health councils.

Secondary Prevention, Targeted Populations Outreach and Education

1. Focused Media – An education and outreach campaign will also be facilitated for newly developed MHSA PEI services. The selection of this/these groups will be determined based on unserved and underserved populations as identified by the Mental Health Services Act, local data, and community input gathered during the PEI process.
2. Breaking Down Barriers – This program uses a Cultural Broker outreach model to create effective collaborations with various agencies, community groups, client and family member organizations, and other stakeholders to reduce mental health stigma and increase access to mental health services by unserved and underserved communities. San Diego County initially implemented *Breaking Barriers* with great success using Community Service and Supports (CSS) one-time-only funding. The services were continued and expanded in 2007 via PEI Planning funds in order to enhance the PEI community planning process and project development with Latino, Native American, and Veteran communities during this period. Mental Health Services will extend the current Breaking Barriers contract to provide prevention and early intervention services with ongoing PEI funding. Building upon the services already provided via the contract, the Cultural Brokers will:
 - o Provide mental health outreach, engagement and education to persons in these communities;
 - o Implement and evaluate strategies to reduce mental health stigma; and
 - o Create effective collaborations with other agencies, community groups, clients, and family member organizations from these communities.

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3. Fotonovela – Community input directed the County to consider using this medium of education. A photo-booklet with Spanish narrative presented in captions at the top and bottom of each frame will be created to educate and outreach to the local Hispanic community. The thematic content of this project will target reduction in stigma and discrimination towards mental illness in culturally appropriate contexts. Focus Groups will be utilized to provide initial input and feedback as to the content, and possibly assist in developing the storyline. Additional subject matter may include suicide risk awareness and education on early detection of mental illness.
4. Support Lines – An additional means of providing outreach and education will occur via two new, confidential phone support lines submitted in the PEI plan (separately proposed in PS02 and PS03).
 - o Youth Peer Support Line – In response to input from community stakeholders expressing the need for increased youth peer services, a non-crisis Youth Peer Support Line will be established to provide countywide telephone counseling services. The line will offer non-crisis support, mental health education, and referral services. The line will be staffed by youth. Community youth stated that barriers to seeking services would be reduced if they had a peer to talk with to ease their fears. The youth will be trained in providing culturally competent support and resources. A program manager will oversee the services provided.
 - o Family Peer Support Line – A Family Peer Support Line will also be established to provide countywide non-crisis support, mental health education, and referral services. The line will be staffed by family members. The family members will be trained in providing culturally competent support and resources. A program manager will oversee the services provided.

County Support and Collaboration

County Regional Health Promotion and Aging and Independence Services staff will support and foster collaboration among the proposed and existing community outreach and education service providers to enhance PS01 program design and delivery across San Diego County. Currently, Regional Health Promotion and Aging Program staff maintain numerous contacts with health service providers and community members. These contacts and their professional expertise will enhance the delivery of the proposed primary and secondary prevention program services.

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Regional Health Promotion Specialist and Aging Program Specialist staff will use existing regional networks and forums to provide mental health education, assist in identifying risk factors, improve access to care, and promote the mental health well being of the communities they serve. Staff will also assist in disseminating prevention and early intervention materials throughout the County, including materials on suicide prevention, stigma, and discrimination. These staff will provide training and presentations about mental health to individuals, families, caretakers, providers, peers, and other community members.

Key Milestones and Timelines

The following are key milestones and their anticipated timeline:

- Receive California DMH approval for plan – Month 1
- Identify and select media/marketing firm – Month 1
- Develop marketing plan – Month 2-3
- Create print outreach and prevention materials (including materials in threshold languages) – Month 3
- Develop video/telemmedia (e.g. PSAs) – Month 3
- Identify focused media project populations and create materials for target populations – Month 3 and ongoing
- Begin distributing materials – Month 4
- Broadcast video outreach materials – Month 5

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4. Programs

Estimates will be obtained through media market outreach (surveys) at post-distribution time points. Estimates of caller volume will be used for the Support Lines, but will not be unduplicated due to the anonymous nature of the calls. Exact service numbers for the Youth and Family Peer Support Lines are available in PS02 and PS03 respectively.

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Primary Prevention, Media-Based Outreach, and Education – Stigma Reduction and Suicide Prevention	Individuals: TBD Families: TBD	Individuals: Families:	
Secondary Prevention, Targeted Populations Outreach, and Education – Focused Media	Individuals: TBD Families: TBD	Individuals: Families:	
Breaking Down Barriers	Individuals: TBD Families:	Individuals: Families:	
Fotonovela	Individuals: TBD Families:	Individuals: Families:	
TOTAL PEI PROJECT ESTIMATED <i>UNDULICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: TBD Families:	Individuals: Families:	

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

Linkages are expected to be identified in the County's process to select and negotiate with contractors that will provide the proposed programs and services.

Individuals in need of resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues. While the Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline. This will also then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services

6. Collaboration and System Enhancements

Mental Health Services will work closely with the County of San Diego Office of Media and Public Affairs (OMPA) with regard to all media outreach and materials. Other collaborations and system enhancements are expected to be identified in the County's process to select and negotiate with contractors that will provide the proposed programs and services. The County MHS Administration and selected contractor will also partner with County Regional Health Promotion and Aging and Independence Services to further integrate and effectively promote the prevention and early intervention intent of this program county-wide.

7. Intended Outcomes

Outcomes may include, though are not limited to, the anticipated outcomes listed below. Specific program outcomes are expected to be identified in the County's process to select and negotiate with contractors that will provide the proposed programs and services. Outcomes will be re-evaluated annually by the County and service provider and, if necessary, revised to improve service provider performance.

Individual outcomes:

- Increased knowledge of social, emotional, and behavioral issues;

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- Increased knowledge of risk and resilience/protective factors; and
- Increase in the number of individuals/families from underserved populations who receive prevention programs and early intervention services.

System and program outcomes:

- Enhanced suicide prevention efforts;
- Reduced stigma and discrimination;
- Reduced negative consequences of untreated serious mental illness;
- Shorter duration of untreated mental illness; and
- Earlier access to MH treatment and services, as appropriate.

8. Coordination with Other MHSA Components

Services provided through these programs will be designed to coordinate and support the services under all other MHSA components. In turn, information on current MHSA funded programs and services, in addition to other existing mental health services, will be provided throughout the media campaigns. Targeted population services will be coordinated with the PEI programs serving those underserved and unserved populations.

Workforce Education & Training – Prevention training will be expanded using the MHSA Workforce Education and Training component, including developing a supplemental survey for suicide prevention training and technical assistance needs.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County:

SAN DIEGO

Workgroup - Focus Area (Cnty PEI List):

Primary & Secondary Prevention Services

Program ID/Name:

PS01

Outreach and Education; Media Campaigns & Targeted Populations

Provider Name (if known):

Pending Competitive Procurement

Provider Category (DMH List):

Other

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	TBD
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	TBD
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues			Est Annual \$	FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
	Classification	FTE	Per FTE			
	County Staff*					
	Community Health Promotion Specialist I	4.00	\$49,150	\$0	\$196,600	\$196,600
	Community Health Promotion Specialist II	2.00	\$55,750	\$0	\$111,500	\$111,500
	Aging Program Specialist II	1.00	\$50,450	\$0	\$50,450	\$50,450
		0.00	\$0	\$0	\$0	\$0
	Total FTE	7.00	Sub-Total	\$0	\$358,550	\$358,550
	b. Benefits% @	51.0%	(County Only)	\$0	\$182,861	\$182,861
c. Total Personnel/Staffing Expenses				\$0	\$541,411	\$541,411
2. Operating Expenditures						
	Indirect/Administrative Costs			\$0	\$0	\$0
	Operating Costs (includes Facility Costs)			\$0	\$0	\$0
	Start-Up/One-Time Only Costs*		\$208,000	\$0	\$208,000	\$208,000
c. Total Operating Expenses				\$0	\$208,000	\$208,000
3. Subcontracts/Professional Services (list/itemize)						
A1	Media Campaign - Suicide Prevention & Stigma Reduction		\$919,190	\$0	\$919,190	\$919,190
A2	Media Campaign - Target Populations					
B	"Breaking Down Barriers"		\$165,000	\$0	\$165,000	\$165,000
C	Fotonovela Campaign		\$100,000	\$0	\$100,000	\$100,000
				\$0	\$0	\$0
				\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$1,184,190	\$1,184,190
4. Total Proposed PEI Program Budget				\$0	\$1,933,600	\$1,933,600
B. Revenues (list/itemize by fund source)						
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$1,933,600	\$1,933,600
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**

Program ID/Name: **PS01 Outreach and Education; Media Campaigns & Targeted Populations**

Program Budget - Proposed Program services will be provided by County staff and County contracted service providers. Program service providers media and Fotonovela campaigns) will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals that improve on County projected Program staffing, performance, and cost effectiveness. Breaking Down Barriers services will be provided by amendment to a current contract.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Only County staff for County provided health promotion services are identified. Classifications, FTEs, and salaries are from County Budget data. Contracted services (media and Fotonovela campaigns, and Breaking Down Barriers) will be purchased on a per project basis and proposed staffing will not be required to be identified.

Clients and Family Members - The Breaking Down Barriers Program will be targeting specific communities and the current contractor works with key community members with appropriate expertise and experience to help ensure their success in assessing and promoting community needs.

A1b Benefits - The Benefit rate (51%) is the current County budgeted rate for County staff.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - No costs are identified. Indirect/Administrative Costs and Operating Costs (which include facility costs) will be included in the proposed project costs of contracted services (media and Fotonovela campaigns, and Breaking Down Barriers) and will not be required to be identified. No new County costs are anticipated for the proposed County positions.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

A2 Subcontracts/Professional Services

Proposed contracted services and projected costs are listed. The Breaking Down Barriers cost is based on current per project contract costs. Fotonovela campaign costs are based on County contracts for similar services. Media campaign cost is the total allocation available for those services and will be defined in the process of procuring those services.

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

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PEI Project Name: Youth Peer Support Line

County: San Diego

Date: 11/19/08

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI Project/Program:				
1. Disparities in Access to Mental Health Services	☒	☒	☐	☐
2. Psycho-Social Impact of Trauma	☐	☐	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	☒	☒		
4. Stigma and Discrimination	☒	☒	☐	☐
5. Suicide Risk	☐	☐	☐	☐

2. PEI Priority Population(s) Note: All PEI Projects/Programs 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/Program:				
1. Trauma Exposed Individuals	☐	☐	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☐
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☒	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒		
6. Underserved Cultural Populations	☒	☒	☐	☐

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

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Primary and Secondary Prevention as one of our 10 priority focus areas. Below is a summary of stakeholder input and background information.

The proposed Youth Peer Support Line Program is supported by community and stakeholder input and by several professional resources. This program is also identified as a needed enhancement of current Children's System of Care services.

Community/Stakeholder Input – The County's PEI Community Forums, each targeting a different priority population, and the general community input of individual public comments identified several key general prevention service needs and recommendations for at-risk youth:

- Establish a toll-free hotline to support stressed and at-risk youth with mental health and other information, support and access to needed resources and appropriate services;
- Establish a "safe" place for at-risk youth that is confidential and reduces stigma and isolation;
- Provide at-risk youth ready access to mental health information, self-screening tools, resources and services;
- Provide services from people youth can trust to help them overcome barriers and guide them through the mental health system; and
- Need for culturally competent peers/role models that have successfully experienced the mental health system and can relate to the needs and concerns of youth.

San Diego County Children's System of Care Conferences – Participants identified a need for a youth phone line and chat room to contact peers about mental health and other issues in a safe and accepting environment.

Other Information Supporting the Proposed Program:

Spotlight Briefing, National Children's Bureau, November 2004 – This publication reported that:

- Peer support encourages both those being helped and the helpers to develop personal and social skills, such as communication skills, improving self-esteem, learning to negotiate with one another and adults over areas of conflict and learning to ask for help and support.

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- Young people can address public health issues in school and in the community, such as mental health, alcohol and other drugs awareness, sex and relationships.
- Those who receive support and the supporters often have improved behavior.
- Peer support can raise adults', children's, and young people's awareness of issues that affect emotional health.
- Peer support can be used to promote inclusion.

Stratten, K; Ainslie, R. (2003) in their Field Guide: Setting Up a Hotline (Johns Hopkins, Bloomberg School of Public Health Director/Center for Communication Programs):

"Hotlines offer an effective way to provide callers with accurate information, counseling, and referrals to appropriate community-based services or resources. The anonymity of a hotline is a key asset, especially in working with adolescents, because it allows the caller to ask questions that may be difficult or awkward to address in a face-to-face context."

National Youth Violence Prevention Resource Center (Centers for Disease Control and Prevention, 2007):

"Peer Supports keep children and teens safe and give them the opportunity to build and explore behavior changes, develop new interests, and to develop relationships with caring adults. Evaluations have shown that quality peer supports can: decrease juvenile crime; decrease youth participation in risky behaviors, such as drug, alcohol; lead youth to develop new skills and interests; improve youth's grades and academic achievement; encourage youth to reach higher in planning their future."

Data Analysis Supporting the Proposed Program – The County of San Diego, Adult Mental Health currently provides non-crisis telephone peer support services for callers that are at least 18 years old. Successful outcomes in that program support the potential value of non-crisis telephone peer support services for Youth. Call volume for the adult peer support line in Fiscal Year 2007-2008 was 8,245 calls. Expected call volume for a youth peer support line is estimated at 1,040 calls annually; adjusting to the fewer operational hours appropriate for a youth peer support line.

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

The proposed Youth Peer Support Line will provide non-crisis, confidential, telephone peer counseling services to youth, including those identified as Transitional Age Youth (TAY), in San Diego County. The line will be staffed by youth (as peer counselors) providing culturally competent information, support and access to needed resources and appropriate services. The line will provide services late afternoons and evenings a minimum of five days per week. A

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Licensed Supervising Clinician will be available a minimum of four hours per week to provide staff consultation on handling difficult and complex phone contacts.

This Youth Peer Support Line will be a first in California – mental health, non-crisis, telephone-based support for youth staffed by youth.

To implement the program, the County will solicit proposals from interested service providers. Proposals are expected to be innovative and address confidentiality, stigma and isolation while providing youth information, support and access to needed resources and appropriate services.

Key Program Services and Elements – The selected service provider's proposed program is expected to include, though is not limited to, the following key program services and elements:

- A toll-free telephone line to support stressed and at-risk youth in San Diego County with mental health and other information, support and access to needed resources and appropriate services;
- A resource manual/reference guide to help staff identify available resources and services and other reference materials;
- Provide access a minimum of six hours per day, five days per week scheduled to meet the access needs of youth;
- Staffing:
 - o Program Manager, full time, that will manage the program and supervise program staff;
 - o Peer Counselors that youth can trust to help them overcome barriers and guide them through the mental health system; these positions will be filled by peers/role models who have successfully experienced the mental health system and can relate to the needs and concerns of youth; an estimated four part-time Peer Counselors will be required to provide adequate phone line coverage; Peer Counselors will be culturally competent and at least one counselor is expected to be bilingual (Spanish);
 - o Licensed Mental Health Clinician to provide staff training and consultation as necessary to provide effective support for youth accessing the line; estimated that clinician services will be required a minimum of four hours a week;
- Advertise and promote the Youth Peer Support Line in schools, youth and community centers, youth groups, other locations and organizations where youth gather and in youth centered local publications.

Anticipated Program Timeline and Key Milestones

- Receive California DMH approval for Plan – Month 1

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- RFP developed, competitive procurement process completed – Month 3
- Contract awarded – Month 4
- Establish work facilities and equipment (telecommunication) – Month 4
- Establish toll-free phone line (800 phone number) – Month 4
- Hire staff – Months 4-5
- Develop staff training curriculum and train staff (including cultural and linguistic needs) – Months 4-6
- Develop Program policies and procedures and submit to County for review – Months 4-6
- Develop Support Line Resource Manual and reference materials – Months 4-6
- Develop and implement outreach/advertising plans, strategies, and materials (including materials in threshold languages) – Months 4-6
- Develop Outcome measurement tools – Months 4-6
- Start Services, the Youth Peer Support Line – Months 7-8
- Collect and assess Outcome data – Months 7-12

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Youth Peer Support Line	Individuals: 1,040 Families:	Individuals: Families:	
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 1,040 Families:	Individuals: Families:	

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

The Youth Peer Support Line will be open and advertised for use by youth who may be expressing stress and in need of support or other services. The Youth Peer Support Line will provide mental health information, support and access to needed resources and appropriate services. Staffing the Youth Peer Support Line with Peer Counselors will lessen youths' fears of making the initial contact and will encourage them to follow through with using the information provided and the referrals to San Diego County resources and services.

Program linkages will include, though are not limited to, the County of San Diego Children's Mental Health Services (CMHS) resource and reference material, as well as the Adult Mental Health Transitional Age Youth Service Provider Directory that identifies an extensive network of County, County-contracted and other organizations providing mental health and other services to children and youth in San Diego County. The Youth Peer Support Line is expected to use that resource and reference material in developing the program's resource manual and key linkages to County Mental Health and other services. Additional linkages are expected to be identified in the County's process to competitively select a contractor to provide the proposed program and services.

The County of San Diego Children's Mental Health Services has established three policies related to Family/Youth partners that will help guide the implementation of this program and help integrate the program with other youth programs: (1) Family/youth/parent support partners as direct service providers; (2) Youth support partners: selection, training and supervision; and (3) Family support partners: selection, training and supervision. These policies delineate the role of youth/family partners, the process for employment and supervision and funding options, including the ability to bill when appropriate.

6. Collaboration and System Enhancements

Anticipated collaborations and system enhancements are listed below. Additional collaborations and system enhancements are expected to be identified in the County's process to competitively select a contractor to provide the proposed program and services.

The selected Youth Peer Support Line service provider will outreach throughout San Diego County to advertise and promote the Youth Peer Support Line to mental health clients and service providers and the general public. Schools will be targeted for dissemination of information on the program. The County of San Diego will assist by ensuring the

PEI PROJECT SUMMARY

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Program is identified in mental health resource manuals used by County and County-contracted service provider staff. Information gathered by the program provider may identify additional service delivery needs and resources that will help the system and service providers improve service delivery. A critical component of the support line will be linkages to the County's 24-hour access and crisis line, the County's 2-1-1 line (one-stop for community, health, and disaster related resources), other proposed PEI Support and Hotlines and other community phone support lines providing support and access to needed resources and services.

7. Intended Outcomes

Outcomes may include, though are not limited to, the anticipated outcomes listed below. Specific program outcomes are expected to be identified as a result of the County's process to competitively select a contractor to provide the proposed program and services. Outcomes will be re-evaluated annually by the County and service provider and, if necessary, revised to improve service provider performance.

Individual Outcomes:

- o Increased knowledge of social, emotional and behavioral issues;
- o Reduced school drop-out, expulsion, suspensions;
- o Improved school performance;
- o Reduced family stress/discord;
- o Reduced involvement with law enforcement and courts, reduced incarceration in Juvenile Justice facilities;
- o Reduced violence;
- o Reduced isolation;
- o Increased social support;
- o Increased appropriate help-seeking;
- o Reduced stigma about mental illness and accessing services;
- o Increased knowledge of mental illness; and
- o A minimum of 80% of youth using the support line will be satisfied with services.

System Outcomes:

- o Increased access to public and confidential mental health services; fewer persons needing services failing to access available services;

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- o Reduced consequences of untreated mental disorders; reduction in prolonged suffering, suicide attempts, school failure, or removal from home;
- o Another data source for evaluating mental health system responsiveness to youth needs; and
- o Increased number of trained youth involved in providing services.

8. Coordination with Other MHSA Components

Anticipated coordination with other MHSA Components is listed below. Coordination with additional MHSA Components may be identified in the implementation of the proposed PEI Projects and Programs and the County's process to competitively select a contractor to provide the proposed program and services.

- **Community Services and Support (CSS) and the County System of Care** – The Youth Peer Support Line Program will be linked to and coordinate with current CSS programs for children, youth, and families as well as the entire County mental health system. The program will use the Children's Mental Health Services Resource Manual, which includes CSS programs, to provide referral resource and service information, as well as the Adult Mental Health TAY Service Provider Directory. It will link to and coordinate with other system access services such as the Access and Crisis Line and the 2-1-1 line (one-stop for community, health, and disaster related resources). Conversely, the Youth Peer Support Line will be a resource for the County's mental health system, which will have a new resource for youth that may be in need of confidential peer support.
- **Workforce Education and Training (WET)** – The program's peer staff (Peer Counselors) and interested youth and family members will be targets for training programs in the Workforce Education and Training (WET) Plan. WET training is expected to enhance the skills of existing peer staff, develop new qualified peer staff, and improve peer staff understanding of the Children's Mental Health System and how to counsel and guide youth with mental health needs.
- **MHSA Technology & Technological Needs** – The Youth Peer Support Line Program is expected to leverage existing and planned County MHSA developed information technology (IT) resources to enhance access to the program and its services and increase program efficiency and effectiveness. IT resources may be used to develop online educational webcasts to expand program outreach and may include internet-based communication with the Youth Peer Support Line. IT support and improvements to the Youth Peer Support Line Program and its services

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will be assessed and developed (with stakeholder input) as part of the development of the MHSA Capital Facilities and Technological Needs (CFTN) Component Plan.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): **Primary & Secondary Prevention Services**
 Program ID/Name: **PS02 Youth Peer Support Line**
 Provider Name (if known): **Pending Competitive Procurement**
 Provider Category (DMH List): **Mental Health Treatment/Service Provider**

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	1040
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	1040
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
Classification	FTE	Per FTE				
Program Manager	1.00	\$54,370		\$0	\$54,370	\$54,370
Licensed Supervising Clinician	0.10	\$51,650		\$0	\$5,165	\$5,165
Peer Counselor/Support Staff	0.25	\$29,510		\$0	\$7,378	\$7,378
Peer Counselor/Support Staff	0.25	\$29,510		\$0	\$7,378	\$7,378
Peer Counselor/Support Staff	0.25	\$29,510		\$0	\$7,378	\$7,378
Peer Counselor/Support Staff	0.25	\$29,510		\$0	\$7,378	\$7,378
Admin Support (Admin Asst, Secr, Clrk)	0.10	\$28,920		\$0	\$2,892	\$2,892
Total FTE	2.20	Sub-Total		\$0	\$91,937	\$91,937
b. Benefits%	@	27.0%		\$0	\$24,823	\$24,823
c. Total Personnel/Staffing Expenses				\$0	\$116,760	\$116,760
2. Operating Expenditures						
Indirect/Administrative Costs		\$28,600		\$0	\$28,600	\$28,600
Operating Costs (includes Facility Costs)		\$46,200		\$0	\$46,200	\$46,200
Start-Up/One-Time Only Costs*		\$23,000		\$0	\$23,000	\$23,000
c. Total Operating Expenses				\$0	\$97,800	\$97,800
3. Subcontracts/Professional Services (list/itemize)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$0	\$0
4. Total Proposed PEI Program Budget				\$0	\$214,560	\$214,560
B. Revenues (list/itemize by fund source)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$214,560	\$214,560
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**
Program ID/Name: **PS02 Youth Peer Support Line**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals and that improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts for peer support lines, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

Position(s) targeted: Peer Counselor/Support Staff, 1.0 FTE/4 Positions.

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Specialized Training, and Consultant costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Specialized Training (including Training for Trainers)
- Consultants to assist Program implementation

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

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PEI Project Name: Family Peer Support Line

County: San Diego

Date: 11/19/08

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition -Age Youth	Adult	Older Adult
Select as many as apply to this PEI Project/Program:				
1. Disparities in Access to Mental Health Services	☒	☒	☐	☐
2. Psycho-Social Impact of Trauma	☐	☐	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	☒	☒		
4. Stigma and Discrimination	☒	☒	☐	☐
5. Suicide Risk	☐	☐	☐	☐

2. PEI Priority Population(s) Note: All PEI Projects/Programs 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/Program:				
1. Trauma Exposed Individuals	☐	☐	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☐
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☒	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		
6. Underserved Cultural Populations	☒	☒	☐	☐

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).

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Primary and Secondary Prevention as one of our 10 priority focus areas. Below is a summary of stakeholder input and background information.

The proposed Family Peer Support Line Program is supported by community and stakeholder input and professional resources.

Community/Stakeholder Input

Community Forums – PEI Community Forums, each targeting a different priority population, and the general community input of individual public comments, identified several key general prevention service needs and recommendations for caregivers and family of at-risk children and youth:

- Expand public access to mental health information, screening tools, resources and services;
- Establish a toll-free hotline to support caregivers and families (parents, siblings, relatives) of at-risk children and youth with mental health and other information, support and access to needed resources and appropriate services’
- Establish a “safe” place for caregivers and families that is confidential and reduces stigma and isolation;
- Educate caregivers and families on how to identify at-risk behaviors of children and youth;
- Provide caregivers and families with screening tools to help assess mental health issues in children and youth;
- Empower caregivers and families to support peers; and
- Provide services with culturally competent peers who have successfully experienced the mental health system and can relate to the needs and concerns of caregivers and families.

Community Focus Groups – The County-contracted Family and Youth Roundtable conducted several focus groups to target San Diego communities not specifically addressed in the Community Forums. The Focus Group Final Report, March 2008, identified a need for an anonymous peer toll-free hotline that avoided mental health “labels.”

Other Information Supporting the Proposed Program:

The Spotlight Briefing, National Children’s Bureau, November 2004 – This publication reported that:

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- Peer support encourages both those being helped and the helpers to develop personal and social skills, such as communication skills, improving self-esteem, learning to negotiate with one another and adults over areas of conflict and learning to ask for help and support;
- Those who receive support and the supporters often have improved behavior;
- Peer support raises adults', children's, & young people's awareness of issues that affect emotional health; and
- Peer support can be used to promote inclusion.

Data Analysis Supporting the Proposed Program

The County of San Diego, Adult Mental Health currently provides non-crisis, telephone peer support services for callers that are at least 18 years old. Successful outcomes in that program support the potential value of non-crisis telephone peer support services for families. Call volume for the adult peer support line in Fiscal Year 2007-2008 was 8,245 calls. Expected call volume for a family peer support line is estimated at 1,040 calls annually; adjusting to the fewer operational hours appropriate for a family peer support line.

Research has shown that having a child with behavioral/mental health issues is often cause for caregiver/family isolation from extended family, friends, school and social activities. Often caregivers do not understand the cause of their child's behavior or how to help or deal with their child and this, coupled with caregivers' isolation and loss of hope for their child's achievements, may have serious impact on the family. Corring, D. (2002) conducted a study with persons with mental illness and family members and the results supported the need for continued peer support. By providing a family peer support line, caregivers and family members will have a safe place to talk about daily issues they experience. The support line will be a stigma-free place where caregivers and family members can access peer support and information, resources and services that will help them cope with and respond to those issues.

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

The proposed Family Peer Support Line will provide non-crisis confidential telephone peer counseling services to caregivers and families, including foster parents of at-risk children, youth and Transitional Age Youth (TAY) in San Diego County. The line will be staffed by caregivers and family members (as peer counselors) providing culturally competent information, support and access to needed resources and appropriate services. The line will provide services late afternoons and evenings a minimum of five days per week. A Licensed Supervising Clinician will be available a minimum of four hours per week to provide staff consultation on handling difficult and complex phone contacts.

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To implement the program, the County will solicit proposals from interested service providers. Proposals are expected to be innovative and address confidentiality, stigma and isolation while providing caregivers and family members of at-risk children and youth information, support and access to needed resources and appropriate services.

Key Program Services and Elements – The selected service provider's proposed Family Peer Support Line program is expected to include, though is not limited to, the following key program services and elements:

- A toll-free telephone line to support caregivers and families of at-risk children and youth in San Diego County with mental health and other information, support and access to needed resources and appropriate services;
- A resource manual/reference guide to help staff identify available resources and services and other reference materials as appropriate;
- Provide access a minimum of six hours per day, five days per week scheduled to meet the access needs of caregivers and families;
- Staffing:
 - o Program Manager, full time, to manage the program and supervise program staff;
 - o Peer Counselors that caregivers and families can trust to help them overcome barriers and guide them through the mental health system; peers who have successfully experienced the mental health system and can relate to the needs and concerns of the caregivers and families; an estimated four part-time Peer Counselors will be required to provide adequate phone line coverage; Peer Counselors will be culturally competent and at least one counselor is expected to be bi-lingual (Spanish);
 - o Licensed Mental Health Clinician to provide staff training and consultation as necessary to provide effective support for caregivers and families accessing the Line; estimated that Clinician services will be required a minimum of four hours a week;
- Advertise and promote the program in schools, community and family centers, other public locations and organizations and in local publications where caregivers and family members may discover and access information on the Family Peer Support Line.

Anticipated Program Timeline and Key Milestones

- Receive California DMH approval for plan – Month 1
- RFP developed, competitive procurement process completed – Month 3
- Contract awarded – Month 4
- Establish work facilities and equipment (telecommunication) – Month 4
- Establish toll-free phone line (800 phone number) – Month 4

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- Hire staff – Months 4-5
- Develop staff training curriculum and train staff (including cultural and linguistic needs) – Months 4-6
- Develop program policies and procedures and submit to County for review – Months 4-6
- Develop support line resource manual and reference materials – Months 4-6
- Develop and implement outreach/advertising plans, strategies and materials (including materials in threshold languages) – Months 4-6
- Develop outcome measurement tools – Months 4-6
- Start services for the Youth Peer Support Line – Months 7-8
- Collect and assess outcome data – Months 7-12

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Family Peer Support Line	Individuals: Families: 1,040	Individuals: Families:	
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: Families: 1,040	Individuals: Families:	

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

The Family Peer Support Line will be open and advertised for use by caregivers and families of at-risk children and youth who are in need of support or other services. The Family Peer Support Line will provide mental health information, support and access to needed resources and appropriate services. Staffing the support line with Peer

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Counselors will lessen caregivers' and family members' fears of making the initial contact and will encourage them to follow through with using the information provided and the referrals to San Diego County resources and services.

Program linkages will include, though are not limited to, the County of San Diego Children's Mental Health Services (CMHS) resource and reference material and the Adult Mental Health Transitional Age Youth Service Provider Directory that identifies an extensive network of County, County-contracted and other organizations providing mental health and other services to children and youth in San Diego County. The Family Peer Support Line is expected to use that resource and reference material in developing the program's resource manual and key linkages to County Mental Health and other services. Additional linkages are expected to be identified in the County's process to competitively select a contractor to provide the proposed program and services.

The County of San Diego Children's Mental Health Services has established three policies related to family/youth partners that will help guide the implementation of this program and help integrate the program with other children and youth programs; (1) Family/youth parent support partners as direct service providers; (2) Youth support partners: selection, training and supervision; and (3) Family support partners: selection, training and supervision. These policies delineate the role of family/youth partners, the process for employment and supervision and funding options, including ability to bill when appropriate.

6. Collaboration and System Enhancements

Anticipated collaborations and system enhancements are listed below. Additional collaborations and system enhancements are expected to be identified in the County's process to competitively select a contractor to provide the proposed program and services.

The selected Family Peer Support Line service provider will outreach throughout San Diego County to advertise and promote the Family Peer Support Line to mental health clients and service providers and the general public. Schools will be targeted for dissemination of information on the support line. The County of San Diego will assist by ensuring the program is identified in mental health resource manuals used by County and County-contracted service provider staff. Information gathered by the Family Peer Support Line provider may identify additional service delivery needs and resources that will help the system and service providers improve service delivery. A critical component of the support line will be linkages to the County's 24-hour access and crisis line, the County's 2-1-1 line (one-stop for

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community, health, and disaster related resources), other proposed PEI support and hotlines and other community phone support lines providing support and access to needed resources and services.

7. Intended Outcomes

Outcomes may include, though are not limited to, the anticipated outcomes listed below. Specific program outcomes are expected to be identified as a result of the County's process to competitively select a contractor to provide the proposed program and services. Outcomes will be re-evaluated annually by the County and service provider and, if necessary, revised to improve service provider performance.

Individual Outcomes:

- o Increased knowledge of social, emotional and behavioral issues;
- o Reduced family stress/discord;
- o Reduced violence;
- o Reduced isolation;
- o Increased social support;
- o Increased appropriate help-seeking;
- o Reduced stigma about mental illness and accessing services;
- o Increased knowledge of mental illness; and
- o A minimum of 80% of caregivers and families using the Support Line will be satisfied with services.

System Outcomes:

- o Increased access to public and confidential mental health services, fewer persons needing services failing to access available services;
- o Reduced consequences of untreated mental disorders; reduction in prolonged suffering, suicide attempts, school failure or removal from home;
- o Another data source for evaluating mental health system responsiveness to caregiver and family needs; and
- o Increased number of trained caregivers and family members involved in providing services.

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8. Coordination with Other MHSA Components

Anticipated coordination with other MHSA Components is listed below. Coordination with additional MHSA Components may be identified in the implementation of the proposed PEI Projects and Programs and the County's process to competitively select a contractor to provide the proposed program and services.

- **Community Services and Support (CSS) and the County System of Care** – The Family Peer Support Line Program will be linked to and coordinate with current CSS programs for children, youth and families, as well as the entire County mental health system. The program will use the Children's Mental Health Services Resource Manual, which includes CSS programs, to provide referral resource and service information. It will link to and coordinate with other system access services such as the Access and Crisis Line and the 2-1-1 line (one-stop for community, health, and disaster related resources). Conversely, the Family Peer Support Line will be a resource for the County's mental health system, which will have a new resource for caregivers and families that may be in need of confidential peer support.
- **Workforce Education and Training (WET)** – The program's peer staff (Peer Counselors) and interested caregivers and family members will be targets for training programs in the Workforce Education and Training (WET) Plan. WET training is expected to enhance the skills of existing peer staff, develop new qualified peer staff, and improve peer staff understanding of the Children's Mental Health System and how to counsel and guide caregivers and families.
- **MHSA Technology & Technological Needs** – The Family Peer Support Line Program is expected to leverage existing and planned County MHSA developed information technology (IT) resources to enhance access to the program and its services and increase program efficiency and effectiveness. IT resources may be used to develop online educational webcasts to expand program outreach and may include internet-based communication with the Family Peer Support Line. IT support and improvements to the Family Peer Support Line Program and its services will be assessed and developed (with stakeholder input) as part of the development of the MHSA Capital Facilities and Technological Needs (CFTN) Component Plan.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): **Primary & Secondary Prevention Services**
 Program ID/Name: **PS03 Family Peer Support Line**
 Provider Name (if known): **Pending Competitive Procurement**
 Provider Category (DMH List): **Mental Health Treatment/Service Provider**

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	1040
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	1040
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
Classification	FTE	Per FTE				
Program Manager	1.00	\$54,370		\$0	\$54,370	\$54,370
Licensed Supervising Clinician	0.10	\$51,650		\$0	\$5,165	\$5,165
Peer Counselor/Support Staff	0.25	\$29,510		\$0	\$7,378	\$7,378
Peer Counselor/Support Staff	0.25	\$29,510		\$0	\$7,378	\$7,378
Peer Counselor/Support Staff	0.25	\$29,510		\$0	\$7,378	\$7,378
Peer Counselor/Support Staff	0.25	\$29,510		\$0	\$7,378	\$7,378
Admin Support (Admin Asst, Secr, Clrk)	0.10	\$28,920		\$0	\$2,892	\$2,892
Total FTE	2.20	Sub-Total		\$0	\$91,937	\$91,937
b. Benefits%	@ 27.0%			\$0	\$24,823	\$24,823
c. Total Personnel/Staffing Expenses				\$0	\$116,760	\$116,760
2. Operating Expenditures						
Indirect/Administrative Costs		\$28,600		\$0	\$28,600	\$28,600
Operating Costs (includes Facility Costs)		\$46,200		\$0	\$46,200	\$46,200
Start-Up/One-Time Only Costs*		\$23,000		\$0	\$23,000	\$23,000
c. Total Operating Expenses				\$0	\$97,800	\$97,800
3. Subcontracts/Professional Services (list/itemize)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$0	\$0
4. Total Proposed PEI Program Budget				\$0	\$214,560	\$214,560
B. Revenues (list/itemize by fund source)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$214,560	\$214,560
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**
Program ID/Name: **PS03 Family Peer Support Line**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals and that improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts for peer support lines, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

Position(s) targeted: Peer Counselor/Support Staff, 1.00 FTE/4 Positions.

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Specialized Training (including Training for Trainers)
- Consultants to assist Program implementation

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

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PEI Project Name: Veterans and Families Outreach and Education

County: San Diego

Date: 11/19/08

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI Project/Program:				
1. Disparities in Access to Mental Health Services	☐	☐	☐	☐
2. Psycho-Social Impact of Trauma	☐	☒	☒	☐
3. At-Risk Children, Youth and Young Adult Populations	☐	☐		
4. Stigma and Discrimination	☐	☒	☒	☐
5. Suicide Risk	☐	☒	☒	☐

2. PEI Priority Population(s) Note: All PEI Projects/Programs 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/Program:				
1. Trauma Exposed Individuals	☐	☒	☒	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☒	☒	☐
3. Children and Youth in Stressed Families	☐	☒		
4. Children and Youth at Risk for School Failure	☐	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		
6. Underserved Cultural Populations	☐	☐	☐	☐

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

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Veterans, Active Duty Military, Reservists, National Guard and Their Families (VMRGF) as one of our 10 priority focus areas.

Veterans and Their Families Community Forum Planning Meetings – Community stakeholders were invited to help plan the Community Forum targeting veterans and their families. Participants identified key areas of need and potential experts to present issues facing VMRGF.

Veterans and Their Families Community Forum, February 21, 2008 – Guest speakers briefed participants on VMRGF mental health needs in San Diego County. Participants then participated in small groups discussions focusing in areas identified in the Forum Planning Meetings: 1) Marriage and Couples, 2) Parenting, 3) Families, 4) Post Traumatic Stress Disorder (PTSD), and 5) Non-Active Duty Population. Forum and small group discussion identified the following key priority population needs and service recommendations:

- Services must address the needs of a varied population; veterans and active duty military personnel including Reservists and National Guard troops and specific need groups such as non-combat personnel, women, LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Questioning), homeless, and those with a dishonorable or bad-conduct discharge.
- Services must be available outside of military environments (informal community “store-fronts,” “hotline”) to increase confidentiality and reduce stigma that may not be afforded through services provided by the Veterans Administration Medical Center or Department of Defense.
- Establish collaboration/coordination among veteran and active duty military service providers to avoid duplication and improve efficiency.
- Engage peers, personal advocates and mentors who, through their personal experiences, can better communicate and understand service participant experiences and service needs.
- Services should be comprehensive; addressing all of a participant’s needs (social and family reintegration, employment, financial, and legal).
- Community and military service providers (discharge planners, veteran’s organizations, behavioral and primary health care providers, businesses, faith-based organizations, schools and colleges/universities, law enforcement and the justice systems) should be educated/trained to recognize service needs and help veterans, active duty military and their family access services.

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Community Veterans and Families PEI Workgroup, March-July 2008 – Following the Community Forum, a PEI Workgroup was formed to design and develop proposed PEI Veterans and Their Families programs. The Workgroup included County staff and community members and clients and their families. The workgroup initiated the process by more clearly and broadly defining the community as the Veterans, Active Duty Military, Reservists, National Guard and their Families (VMRGF) community and refining community identified needs and service recommendations to define the key program services:

- Community Outreach and Education/Training – Improve access to mental health information, resources, and services that address the needs of the members of the VMRGF community at-risk for, or with beginning, mental health issues:
 - o Provide support and education to the VMRGF community and education and training to providers of services to the VMRGF community on how to understand the military culture and improve recognition of mental health issues unique or relevant to the VMRGF
 - o Establish a peer support Hot-Line to serve as a recognized contact for accessing information and resources to address VMRGF mental health issues
 - o Create a comprehensive “Network of Care” Veteran’s webpage/resource directory that includes mental health self-screening tools
- Childcare Based Services – Provide services to military families who have children enrolled in childcare centers such as Head Start.
- Community Liaison – Establish a Community Liaison between the County and VMRGF to assist in ongoing monitoring of VMRGF service needs and available services.

Data Analysis Supporting the Proposed Program – The VMRGF population in San Diego County is approximately 292,000 veterans and 125,000 active duty military, increasing by an average of 17,000 annually. If families of veterans and active duty military are included, the potential target population exceeds 1,000,000. Since 2001, approximately 1.64 million U.S. troops have deployed as part of Operation Enduring Freedom (OEF; Afghanistan) and Operation Iraqi Freedom (OIF; Iraq). The pace of the deployments in current conflicts is unprecedented in the history of an all-volunteer force. Mental health conditions are emerging and aside from direct impact on the individual, impact can lead to impaired relationships, disrupted marriages, aggravate the difficulties of parenting, and cause problems in children that may extend the consequence of combat experiences across generations. San Diego County has services in place to assist its existing military population and families but as OEF/OIF operations continue, and the number of returning vets climbs ever higher, we are in danger of being overwhelmed by the number of veterans and

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their families needing reintegration and family supports. Additionally, existing systems are often not accessed because of confidentiality and stigma issues. It is noted that improving access to mental health services for OEF/OIF veterans will require reaching beyond the Department of Defense and the Department of Veterans Affairs health care systems (Center for Military Health Policy Research. *Invisible Wounds of War – Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*).

San Diego County:

- Active Duty Military: 125,000 (60% White, 13% Black, 17% Hispanic, 6% Asian, 1% American Indian, 3% Other – percentages extrapolated from US census 2000 data)
- Active Duty Family: 187,500 (includes spouses and dependents)
- Civilian Veterans: 292,000 (US census 2000 data)
 - o Male: 266,000 (91%)
 - o Female: 26,000 (9%)
 - o Percent of males 65 or over who are civilian veterans: 68% (90,000 out of 133,000)
- Civilian Veterans Family: 627,500 (includes spouses and dependents)
- Average number of military members discharged from service annually: 17,000
- The potential target population of this PEI project is in excess of 1,000,000, roughly 1/3rd of the total population of San Diego County.

Other Relevant Data (Mental Health Advisory Team (MHAT) IV Brief developed by Pentagon (2006):

- Military personnel returning from Afghanistan & Iraq with Mental Health issues (one deployment): 17%
- Military personnel returning from Afghanistan & Iraq with Mental Health issues (multiple deployment): 27%
- Military personnel returning from Afghanistan and Iraq with PTSD issues (one deployment): 15%
- Military personnel returning from Afghanistan and Iraq with PTSD issues (multiple deployment): 24%
- Suicide rate Military personnel returning from Afghanistan and Iraq: 17.3 per 100,000 (49% above average)
- Military personnel returning from Afghanistan & Iraq with mental health concerns but do not seek treatment: 58%

3. PEI Project/Program Description:

The proposed PEI Veterans, Active Duty Military, Reservists, National Guard and Their Families (VMRGF) Program will provide confidential peer-supported Outreach and Education/Training services to both the VMRGF community and

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its service providers to make available prevention and early intervention services to those at risk for developing mental illness. More specifically, the program will:

- Provide education, debriefings and peer counseling by Veterans, their spouses, or dependents to reduce mental health risk factors or stressors;
- Provide linkages to additional mental health services such as psychiatry when indicated;
- Assist with establishing linkages to essential services;
- Provide mental health information, self screening tools and lists of appropriate resources; and
- Offer a VMRGF Hotline to provide additional support and access to resources and services.

The Program is expected to focus on populations not served or whose needs are not met by traditional veteran and active duty military service providers. Services are expected to be provided by a competitively selected County contracted service provider with a proposal that specifically addresses unique cultural competency issues for unserved and underserved populations and that incorporates appropriate culturally driven and ethnically sensitive strategies. The Program is expected to be located in one or more Health and Human Services Agency (HHS) service regions readily accessible by the VMRGF.

The Workgroup determined that a non-traditional program would provide the best methodology for success in prevention services for VMRGF. VMRGF are concerned about maintaining confidentiality and the stigma of being identified as requiring Mental Health support or services, especially as it is perceived to negatively affect military careers (involuntary separation, limited promotability, diminished assignments, etc). Traditional programs, especially those closely linked to services or programs provided by the Veterans Administration (VA) and Department of Defense (DOD), including programs and services provided by the VA and DOD, would be likely viewed with skepticism and would be expected to have limited use. The County will solicit proposals from interested service providers. Proposals are expected to be innovative and successfully address confidentiality and stigma while helping VMRGF access needed resources and appropriate services, including those provided by the VA and DOD.

Key Program Services and Elements – The selected service provider's proposed program is expected to include, though, not be limited to, the following key program services and elements:

- **Outreach and Education/Training** – This Program service will provide support and education to the VMRGF community. The selected service provider will be expected to assess the priority needs of the VMGRF community as identified in the Community input process and other methods and provide the support and education necessary

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to meet those priority needs. This Program element will also provide education and training to providers serving the VMRGF community (behavioral and primary health care providers, businesses, faith-based organizations, schools and colleges/universities, law enforcement, and justice system). The education and training will be expected to improve understanding of the military culture and improve recognition of mental health issues unique or relevant to the VMRGF. Staff of the selected service provider must be knowledgeable and experienced in the military culture and how to access available resources and services provided by Mental Health Services (MHS), Alcohol and Drug Services (ADS), and other community behavioral health service providers, Aging and Independence Services (AIS), physical health service providers, education systems, faith based organizations, law enforcement and the justice system, VA and DOD services and programs, and other military and veterans based support organizations.

The selected service provider's Outreach and Education/Training services are expected to include, though not be limited to, the following:

- o Conduct education and training sessions for staff of behavioral and primary health care providers, businesses, faith-based organizations, schools and colleges/universities, law enforcement, and the justice system serving VMRGF.
 - o Conduct workshops and other education sessions for VMRGF on relevant mental health topics.
 - o Establish and maintain VMRGF-based support groups.
 - o Identify and maintain linkage to VMRGF-eligible resources and services.
 - o Outreach to key military and veterans based support organizations and other locations or organizations where VMRGF congregate.
 - o Liaise with key VMRGF community leaders, groups, and organizations and key community support organizations to build coordination and collaboration.
- **VMRGF Hotline** – During the community input process, stakeholders clearly stated their desire for a veteran “hotline,” staffed with veterans (veterans serving veterans), to provide, outside of military channels, comprehensive information, support, and access to resources and services. The selected service provider is expected to provide 24 hours a day, 7 days a week (24/7) “hotline” access and staffing.
 - **Peer Support** – To build trust and confidence with the VMRGF, program staffing must include trained peer-to-peer professionals who will provide the needed support and education to the VMRGF community. The selected provider

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is expected to propose an evidenced-based or promising practice that has proven successful with veterans and/or those having experienced trauma.

- **Childcare Based Services** – To address the current need and risk in the military community, parenting services are to be offered to military families who have children enrolled in childcare centers such as Head Start.
 - o The PEI Early Childhood Project's (EC01) proposed program will include providing services to a minimum of three Head Start Centers that have a significant level of military family enrollment. Triple P (Positive Parenting Program) is an evidence based model used to educate participating parents/families and assist in skill building. The Program will also enhance childcare providers' ability to screen for risk of mental illness and provide support to families. Funding for the Early Childhood program was increased by \$200,000 with a re-allocation from the VMRGF priority area.
- **Anticipated Program Positions and Responsibilities** – The VMRGF Program is anticipated to include the following key positions:
 - o Program Coordinator – Plan, organize, and manage the VMRGF Program. Provide Program administration and supervision. Ensure that the program meets applicable state requirements and the needs of the clients and families in programs.
 - o Community Outreach Specialist – Under the supervision of the Program Coordinator, work closely with the VMRGF community to ensure that the community is aware of mental health services and other resources and services. Develop contacts with resource and service providers. Refer VMRGF participants to appropriate resources and services and referrals and help ensure successful access. Identify and assess community needs and help modify Program design to ensure that the program continues to meet community needs.
 - o Peer Counselor – Provide VMRGF members with peer counseling services and develop and provide training to others who wish to participate and/or volunteer in supportive activities. Individual(s) in this position must be a military veteran, dependent or spouse.
 - o Community Liaison – Establish a Community Liaison between the County and VMRGF to assist in ongoing monitoring of VMRGF service needs, available services, and other resources to help direct additional service development and expansion. This position was filled during the community planning process by using PEI Planning funds. Once approved by State DMH, it will be funded via PEI program dollars.

Anticipated Program Timeline and Key Milestones –

- Receive California DMH approval for Plan – Month 1

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- RFP developed, competitive procurement process completed – Month 3
- Establish work facilities and equipment – Month 4
- Hire staff – Months 4-5
- Develop staff training curriculum and train staff (including cultural needs of the population) – Months 4-6
- Develop Program policies and procedures and submit to County for review – Months 4-6
- Develop Outreach reference materials and Education/Training Curricula – Months 4-6
- Establish Hotline (800 phone number) – Month 5
- Develop Hotline Resource Manual and reference materials – Months 5-6
- Develop Outcome measurement tools – Months 4-6
- Develop and implement Outreach plans, strategies, and materials – Months 5-6
- Implement Services, the VMRGF Program – Months 7-8
- Collect and assess Outcome data – Months 7-12

Additional Planned Services:

VMRGF Website – To support Outreach and Education/Training services and other VMRGF services, a Veterans' website will be proposed for the MHSA Technological Needs funding component. The Website is anticipated to include a resource directory, self-screening tools, and a confidential chat site. Most of today's VMRGF community is part of a technological generation familiar with and immersed in digital technology and uses technology regularly to access information. County staff are participating in the website planning process to ensure that the project will integrate with all current County-linked programs and services, including other MHSA programs and the proposed VMRGF Program.

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4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
VMRGF Program	Individuals: 1000 Families: 1000	Individuals: 0 Families: 0	None
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 1000 Families: 1000	Individuals: 0 Families: 0	None

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

Some anticipated linkages are listed below. Additional linkages are expected to be identified in the County's process to competitively select a contractor to provide the proposed program and services.

The VMRGF Program will work closely with VMGRF service providers to enhance and leverage existing services. The selected service provider is expected to identify, compile and catalog data on existing organizations and services (a resource directory). To comprehensively serve the VMGRF, the catalog of services will include organizations and services not traditionally serving veteran or military populations. Based on community input, service providers typically not associated with veterans and military organizations and services will likely be more appealing to VMRGF needing services.

The catalog of organizations and services is expected to include, though is not limited to:

- County of San Diego Behavior Health Services (BHS) contracted service providers
- County of San Diego Aging and Independence Services (AIS), Veterans Service Office
- Veterans Affairs (VA)
- Veteran Centers
- Veterans Village of San Diego (VVSD) – Warrior Tradition – One-Stop-Shop

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- Post Traumatic Stress Disorder (PTSD) Clinic
- University of California, San Diego (UCSD)
- Welcome Home Family Program
- American Combat Veterans of War (ACVOW)
- Vet to Vet
- Camp Pendleton Family Marine Program
- Consumer Center for Health Education & Advocacy (CCHEA)
- Protection and Advocacy Inc.
- National Alliance on Mental Illness (NAMI)
- Mental Health America (MHA) San Diego County Chapter
- Parent Teacher Association/Organization (PTA/PTO)
- San Diego School Districts

Individuals in need of resources may also be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues. While the Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services.

Veterans' Website – When the planned Veterans' website is implemented, the VRMGF Program is expected to provide access that supports Outreach and Education/Training services and any other existing and planned VMRGF services.

6. Collaboration and System Enhancements

Anticipated collaborations and system enhancements are listed below. Additional collaborations and system enhancements are expected to be identified in the County's process to competitively select a contractor to provide the proposed program and services.

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- **Continuing Collaborations** – County of San Diego Mental Health Services is committed to providing support to the highly vulnerable VMGRF population that is a large component of the San Diego County population. The collaborative relationships established through the PEI Plan community input and development process will be continued, and used to regularly review and assess the changing needs and priorities of the VMGRF community, and used to modify the VMGRF Program and related programs as necessary to best serve the community.

To help serve that purpose, a new VMGRF community organization has been created, the Vet/Fam Regional Forum of San Diego. The forum plans to meet monthly. The forum, which includes representatives from the Mental Health Board, Public Defenders, American Combat Veterans of War (ACVOW), Veterans Village of San Diego (VVSD), Veterans Center, Veterans Affairs (VA), University of California at San Diego (UCSD), Camp Pendleton, Consumer Center for Health Education & Advocacy (CCHEA), Mental Health America (MHA) San Diego County Chapter, County staff (Behavioral Health Services (BHS), Aging and Independence Services (AIS), Veterans Services Office, Patient Advocacy), and clients and their families, can become a great resource to help reach and inform the VMGRF Community and the numerous organizations and agencies serving the Mental Health and VMGRF communities.

- **Childcare Based Services** – To avoid duplication in proposed PEI programs, the County combined proposed VMGRF Childcare Based Services with the proposed PEI Early Childhood – Positive Parenting Program (Triple P). The proposed PEI Early Childhood – Positive Parenting Program will include services to military families through Head Start Centers located in the North County region. To fund expansion of the proposed Early Childhood Program, the original County allocation of PEI funds to the Early Childhood Program was increased by a re-allocation from the original County allocation for Veterans and Their Families.
- **Community Liaison** – A Community Liaison, recruited, hired and trained by a current County contractor, Mental Health America, is providing liaison services between the County and the VMGRF community to assist in ongoing monitoring of VMGRF service needs, available services, and other resources to help direct additional service development and expansion. The Community Liaison is expected to work closely with the selected VMGRF service provider. This position was developed and implemented using PEI planning funds and will be later incorporated into the PEI funded VMGRF Program.

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7. Intended Outcomes

Outcomes may include, though are not limited to, the anticipated outcomes listed below. Specific program outcomes are expected to be identified as a result of the County's process to competitively select a contractor to provide the proposed program and services. Outcomes will be re-evaluated annually by the County and service provider and, if necessary, revised to improve service provider performance.

- **Intended individual outcomes:**
 - Increase in successful follow-through on linkage/referrals
- **Intended system and program outcomes:**
 - Increase in number and quality of linkage relationships to Mental Health and other critical service organizations
 - Enhanced cultural competence in dealing with referrals
 - Enhanced quantity and quality of cooperative relationships with other organizations and systems
 - Enhanced partnering with ethnic/cultural organizations
- **Proposed methods to measure success:**
 - Improve access to Mental Health and other PEI services/information and support to veterans and their families
 - Measure the number of clients and families contacted – develop baseline first year and evaluate for increase/improvement in subsequent years.
 - Increased awareness of the prevalence of mental illness risk in veteran and military communities by interacting with the community
 - Measure the number of public presentations given – minimum one per month
 - Increase information on the availability of PEI mental health resources through distribution of brochures and fliers to the public
 - Measure the amount of material distributed

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8. Coordination with Other MHSA Components

Anticipated coordination with other MHSA components is listed below. Coordination with additional MHSA Components may be identified in the implementation of the proposed PEI projects and programs and the County's process to competitively select a contractor to provide the proposed program and services.

- **Workforce Education and Training (WET)** – The VMRGF will be a target population for consumer/family member pipeline training programs in the Workforce Education and Training plan.
- **MHSA Technology & Technological Needs** – The VMRGF Program is expected to leverage existing and planned County MHSA developed information technology (IT) resources to enhance access to the proposed program and its services and increase Program efficiency and effectiveness. With the implementation of the Veterans' website and ability of the VMRGF community to access computer-based resources and services through the purchase of IT equipment, the clients and family members will gain greater entrée to the resources of the Veterans Website, which will include a resource directory, self-screening tools, and confidential chat lines. IT support and improvements to the Program and its services will be assessed and developed (with stakeholder input) as part of the development of the MHSA Capital Facilities and Technological Needs (CFTN) Component Plan.

This Plan will also benefit from the Primary and Secondary Prevention Project (PS01) in the following ways:

- **Media Campaign** – The campaign will include elements that address raising public awareness about the risk factors and warning signs of suicide. It will incorporate cultural perspective in the resulting printed materials and TV/Radio/print ads.
- The contracted service provider of the CO01 Project shall participate on the Interagency Suicide Meeting (referenced in PS01). As a member of this group, they will assist to develop the County's suicide action plan and ensure cultural sensitivity and awareness for the distinct needs of the target population that they represent and provide PEI services for.
- Suicide Prevention services offered through PEI will be included in Primary Prevention printed materials (described in PS01). This will assist in raising awareness about the availability of suicide prevention services funded under MHSA in San Diego County.

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9. Additional Comments (optional)

- UCSD PTSD Research Grant – The local University of California San Diego (UCSD) has been recently awarded a Post Traumatic Stress Disorder (PTSD) research grant. The County will explore the possibility of accessing or using the data, outcomes, or promising practices that result from UCSD's PTSD research grant.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Instructions: Please complete one Budget Form No. 4 for each PEI Program. Complete hi-lited cells.

Date: 10/31/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): **Veterans & Their Families**
 Program ID/Name: **VF01 Veterans and Families Outreach and Education Program**
 Provider Name (if known): **Pending Competitive Procurement**
 Provider Category (DMH List): **Mental Health Treatment/Service Provider**

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	2000
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	2000
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
Classification	FTE	Per FTE				
Program Coordinator	1.00	\$70,000		\$0	\$70,000	\$70,000
Community Outreach Specialist	3.00	\$58,000		\$0	\$174,000	\$174,000
Peer Educator (Para Professional)	3.00	\$45,000		\$0	\$135,000	\$135,000
Resource/Tech Specialist	1.00	\$58,000		\$0	\$58,000	\$58,000
Admin Support	1.00	\$34,000		\$0	\$34,000	\$34,000
Total FTE	9.00	Sub-Total		\$0	\$471,000	\$471,000
b. Benefits%	@ 27.0%			\$0	\$127,170	\$127,170
c. Total Personnel/Staffing Expenses				\$0	\$598,170	\$598,170
2. Operating Expenditures						
Indirect/Administrative Costs		\$117,000		\$0	\$117,000	\$117,000
Operating Costs (includes Facility Costs)		\$189,000		\$0	\$189,000	\$189,000
Start-Up/One-Time Only Costs*		\$120,000		\$0	\$120,000	\$120,000
c. Total Operating Expenses				\$0	\$426,000	\$426,000
3. Subcontracts/Professional Services (list/itemize)						
Training		\$25,000		\$0	\$25,000	\$25,000
Communication Equip, Sftwr, & Svcs		\$15,830		\$0	\$15,830	\$15,830
Call Center ("Hotline") Line & Svcs		\$55,000		\$0	\$55,000	\$55,000
a. Total Subcontract/Professional Svcs Expenses				\$0	\$95,830	\$95,830
4. Total Proposed PEI Program Budget				\$0	\$1,120,000	\$1,120,000
B. Revenues (list/itemize by fund source)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$1,120,000	\$1,120,000
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**

Program ID/Name: **VF01 Veterans and Families Outreach and Education Program**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals that improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

Position(s) targeted: Peer Educator (Para Professional), 3.00 FTE.

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

A2 Subcontracts/Professional Services

Training - Estimated ongoing costs of providing community and staff training and will include training development, trainers, training facilities, and materials.

Communication Equipment, Software, and Services and Call Center Line and Services - Estimated ongoing costs of maintaining communication and call center services.

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

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PEI Project Name: South Region Point of Engagement

County: San Diego

Date: 11/19/08

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

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

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Community and Domestic Violence as one of our 10 priority focus areas. Below is a list of venues and opportunities offered to community stakeholders to participate in planning and to provide their valuable input.

Community & Domestic Violence Forum – February 20, 2008: Expert guest speakers presented material on community and domestic violence to a forum of community members. The forum was well attended by the community, providers, experts, and other key stakeholders. The following themes emerged from the February Community and Domestic Violence Community Forum and various Focus Groups that took place in the early part of 2008:

- Trauma and exposure to community and domestic violence could mean many things:
 - o Refugees/Immigrants: displacement/instability (culture, home, family);
 - o Poverty, chronic illness, suicide, loss/grief;
 - o War, gang violence, historical trauma;
 - o Natural disasters such as firestorms and flooding; and
 - o Due to traumatic experiences in their home country and cultural barriers, domestic violence may go unreported in refugee families.
- Being identified as a domestic violence offender is a huge barrier to getting a job which can cause more family stress and has the potential for more violence.
- There are a lot of misconceptions about female domestic violence offenders: that a weapon was used, that the women are psychotic, that they were all victims who retaliated, this is not always the case. Education is needed for the community to address these misconceptions.
- Services are needed for children placed at Polinsky that do not meet medical necessity but are at risk because of trauma exposure. These children are predominately ages 0-6, exposed to domestic violence, abuse and substance abuse.
- Targeted interventions are needed for neighborhoods with high incidences of violence and where there are a high number of youth who are exposed to trauma & violence, including gang involvement. This increases the likelihood

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of adult onset PTSD. There is also a need to target high-risk children and families identified by Child Welfare Services.

- There is a need for early intervention for youth in Southeast San Diego including African American youth.
- Gang prevention programming needs to start at a young age including grief groups for siblings, parents and others affected by gang violence.
- Teen Violence reduction programs are needed.
- Efforts are needed to break the cycle of violence for children exposed to domestic violence.
- There is a need to educate/train parents to recognize problems and communicate with at-risk children thereby reducing the need for higher-level mental health services.
- The mental health system must enhance, integrate and coordinate services with other child/family services;
- The whole family must be treated holistically.
- It is important to identify points of assessment and engagement for at-risk children/families.
- Identify service needs as early as possible.
- Provide culturally competent/sensitive services.
- Identify and engage community resources to provide both preventive interventions and/or mental health services to traumatized children and families.
- A standard/universal screen for at-risk children/families is needed.
- Need to address family issues that may contribute to an at-risk child's behavioral health problems.

Mental Health Board (MHB) Presentation, April 3, 2008. A summary of community input was presented to the MHB for their review and guidance. The Board reviewed inputs and concurred with Mental Health Services' assessments to develop programs based on the identified needs.

A Community & Domestic Violence workgroup was convened and attended by multiple representatives of County Mental Health, the Executive Director of the San Diego Commission on Gang Prevention and Intervention, HHSA South Region

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Child Welfare Agency Staff, Mental Health Juvenile Forensic staff, County Juvenile Probation Department staff, the Office of Violence Prevention, and the San Diego First Five Commission.

This workgroup reviewed the community input and conducted additional research to develop San Diego's Community and Domestic Violence Project to be supported by Prevention and Early Intervention funding. The three programs developed for this Project area include:

1. A "Point of Engagement" Services in the South Region with the purpose of assessing families and children who have been exposed to family violence and/or trauma and whose children may be at risk of entering the Child Welfare Services system;
2. The development of evidence-based referral services for those children assessed at the "Point of Engagement" Services in the South Region as well as those without a medical necessity for mental health treatment services who have been placed at the Polinsky Children's Center; and
3. A Community Violence Response Services focused intervention program that addresses the needs of siblings of identified gang members and youth exposed to or at risk of exposure to violence. This community-based program will work to enrich the skills of providers, including many grassroots, community based and faith based organizations, as well as neighborhood schools to ensure a coordinated and neighborhood response to gang/community violence.

All three programs will be community-based, family driven, and evidence-based with emphasis on collaborations with existing programs and agencies. These programs will address the disparity in access to mental health services, educate providers and victims as to the psycho-social impact of trauma, identify the risk for stigmatization and discrimination subsequent to exposure to trauma, identify the risk of suicide due to exposure to trauma and provide prevention and early intervention services in conjunction with referral for comprehensive mental health services when the need is identified.

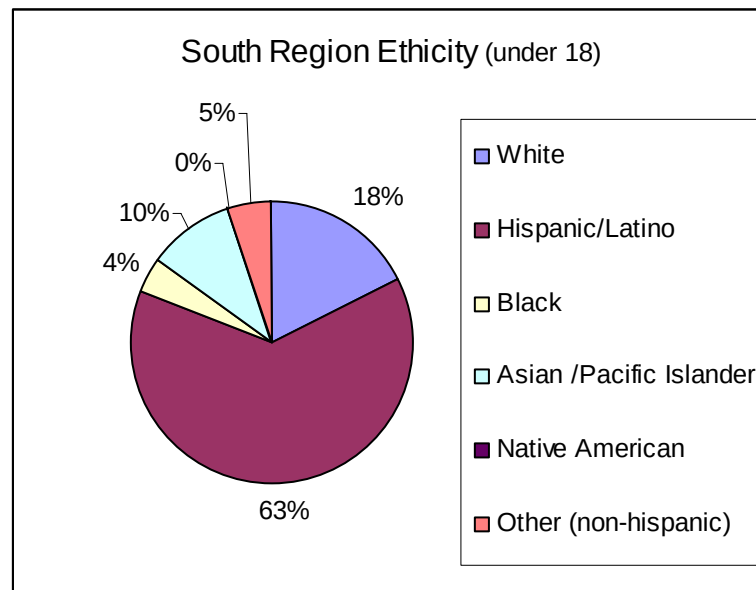
Other Data Analysis to support the selection of this program:

The South Region Child Welfare Services identified a need for an assessment center to divert children from placement in the South Region. Under the leadership of the Deputy Director of HHSA Central and South Regions, Rene Santiago, the vision and goals for this project were outlined. The POE Services plan includes but is part of a larger integrated system of services for high risk children and families in the South Region of San Diego. Through the planning process the following data was reviewed:

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- The population of the South Region is approximately 460,680 (June 2008 HHSA Fact Sheet).
- Twenty-eight percent (28%) or 127,479 persons in the region are age seventeen or younger (June 2008 HHSA Fact Sheet).
- It is estimated that forty-six (46%) of the households in the South Region are at or below 200% of the Federal Poverty Level – the median household income is \$57,970 (June 2008 HHSA Fact Sheet).
- The region is in need of reducing the incidence of placement into the Child Welfare System. Research indicates that a child's removal from their home is an additional trauma that places them at risk for emotional difficulties and the greater number of placements the greater the likelihood for emotional disturbance requiring a higher level of mental health intervention.
- The South Region is one of the most culturally diverse in San Diego with seventy-four percent (74%) of the population as non-white.



HHSA Fact Sheet June 2008

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- The ethnicity of child welfare referrals generally reflects the ethnicity of the region (see chart above).
- Approximately thirty (30%) of children referred had a primary language other than English (June 2008 HHSA Fact Sheet).
- In a one-month period Child Welfare Services received 392 referrals for 635 children (June 2008 HHSA Fact Sheet).
- Of the referrals, a majority of allegations received were for general neglect (43%), emotional abuse (37%), physical abuse (30%) and at-risk but not abused (19%). Note referrals included multiple allegations. (June 2008 HHSA Fact Sheet).

3. PEI Project Description:

The “Point of Engagement” (POE) Services in the South Region is a partnership between families, Child Welfare Services, and community service providers that will establish a community safety net to ensure the safety and well being of South Region children and their families. The POE program establishes a focal point for integrated and coordinated services to high-risk children and families in the South Region. This program will focus on the family’s needs and the immediate provision of services and engagement with community resources and supports in order to assist families in maintaining a safe home for their children and reducing the effects of trauma exposure. Trauma has been shown to put children and youth at risk for behavioral health difficulties including impulse control and learning disorders, affective disorders, substance abuse disorders, and conduct disorders. The overall purpose of the model will be to streamline case flow processes to provide a faster, seamless “hand-off” and response for stressed families in crisis.

The POE Services will have two components funded by PEI for children and families. One component will be assessment based services (PEI plan DV01) and the second will be referral services for those who have been exposed to trauma (PEI plan DV02). All of the participants served will be those who have been exposed to domestic violence and/or community violence or children whose parents are mentally ill or who may have had contact with law enforcement due to a crime or drug related offenses. Referrals will come from law enforcement, Child Welfare Services, Domestic Violence Response Team, and/or community based organizations.

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The initial assessment component will include the development and implementation of an assessment/screening tool that will assess the parent/family needs, as well as assess the children who have been exposed to family violence and/or trauma and who may be at risk of entering the child welfare system. Children determined not be at risk for home removal will be diverted from out of home placement and the family will be provided resources to receive prevention and early intervention services (See *PEI DV02 Plan - Trauma Exposed Response Services - South Region/Polinsky*).

Assessment/Screening (DV01)

A standardized screening process will be developed that will be integrated with Child Welfare Services screening processes and tools. Clinical staff will go to the home and conduct a standardized assessment on the caregiver in order to determine their capability to provide a safe environment for their child(ren). This screening process will include a safety and risk assessment for children, as well as a caregiver stress assessment. These screenings will incorporate developmental and psycho-social elements focused on both child and parent/caregiver and how the episode that preceded the POE contact may be a symptom of other stressors occurring within the family environment. This tool will be utilized by a service provider, to be determined, in partnership with Child Welfare Services, Mental Health Services and other community and/or public partners involved with the families. The purpose of the tool will be to assess the following: 1) whether or not a child can be safely returned to his/her home, 2) both medically and non-medically necessary mental health needs, and 3) other types of services and supports needed for the child and family.

The development of a screening tool for children ages 0-5 will be coordinated via a First Five Partnership. For children age 6-17 other developmentally appropriate assessment/screening tools will be identified. For families, screenings such as the Child Abuse Potential (CAP) Inventory, Women's Experience with Battering Scale (WEB) as well as methods for assessing positive attitudes towards parenting may be used.

Communication regarding the results of the screening will be shared with the County social worker, the caregiver, and any community-based service provider as necessary. This information sharing will occur both in writing and in one-on-one meetings or family team decision-making meeting(s).

Children identified as seriously emotionally disturbed (SED) will be referred to existing services. Those who do not meet medical criteria for SED services will be referred for Prevention and Early Intervention funded services through the Trauma Exposed Response Services at South Region/Polinsky (PEI plan *DV02*). MHSA funding can be leveraged to obtain Early Periodic Screening Diagnosis and Treatment (EPSDT) funding to subsidize the assessment of children with full scope Medi-Cal coverage.

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Key Milestones and Timelines

- Receive California DMH approval for plan – Month 1
- RFP developed, competitive procurement process completed – Months 1-6 (completed within the first 6 months)
- Contract awarded – Month 7
- Hire staff within the first two months of contract execution – Months 7-8
- Identify developmentally appropriate assessment/screening tools – Months 7-8
- Staff training (including cultural and linguistic needs of population) begins – Month 8
- The selected provider will obtain formal training to utilize approved screening assessment tool within the first 2 months of contract execution.
- It is expected that the initial start up phase will be spent setting up infrastructure to work with South Region HHSA, Child Welfare Services, law enforcement and the Domestic Violence Response Team. This includes the development of policies and procedures – Months 7-9
- Draft policies and procedures submitted to County for approval – Months 7-8
- Outcome tools identified, surveys created – Months 8-9
- Create brochures and purchase materials (including materials in multiple languages) to be offered at each facility – Month 9
- Services begin – Month 9

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4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
South Region Point of Engagement Services	Individuals: 1,450 Families: 1,450	Individuals: Families:	
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 1,450 Families: 1,450	Individuals: Families:	

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

- The selected service provider will be tasked with creating collaborations and partnerships with other providers throughout the South Region with the intended goal of providing prevention and early intervention services and mental health interventions as appropriate.
- The provider will be expected to network with the Child Welfare Services to coordinate the appropriate transfer of children and screening/assessment related information to any youth who is placed at the Polinsky Children's Center, for those children whose homes are determined to be unsafe for their immediate return.
- The provider is expected to network with the Juvenile Forensic Services Crisis Team at the Polinsky Children's Center should assessment determine that mental health services are indicated.
- The provider will collaborate with law enforcement to guarantee the safety of children and families and to provide appropriate levels of care.
- The provider will collaborate with the Probation Department to assist in the appropriate referral for services to wards.

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- The provider will collaborate and establish a partnership with the selected provider of *Trauma Exposed Response Services - South Region/Polinsky (See PEI plan DV02)*.
- Provider will establish a partnership with Alcohol and Drug Services to facilitate the treatment of drug exposed children and services to their families.

Individuals in need of resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues.

While the County-funded Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will also then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services.

6. Collaboration and System Enhancements

The POE program reflects a system change that offers different ways of responding to reports of child abuse and neglect. POE utilizes a collaborative and multi-disciplinary approach and includes the family in the team decision-making process. It is critical that efforts are made to avoid the removal of children from their homes through a strength-based family approach. The key is to quickly and appropriately assess the safety and well being of a child's situation and then have the immediate connection to resources and needed services that will allow minors to remain safely in their homes.

Collaborations and system enhancements will include connections with the following County departments: Probation Department, Mental Health Juvenile Forensics, Child Welfare Services, South Region HHSA, and Alcohol and Other Drug Services.

7. Intended Outcomes

- Reduce the negative psycho-social impact of trauma – measured by the number of assessments/screenings.

PEI PROJECT SUMMARY

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- Reduction of out-of-home placements where imminent risk has not been identified – measured by number of home removals.
- Increase prevention efforts and response to early signs of trauma and emotional and behavioral health problems – measured by the increase in referrals and reduction of multiple referrals from the same households.
- Increase services in under-served communities – measured by the establishment of an increase number of services.
- Increase collaboration and integration among providers including the faith-based community – measured by narrative progress reports.
- Increase in number of individuals and families receiving PEI services – measured by the participant reports.
- Increase in successful follow through on linkages/referrals – measured by the number of referrals.
- Increased satisfaction with linkage/referral – measured by post referral follow-up.

8. Coordination with Other MHSA Components

Upon assessment by the South Region Point of Engagement (POE), some children and families will likely emerge as being eligible for a higher level of intervention, such as those programs provided through MHSA-CSS. These referrals will be made through the PEI program *Trauma Exposed Response Services - South Region/Polinsky* (See *PEI plan DV02*).

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): **Community & Domestic Violence**
 Program ID/Name: **DV01 South Region Point of Engagement**
 Provider Name (if known): **Pending Competitive Procurement**
 Provider Category (DMH List): **Mental Health Treatment/Service Provider**

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	1450
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	1450
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
Classification	FTE	Per FTE				
Licensed Program Manager	1.00	\$80,000		\$0	\$80,000	\$80,000
Licensed Mental Health Clinician	1.25	\$55,000		\$0	\$68,750	\$68,750
Office Manager	0.50	\$43,200		\$0	\$21,600	\$21,600
Paraprofessional	3.00	\$42,825		\$0	\$128,475	\$128,475
	0.00	\$0		\$0	\$0	\$0
Total FTE	5.75	Sub-Total		\$0	\$298,825	\$298,825
b. Benefits%	@ 27.0%			\$0	\$80,683	\$80,683
c. Total Personnel/Staffing Expenses				\$0	\$379,508	\$379,508
2. Operating Expenditures						
Indirect/Administrative Costs		\$74,750		\$0	\$74,750	\$74,750
Operating Costs (includes Facility Costs)		\$120,750		\$0	\$120,750	\$120,750
Start-Up/One-Time Only Costs*		\$120,000		\$0	\$120,000	\$120,000
c. Total Operating Expenses				\$0	\$315,500	\$315,500
3. Subcontracts/Professional Services (list/itemize)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$0	\$0
4. Total Proposed PEI Program Budget				\$0	\$695,008	\$695,008
B. Revenues (list/itemize by fund source)						
EPSDT		\$75,000		\$0	\$75,000	\$75,000
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$75,000	\$75,000
C. Total Funding Requested for Proposed PEI Program				\$0	\$620,008	\$620,008
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**
Program ID/Name: **DV01 South Region Point of Engagement**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals that improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

Position(s) targeted: Paraprofessional, 3.00 FTE

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

B Revenues:

EPSDT - The revenues are the estimated services eligible for the assessment of children with full scope Medi-Cal coverage. Other Revenue - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

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PEI Project Name: South Region Trauma Exposed Services

County: San Diego

Date: 11/03/08

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

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).

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Community and Domestic Violence as one of our 10 priority focus areas. Below is a list of venues and opportunities offered to community stakeholders to participate in planning and to provide their valuable input.

Community & Domestic Violence Forum – February 20, 2008: Expert guest speakers presented material on community and domestic violence to a forum of community members. The forum was well attended by the community, providers, experts and other key stakeholders. The following themes emerged from the February Community and Domestic Violence Community Forum and various focus groups that took place in the early part of 2008.

- Trauma and exposure to community and domestic violence could mean many things:
 - o Refugees/Immigrants: displacement/instability (culture, home, family);
 - o Poverty, chronic illness, suicide, loss/grief;
 - o War, gang violence, historical trauma;
 - o Natural disasters such as firestorms and flooding; and
 - o Due to traumatic experiences in their home country and cultural barriers, domestic violence may go unreported in refugee families.
- Being identified as a domestic violence offender is a huge barrier to getting a job, which in turn can cause more family stress and has the potential for more violence.
- There are a lot of misconceptions about female domestic violence offenders - that a weapon was used, that the women are psychotic, that they were all victims who retaliated. This is not always the case. Education is needed for the community to address these misconceptions.
- Services are needed for children placed at Polinsky that do not meet medical necessity, but are at risk because of trauma exposure. These children are predominately ages 0-6, exposed to domestic violence, abuse and substance abuse.

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- Targeted interventions are needed for neighborhoods with high incidences of violence and where there are a high number of youth who are exposed to trauma and violence, including gang involvement. Exposure to trauma and violence increases the likelihood of adult onset PTSD. There is also a need to target high-risk children and families identified by Child Welfare Services.
- There is a need for early intervention for youth in Southeast San Diego including African American youth.
- Gang prevention programming needs to start at a young age including grief groups for siblings, parents and others affected by gang violence.
- Teen violence reduction programs are needed.
- Efforts are needed to break the cycle of violence for children exposed to domestic violence.
- There is a need to educate/train parents to recognize problems and communicate with at-risk children thereby reducing the need for higher-level mental health services.
- The mental health system must enhance, integrate and coordinate services with other child/family services.
- The whole family must be treated holistically.
- It is important to identify points of assessment and engagement for at-risk children/families.
- Identify service needs as early as possible.
- Provide culturally competent/sensitive services.
- Identify and engage community resources to provide both preventive interventions and/or mental health services to traumatized children and families.
- A standard/universal screen for at-risk children/families is needed.
- Need to address family issues that may contribute to an at-risk child's behavioral health problems.

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Mental Health Board (MHB) Presentation, April 3, 2008. A summary of community input was presented to the MHB for their review and guidance. The Board reviewed inputs and concurred with Mental Health Services' assessments to develop programs based on the identified needs.

A Community & Domestic Violence workgroup was convened and attended by representatives of County Mental Health, San Diego Commission on Gang Prevention and Intervention, HHSA South Region Child Welfare Agency, Mental Health Juvenile Forensic, County Juvenile Probation Department, the Office of Violence Prevention, and the San Diego First Five Commission.

This workgroup reviewed the community input and conducted additional research to develop San Diego's Community and Domestic Violence Project to be supported by Prevention and Early Intervention funding. The three programs within this project area include:

1. A "Point of Engagement" program in the South Region with the purpose of assessing families with children exposed to family violence and/or trauma and who may be at risk of entering the Child Welfare Services system (PEI plan DV01);
2. The development of evidence-based referral services for those children assessed through the "Point of Engagement" Program in the South Region as well as children placed at the Polinsky Children's Center who have been determined to be without medical necessity for mental health treatment services (PEI plan DV02); and
3. A community violence response services focused intervention program that addresses the needs of siblings of identified gang members and youth exposed to or at risk of exposure to violence. This community-based program will work to enrich the skills of providers, including many grassroots, community-based and faith-based organizations, as well as neighborhood schools to ensure a coordinated and neighborhood response to gang/community violence (PEI plan DV03).

All three programs will be community based, family driven, and evidence based with emphasis on collaborations with existing programs and agencies. These programs will address the disparity in access to mental health services, educate providers and victims as to the psycho-social impact of trauma, identify the risk for stigmatization and discrimination subsequent to exposure to trauma, identify the risk of suicide due to exposure to trauma and provide prevention and early intervention services in conjunction with referral for comprehensive mental health services when the need is identified.

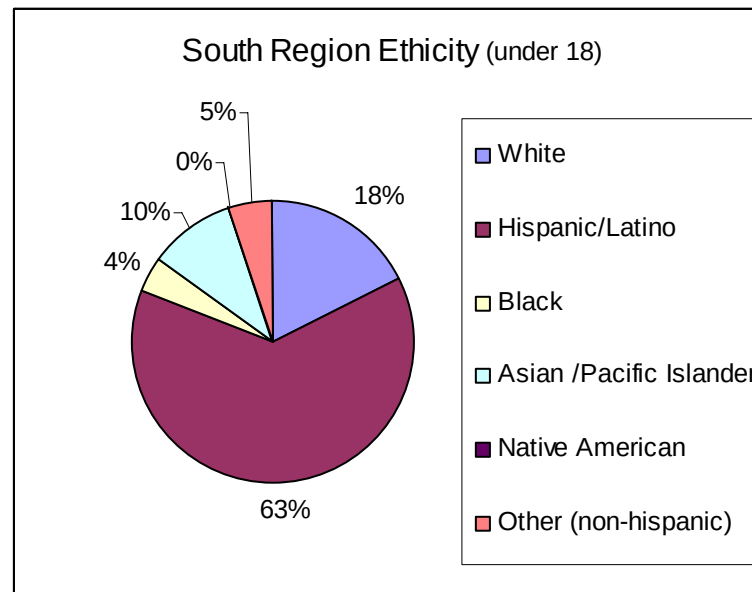
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Other Data Analysis to support the selection of this program:

As part of the workgroup planning process the following additional data was reviewed:

- The population of the South Region is approximately 460,680 (June 2008 HHSA Fact Sheet).
- Twenty-eight percent (28%) or 127,479 persons in the region are age seventeen or younger (June 2008 HHSA Fact Sheet).
- It is estimated that 46% of the households in the South Region are at or below 200% of the Federal Poverty Level – the median household income is \$57,970 (June 2008 HHSA Fact Sheet).
- The South Region is one of the most culturally diverse in San Diego with 74% of the population as non-white.



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- The ethnicity of child welfare referrals in the South Region generally reflects the ethnicity of the region (see chart above).
- Approximately 30% of children referred in the South Region had a primary language other than English (June 2008 HHSA Fact Sheet).
- In a one-month period the Child Welfare Services received 392 referrals for 635 children in the South Region (June 2008 HHSA Fact Sheet).
- Of the referrals, a majority of allegations received were for general neglect (43%), emotional abuse (37%), physical abuse (30%) and at-risk but not abused (19%). Note referrals included multiple allegations (June 2008 HHSA Fact Sheet).
- During fiscal year 2007/2008 Polinsky Children's Center (PCC) had 2,283 admits.
- During fiscal year 2007/2008, 45% (322 of 724) of the 23-hour Assessment Center admits were placed within 23-hours avoiding entry in to PCC.
- During fiscal year 2007/2008 the average length of stay at Polinsky Children Center was 12 days.
- Report Card on Children and Families identifies the need for more mental health consultants to provide services to children in early childcare settings (Polinsky Children's Center) and to work with staff to improve the quality of care.
- Research reveals that children who play, resolve disagreements, and collaborate with peers and adults strengthen their social competence and are likely to have better emotional health.
- Research shows that parents have a direct impact on the cognitive development of their child. As the child listens to conversations and participates in activities in the home, he/she acquires increased language skills. The development of language and reading skills are keys to subsequent success.
- Recent brain research and other studies indicate that environments must be provided to children that are both nurturing and enriched. This research demonstrates that early childhood care and education in a quality setting can improve the school readiness and overall development of young children. It also can improve their education, employment and positive outcomes throughout life. Quality care and education can help a child to avoid ensuing emotional difficulties and promote economic benefits for society.

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3. PEI Project Description:

This intervention model will address the issue of re-traumatization of children and families who experience trauma related to exposure to domestic violence and/or community violence. This model will also target children whose parents are mentally ill or who may have had contact with law enforcement due to a crime or drug related offenses. The program shall provide evidence-based programming to both children and their parents. Early intervention services will be based upon referrals for two distinct populations of children and families:

1. Those living in the South Region and identified by the South Region Point of Engagement (PEI plan DV01) program as at risk of having children removed from the home and
2. Those who have been placed at the Polinsky Children's Center, but are not manifesting symptoms that have been determined to be a medical necessity requiring comprehensive mental health services. These children will be served regardless of the region in which they live.

Even in the most high-risk families, unless a child's safety is at stake, the best way to promote healthy development and reduce risks is to provide support to parents and caregivers. In general, research supports an integrated approach that includes:

- The promotion of healthy, effective parenting responsive to complex parental risks;
- Providing interventions that explicitly address parental risk factors;
- Connecting children with necessary health and related services; and
- Addressing the concrete needs of the family.

These approaches will be included in the program design. Minors who cannot remain safely in their homes will be placed in the custody of Child Welfare Services. Those children assessed as being safe to remain at home will be provided with short-term services and referrals for comprehensive services to mitigate the possibility of subsequent mental health difficulties and subsequent referrals to Child Welfare Services (CWS). The CWS social worker providing ongoing case management will ensure that the home environment continues to be a safe and healthy one for each child.

There are several evidence-based models that may be employed by the program. These practices are to be determined, but may include models such as Positive Parenting Program (Triple P), Incredible Years, Healthy Start, Baby FAST, Tools

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of the Mind, resiliency training, parent-child modeling interventions, debriefing strategies, home visits, and cognitive behavioral interventions. The program will provide basic social and emotional skills for children and their families. Other models may be identified that assist previously resistant clients and those unresponsive to treatment by building resilience and focusing on developing healthy attachments. Any model utilized will be developed with the intent to be a culturally appropriate and effective treatment for both parent and child for depression and mental illness, particularly for immigrant and refugee families.

Other key components will be to find and retain high-quality and appropriately skilled staff and provide resources to address staff depression and job stress among those working directly with high-risk children and families. It is also important for this model to work and build “healthier” partnerships among Child Welfare Services, early intervention, mental health, substance abuse treatment, law enforcement, and domestic violence services in the context of the broader early childhood agenda.

South Region Referrals

In the South Region, priority will be given to clients identified through the South Region Point of Engagement Program (DV01). The program will identify and employ evidence-based practices. Parents will learn how their traumatic experiences influence their parenting styles. Similarly parenting curricula will be utilized for parents and children affected by substance abuse and mental illness, as well as other forms of trauma. The goal is to enhance coping strategies through evidenced based programming and to develop a community-based support system that is strength-based and family-centered. The successful program shall be culturally diverse and ethnically sensitive, enabling children and their families to understand the effects of trauma and break the cycle of violence.

In-home services will be provided throughout the South Region including core services through the Point of Engagement Program or co-located with other South Region County funded service centers.

Polinsky Children's Center

The second component for this program will be for children referred by the Polinsky Children's Center (PCC) who have been removed from their home and are not exhibiting behavioral or emotional difficulties rising to the level of medical necessity and/or are the young children not traditionally served by the mental health crisis team. Having been removed from their home, it is reasonable to believe that this is a traumatic experience for children requiring intervention to diminish the effects of being placed outside of the home. Again, the program will identify and employ evidence-based practices, to

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be determined, include a focus on both children and families, assist parents to learn how their traumatic experiences influence their parenting styles and address developmentally appropriate coping mechanisms for children.

Program services will be provided by a contracted service provider to be procured competitively by the County. The provider shall obtain formal recognition and certification in the evidenced based model as determined appropriate for all staff working on the project. The service provider shall maintain fidelity to the program model, including evidenced based practices, as well as demonstrate cultural and linguistically sensitive services. Any parenting curriculum and other program materials for participants will be available in both English and Spanish. A minimum of two parenting seminars shall be advertised and offered to the community and other providers. The program will provide transportation, access to childcare when needed and offer family incentives for program participation. The selected service provider will be required to demonstrate in advance of being awarded a contract that they have the capacity to meet cultural and linguistic needs of the population.

The selected service provider would also be required to provide education and training to PCC's cottage staff, EPSDT, Child Welfare Services, and Juvenile Forensics staff on issues regarding attachment, structure, reading cues, etc., in order to ensure a thorough understanding of Parent-Child Interaction Therapy and Parent-Child Attunement Therapy (PCAT/PCIT) paradigms. These trainings will assist to enhance the Polinsky Children's Center practices as a whole in terms of evidence-based relationships and program with these children.

Key Milestones and Timelines

- Receive California DMH approval for plan – Month 1
- RFP developed, competitive procurement process completed – Months 1-6 (completed within the first 6 months)
- Contract awarded – Month 7
- Hire staff within the first two months of contract execution – Months 7-8
- Staff training (including cultural and linguistic needs of population) begins – Month 8
- The selected provider will obtain formal training to utilize approved service model – First 2 months of contract execution
- It is expected that the initial start up phase will be spent setting up infrastructure to work with South Region HHSA, Polinsky Children's Center, Child Welfare Services, law enforcement and the Domestic Violence Response Team; this includes the development of policies and procedures – Months 7-9
- Draft policies and procedures submitted to County for approval – Months 7-8

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- Outcome tools identified, surveys created – Months 8-9
- Create brochures and purchase materials (including materials in multiple languages) to be offered at each facility – Month 9
- Services begin – Month 9

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Prevention and Early Intervention Domestic Violence Service	Individuals: Families:	Individuals: Families: 700	
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: Families:	Individuals: Families: 700	

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

County Mental Health will assist to broker linkages between MHS, Child Welfare Services and other County HHSA services and the selected service provider. This will include:

- The establishment of a Memorandum of Understanding or partnership with the Child Welfare Services to coordinate appropriate services at the Polinsky Children's Center,
- Referral procedures with Juvenile Forensic Services Crisis Team at the Polinsky Children's Center should more comprehensive mental health services be required,

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- Establishing and maintaining communication and referral protocols with law enforcement when indicated,
- Establishing and maintaining communication and referral protocols with Probation Department to assist in the provision and/or referral for appropriate services to wards,
- Establishing and maintaining communication and referral protocols with South Region Point of Engagement to ensure the efficient and seamless transition of clients, and
- Establishing partnerships and referral protocols with Alcohol and Drug Services to facilitate the treatment and/or referral of drug exposed children and their families.

In addition, the selected service provider will be tasked with creating collaborations and partnerships with a variety of other community based services throughout the South Region including, but not limited to, community-based organizations, faith-based organizations, schools, community clinics, and pediatricians.

Individuals in need of resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues.

While the County-funded Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will also then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services.

6. Collaboration and System Enhancements

The Trauma Exposed Response Services in South Region/Polinsky reflects a system change that offers different ways of responding to reports of child abuse and neglect. This program utilizes a collaborative and multi-disciplinary approach and includes the family in the team decision-making process. It is critical that efforts are made to avoid the removal of children from their homes through a strength-based family approach. The key is to quickly and appropriately assess the safety and well being of a child's situation and then have the immediate connection to resources and needed services that will allow minors to remain safely in their homes.

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In order to address the needs of children and families through partnership and community collaborations, the selected service provider will identify a plan to establish memorandums of understanding with a variety of agencies and services throughout the South Region, as well as those who provide services for Polinsky Children's Center clients.

Collaborations and system enhancement will include connections with the following County departments: Probation Department, Mental Health Juvenile Forensics, Child Welfare Services, South Region HHSA, and Alcohol and Other Drug Services.

7. Intended Outcomes

- Increase knowledge of risk and resilience/protective factors – measured by post assessments/evaluations.
- Improve parenting knowledge and skills – measured by post assessments/evaluations.
- Reduce family stress and discord – measured by post assessments/evaluations and the decrease of referrals to law enforcement or Child Welfare Services.
- Increase social supports – measured by post assessments/evaluations.
- Increase appropriate help-seeking behavior – measured by service referrals.
- Increased satisfaction with linkage referrals – measured by post assessments/evaluations.
- Increase number of programs with process for identifying children/families with emotional and behavioral issues – measured by partnership and collaborative building assessments/evaluations.
- Enhance system capacity to provide prevention services – measured by partnership and collaborative building assessments/evaluations.
- Enhance partnering with ethnic/cultural organizations and communities – measured by service reports indicating demographics of those served.
- Increase number of children/families reached – measure by service reports indicating referrals.
- Increase number of children/families from under-served populations receiving prevention and early intervention services – measured by service reports indicating demographics of those served.

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8. Coordination with Other MHSA Components

The connection between Trauma Exposed Response Services - South Region/Polinsky (PEI Plan DV02) and the South Region Point of Engagement (PEI Plan DV01) will be highly linked and visible. Some children and families assessed in the DV01 component will likely emerge as being in need of a higher level of intervention in DV02. In addition, some served through these Domestic & Community Violence programs may be elevated to treatment level services through MHSA-CSS.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County:

SAN DIEGO

Workgroup - Focus Area (Cnty PEI List):

Community & Domestic Violence

Program ID/Name:

DV02 South Region and Polinsky Children's Center Trauma Exposed Services

Provider Name (if known):

Pending Competitive Procurement

Provider Category (DMH List):

Mental Health Treatment/Service Provider

FY 07-08

FY 08-09

Proposed Total Number of Individuals/Families to be served:

0

700

Total Number of Individuals/Families currently being served:

0

0

Total Number of Individuals/Families served through PEI Expansion:

0

700

Estimated Months of Operation:

0

12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
Classification	FTE	Per FTE				
Licensed Program Manager	1.00	\$80,000		\$0	\$80,000	\$80,000
Licensed/Eligible Clinician	1.50	\$55,000		\$0	\$82,500	\$82,500
Office Manager	0.50	\$43,200		\$0	\$21,600	\$21,600
Paraprofessional	4.00	\$45,000		\$0	\$180,000	\$180,000
	0.00	\$0		\$0	\$0	\$0
Total FTE	7.00	Sub-Total		\$0	\$364,100	\$364,100
b. Benefits%	@ 27.0%			\$0	\$98,307	\$98,307
c. Total Personnel/Staffing Expenses				\$0	\$462,407	\$462,407
2. Operating Expenditures						
Indirect/Administrative Costs		\$91,000		\$0	\$91,000	\$91,000
Operating Costs (includes Facility Costs)		\$147,000		\$0	\$147,000	\$147,000
Start-Up/One-Time Only Costs*		\$122,000		\$0	\$122,000	\$122,000
c. Total Operating Expenses				\$0	\$360,000	\$360,000
3. Subcontracts/Professional Services (list/itemize)						
Training (Ongoing for Childrens Services Provider)		\$101,500		\$0	\$101,500	\$101,500
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$101,500	\$101,500
4. Total Proposed PEI Program Budget				\$0	\$923,907	\$923,907
B. Revenues (list/itemize by fund source)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$923,907	\$923,907
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**

Program ID/Name: **DV02 South Region and Polinsky Children's Center Trauma Exposed Services**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals that improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

Position(s) targeted: Paraprofessional, 4.00 FTE

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

A2 Subcontracts/Professional Services

Training - Estimated ongoing costs of providing community parenting seminars and will include training development, trainers, training facilities, and materials.

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

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PEI Project Name: Central Region Community Violence Services

County: San Diego

Date: 11/19/08

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

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

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Community and Domestic Violence as one of our 10 priority focus areas. Below is a list of venues and opportunities offered to community stakeholders to participate in planning and to provide their valuable input.

There were two community forums held that informed this plan including the Early Childhood and Education Based Services – January 28, 2008 and the Community & Domestic Violence Forum – February 20, 2008. At both of these forums, expert guest speakers presented material on child development and trauma, as well as the effects of community and domestic violence. The forums were attended by community members, providers, experts, and other key stakeholders. The following themes emerged from these two community forums and various focus groups concentrating on the needs of children and adolescents in areas that experience community violence.

- There is a need to focus services to children and families with specific indicators and/or going through life transition points, including educational transition points. This includes those who have experienced trauma, family stress, severe medical issues, or other emerging or existing behavioral issues that may indicate future mental health risk. These include:
 - o Siblings of youth involved in juvenile justice;
 - o Children of parents/caregivers in drug or alcohol treatment, sober living or in recovery;
 - o Children of parents/caregivers incarcerated;
 - o Children of mentally ill parents;
 - o Immigrants and refugees from war torn regions, newly arrived refugees, and immigrants;
 - o Youth who are wards or dependents;
 - o Children from families experiencing domestic violence;
 - o Children experiencing obesity or from families suffering from obesity;
 - o Children of divorce and in co-parenting households;
 - o Children of veterans or active military; and
 - o Services during educational transition points – entering pre-school, kindergarten, grade school, middle school, and high school.
- There are resources for programming that support risk and resiliency factors through the Office of Juvenile Justice Delinquency Prevention (OJJDP).
- Trauma and exposure to community and domestic violence could mean many things:
 - o Refugees/immigrants – displacement/instability (culture, home, family);
 - o Poverty, chronic illness, suicide, loss/grief;

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- o War, gang violence, historical trauma;
 - o Natural disasters such as firestorms and flooding; and
 - o Due to traumatic experiences in their home country and cultural barriers, domestic violence may go unreported in refugee families.
- Focused interventions are needed for neighborhoods with high incidences of violence and where there are a high number of youth who are exposed to trauma and violence, including gang involvement. This increases the likelihood of adult onset PTSD. There is also a need to focus on high-risk children and families identified by Child Welfare Services.
- There is a need for early intervention for youth in Southeast San Diego including African American youth.
- Gang prevention programming needs to start at a young age including grief groups for siblings, parents, and others affected by gang violence.
- Teen violence reduction programs are needed.
- Efforts are needed to break the cycle of violence for children exposed to domestic violence.
- There is a need to educate/train parents to recognize problems and communicate with at-risk children thereby reducing the need for higher-level mental health services.
- The mental health system must enhance, integrate, and coordinate services with other child/family services.
- Identify and engage community resources to provide both preventive interventions and/or mental health services to traumatized children and families.

Mental Health Board (MHB) Presentation, April 3, 2008. A summary of community input was presented to the MHB for their review and guidance. The Board reviewed inputs and concurred with Mental Health Services' assessments to develop programs based on the identified needs.

A Community & Domestic Violence workgroup was convened and attended by multiple representatives of County Mental Health, Executive Director of the San Diego Commission on Gang Prevention and Intervention, HHSA South Region Child Welfare Agency Staff, Mental Health Juvenile Forensic staff, County Juvenile Probation Department staff, the Office of Violence Prevention, and the San Diego First Five Commission.

This workgroup reviewed the community input and conducted additional research to develop San Diego's Community and Domestic Violence Project to be supported by Prevention and Early Intervention funding. The three programs within this Project area include:

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1. A “Point of Engagement” Program in the South Region with the purpose of assessing families with children exposed to family violence and/or trauma and who may be at risk of entering the Child Welfare Services system (*PEI plan DV01*);
2. The development of evidence-based referral services for those children assessed through the “Point of Engagement” Program in the South Region, as well as children placed at the Polinsky Children’s Center, who have been determined to be without medical necessity for mental health treatment services (*PEI plan DV02*); and
3. A Community Violence Response Services focused intervention program that addresses the needs of siblings of identified gang members and youth exposed to or at risk of exposure to violence. This community based program will work to enrich the skills of providers, including many grassroots, community based and faith based organizations, as well as neighborhood schools to ensure a coordinated and neighborhood response to gang/community violence (*PEI plan DV03*).

All three programs will be community-based, family driven, and evidence-based with an emphasis on collaborations with existing programs and agencies. These programs will address the disparity in access to mental health services, educate providers and victims as to the psycho-social impact of trauma, identify the risk for stigmatization and discrimination subsequent to exposure to trauma, identify the risk of suicide due to exposure to trauma and provide prevention and early intervention services in conjunction with referral for comprehensive mental health services when the need is identified.

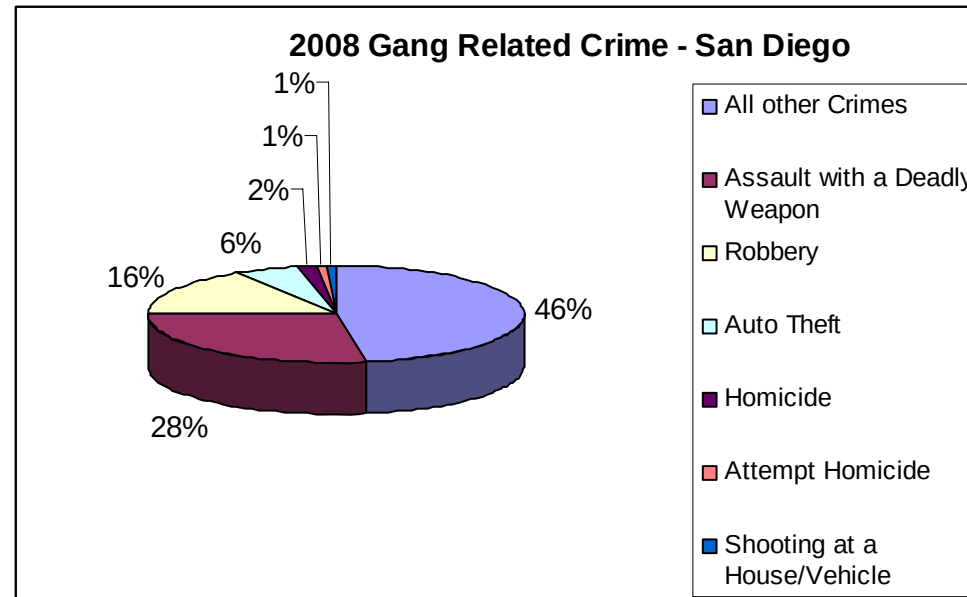
Other Data Analysis to support the selection of this program:

As part of the workgroup planning process, the following additional data was reviewed:

- During the time period of January 1, 2006, through March 31, 2007, there were a total of 434 crimes handled by the San Diego Police Department’s gang unit.
- In 2007, the following gang related crimes were committed in San Diego: 12 homicides, 9 reported shootings, and 8 attempted homicides.
- Assault with a deadly weapon was the second most prevalent gang-related crime and appears to be on the rise in 2008 (140 incidences reported to date) compared to 2007 (134 incidences).

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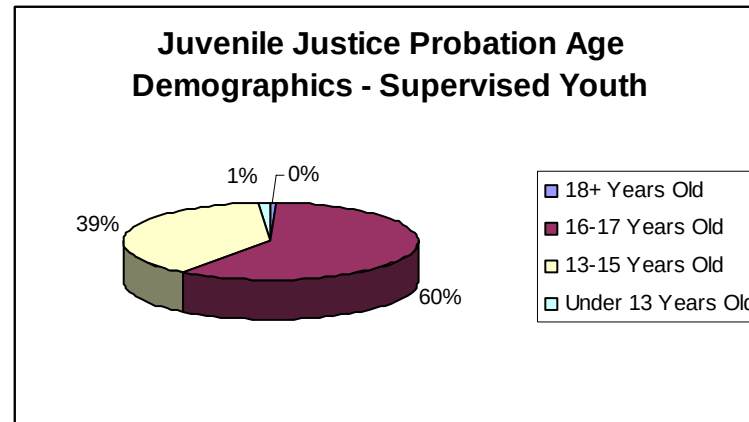


San Diego Police Department Gang Unit

- The four zip code areas that approximately make up Southeastern San Diego (92102, 92113, 92105, 92114) account for 38% of the gang related crimes in San Diego (San Diego Police Department's Gang Unit).
- Documentation of gang membership is on the rise in San Diego, from 210 documented cases in 2007 and 337 reported through June 2008. This accounts for a 60% increase in the first half of 2008 (San Diego Police Department's Gang Unit).
- The majority of youth supervised by the Juvenile Probation Department are between the ages of 16-17, followed by the next most prevalent age group of 13-15 year olds. This data points to the need for services prior to teen years to avoid further progression into the criminal justice system (County of San Diego Juvenile Probation).

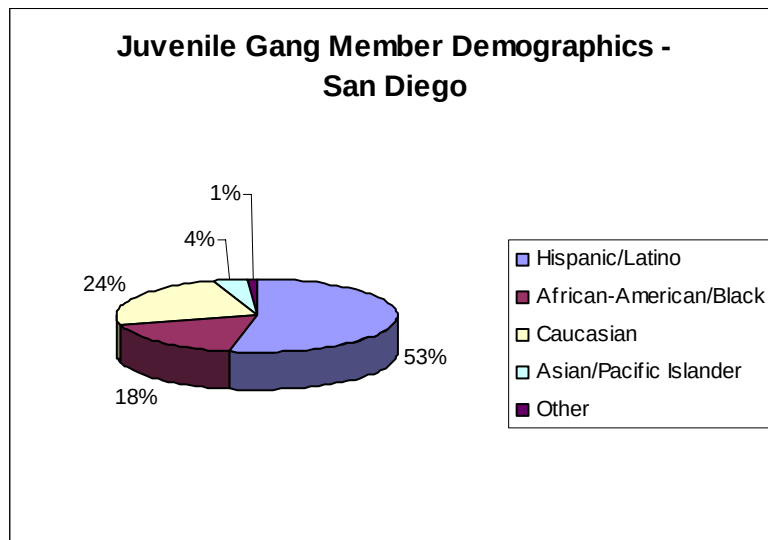
PEI PROJECT SUMMARY

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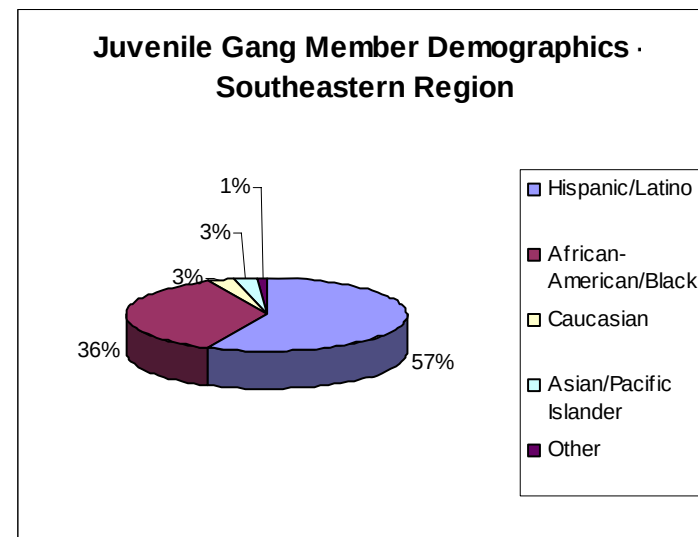


County of San Diego Juvenile Probation

- A typical case study of a gang member in San Diego reveals: a minority male, age 16 years old, living at home with a head of household mother. Each parent has a criminal history. The household typically includes younger siblings as well as other extended family members (San Diego Commission on Gang Prevention and Intervention).



San Diego Police Department Gang Unit



San Diego Police Department Gang Unit

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- Research on gang prevention programming points to the effectiveness of building family, individual, and community resiliency through the development of social competence, problem solving, autonomy, and sense of purpose.
- *Murder is no Accident* (2004) authors Stith and Spivak recommend that “a single approach to the issue of youth violence will not be effective.” Instead the authors assert that strategies should include “a change in social norms and cultural attitudes and behaviors,” and “a collective effort involving every discipline, every family and especially the entertainment media is necessary.”
- *Youth Violence, Prevention Intervention and Social Policy* (1999) states that “it is clear that effective prevention efforts must include as a primary target, improved parenting practices...However, concentration on parenting without attention to other important aspects of family function such as family relationship characteristics are not likely to have limited impact.”
- *Youth Violence: A Report of the Surgeon General* details promising practices for violence prevention programs and recommends including system wide strategies.

3. PEI Project Description:

This program will provide prevention and early intervention services to those living in the Central Region of San Diego County with attention in the South Eastern region. The goals of this program are to:

- Increase the knowledge of parents, professionals, organizations, schools and the community regarding appropriate responses to violence in the community through establishing multidisciplinary response teams;
- Increase the resiliency of individuals, families and the community to address and reduce the impact of community violence and trauma;
- Provide home-based services in response to trauma, as well as to provide on-going family supports;
- Provide direct support and positive alternatives to gang involvement for at-risk children;
- Build family assets for positive parenting;
- Provide a convening function to improve collaboration through joint training and information sharing; and
- Establish asset-based linkages between the community and law enforcement, courts, and probation services.

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There are two components of the Community Violence Response Services (*PEI plan DV03*):

1. Direct services to children at-risk for gang involvement and their families and
2. Trauma response services.

A service provider will be competitively selected who has an understanding of community needs and resources in the Southeastern San Diego area to provide both of the above components. This includes culturally competent programming that demonstrates an awareness of and addresses the culture and history of the neighborhood. In addition, the selected service provider will be required to provide culturally competent activities, services, and staffing, especially services in Spanish.

Direct Services to Children At-Risk and Their Families

The primary focus population for this component will be younger siblings of adolescents and young adults who have been identified as gang members or affiliates. Participants may also be children of incarcerated parents. The age range for youth will be 10-14 years old, middle school aged boys and girls. This population is at risk for future juvenile justice involvement, including involvement in gangs, and for trauma due to exposure to community and household violence. In addition, the parents of these youth will be served through both home-based services and parenting support.

Services will include anger management, conflict resolution, positive peer-based services, grief awareness, cognitive behavioral interventions that address the effects of historical trauma, resiliency building activities, activities that create positive peer networks, mentoring, youth leadership, case management, family advocacy and support, school-based support including interventions and advocacy for behavioral referrals, parenting classes, and/or parent child interaction therapy.

Referrals will come from schools, the probation department, faith-based and community-based organizations, law enforcement, San Diego Family Justice Center, community members, and other youth.

The program design will be informed by evidenced based and/or promising practices with the final design determined by the selected service provider. The selected service provider will be required to demonstrate the ability to engage collaborative partnerships with faith-based organizations, community-based organization, schools, law enforcement and other community stakeholders in Southeastern San Diego.

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Community Violence Response Services

Community violence response services are to be provided when community violence occurs, specifically violent gang-related crimes. This includes stabbings, violent assaults, and homicides. A Community Violence Response Team (CVR Team) lead by a PEI funded service provider will partner with law enforcement, faith based organizations, schools, Probation Department, public health facilities, the Commission on Gang Prevention and Intervention, San Diego Foundation's STOP Now, and other community organizations, including grassroots groups, to assist the CVR Team and provide any subsequent service referrals.

The CVR Team will focus on addressing the emotional effects of this violence on youth, family and the community. The intent is for the program to become established in the neighborhood and gain the trust and recognition of the community through its availability and response to the needs of the community.

Services may include culturally competent personal/family grief sessions; immediate assessment of situations after traumatic events; identifying and contacting those children and families who may be experiencing trauma related difficulties; referring these families to comprehensive services when appropriate including medical, emotional, educational and financial services; and interfacing with schools, churches, and pastors in order to help them support students, their families and parishioners who are emotionally affected by the incidents. Educators, ministers, and other groups will be taught and encouraged to publicly discuss the traumatic affects of violence so as to encourage families with young children to seek mental health support and care. Typically, families and individuals will be served for several weeks to several months after such events in order to provide consistency and on-going support.

The population to be served will include, but not be limited to, victims of violence, witnesses, siblings of victims and witnesses and other members of the community affected. The selected service provider will identify appropriate culturally and ethnically diverse evidence based models such as THRIVE, Promoting Alternative Thinking Strategies (PATHS), Incredible Years, Functional Family Therapy, and Strengthening Families Program. This may also include public service education and train-the-trainer models.

Key Milestones and Timelines

- Receive California DMH approval for plan – Month 1
- RFP developed, competitive procurement process completed – Months 1-6 (completed within the first 6 months)
- Contract awarded – Month 7
- Hire staff within the first two months of contract execution – Months 7-8
- Staff training (including cultural and linguistic needs of population) begins – Month 8

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- The selected provider will obtain formal training to utilize approved evidenced based service model – First 2 months of contract execution.
- It is expected that the initial start up phase will be spent setting up infrastructure to develop a network of partners for the CRV Team including Southeastern San Diego community stakeholders such as law enforcement, faith based organizations, schools, Probation Department, public health facilities, the Commission on Gang Prevention and Intervention, San Diego Foundation's STOP Now, and other community organizations, including grassroots groups. This includes the development of policies and procedures – Months 7-9
- Draft policies and procedures submitted to County for approval – Months 7-8
- Outcome tools identified, surveys created – Months 8-9
- Create brochures and purchase materials (including materials in multiple languages) to be offered at each facility – Month 9
- Services Begin – Month 9

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
	Individuals: 200 Families: 200	Individuals: Families: 200	
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals and Families: 200	Individuals and Families: 200	

Note on proposed numbers served:

- 200 youth and their families will be served in the Direct Services to Children At-Risk and Their Families component of this program

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- 200 Families will be directly served by the Community Violence Response Teams. In addition, other community members will be served through this component.

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

- The contractor will be tasked with creating collaborations and partnerships with other providers throughout the Central Southeastern San Diego region with the intended goal of providing prevention and early intervention services and referrals as appropriate.
- The contractor will be expected to network with the law enforcement, faith based organizations, schools, Probation Department, public health facilities, the Commission on Gang Prevention and Intervention, San Diego Foundation's STOP Now, and other community organizations, including grassroots groups in order to coordinate services and potential referrals.
- The contractor may network with the Juvenile Forensic Services Crisis Team to both understand the role of juvenile justice and to provide continuity of care.
- The contractor will establish a partnership with Alcohol and Drug Services to facilitate the treatment of drug exposed children and youth.
- The contractor will establish partnerships with community-based and faith-based organizations to develop a unified response to community violence and trauma.
- The contractor will develop a collaboration with the schools to develop a unified response to community violence and trauma, and to assist with referrals for additional mental health services.

Individuals in need of resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues. While the Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will also then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services.

PEI PROJECT SUMMARY

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6. Collaboration and System Enhancements

The Community Violence Response services in Central Southeastern San Diego reflect a system change that offers an innovative approach to respond to neighborhood gang violence and trauma. This program utilizes a collaborative and multi-disciplinary approach and includes the family, youth, and community in an asset-based, resiliency focused intervention. This program strives to fill a critical need in this region due to the high incidence of neighborhood gang related violence, high rates of juvenile delinquency, high rates of school failure, and the effects of trauma on the entire community. This program has the ability to move beyond a singular response to these community issues and allows the integration of a multitude of community and individual assets to address the prevention of the on-going effect of trauma on the neighborhood and the individual.

7. Intended Outcomes

The assessment and measurement tool(s) are to be identified based upon the selected evidenced-based program. However, the intent is to track the following outcomes:

- Increase knowledge of risk and resilience/protective factors – measured by pre-post assessments.
- Increase prevention efforts and response to early signs of trauma and emotional and behavioral health problems – measured by the increase in referrals and reduction of multiple referrals from the same households.
- Increase collaboration and integration among providers including the faith-based community – measured by narrative progress reports.
- Improve parenting knowledge and skills in order to promote the development, growth, health, and social competence of young children – measured by pre-post assessments.
- Reduce the incidence of juvenile delinquency – measured by juvenile probation data and referrals.
- Enhance the competence, resourcefulness, and self-sufficiency of parents raising children – measured by pre-post assessments.
- Reduce the negative psycho-social impact of trauma – measured by pre-post assessments.
- Increase services in under-served communities – measured by the establishment of an increased number of services.

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8. Coordination with Other MHSA Components

Upon exposure and involvement in the program, it is hypothesized that parents and the community in general will begin to develop an awareness of and trust in services being rendered and those available through other resources. Through the process some individuals and families will emerge as eligible for a higher level of intervention such as those programs provided through MHSA-CSS. The program will establish relationships with other providers in order to facilitate referrals and to educate parents regarding potential services for which they may be eligible.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): **Community & Domestic Violence**
 Program ID/Name: **DV03 Central Region Community Violence Services**
 Provider Name (if known): **Pending Competitive Procurement**
 Provider Category (DMH List): **Mental Health Treatment/Service Provider**

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	400
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	400
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
Classification	FTE	Per FTE				
Licensed Program Manager	1.00	\$80,000		\$0	\$80,000	\$80,000
Licensed/Eligible Clinician	1.00	\$55,000		\$0	\$55,000	\$55,000
Office Manager	0.50	\$43,200		\$0	\$21,600	\$21,600
Paraprofessional	2.35	\$45,000		\$0	\$105,750	\$105,750
	0.00	\$0		\$0	\$0	\$0
Total FTE	4.85	Sub-Total		\$0	\$262,350	\$262,350
b. Benefits%	@ 27.0%			\$0	\$70,835	\$70,835
c. Total Personnel/Staffing Expenses				\$0	\$333,185	\$333,185
2. Operating Expenditures						
Indirect/Administrative Costs		\$63,050		\$0	\$63,050	\$63,050
Operating Costs (includes Facility Costs)		\$101,850		\$0	\$101,850	\$101,850
Start-Up/One-Time Only Costs*		\$95,000		\$0	\$95,000	\$95,000
c. Total Operating Expenses				\$0	\$259,900	\$259,900
3. Subcontracts/Professional Services (list/itemize)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$0	\$0
4. Total Proposed PEI Program Budget				\$0	\$593,085	\$593,085
B. Revenues (list/itemize by fund source)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$593,085	\$593,085
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**

Program ID/Name: **DV03 Central Region Community Violence Services**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals that improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

Position(s) targeted: Paraprofessional, 2.35 FTE

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

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PEI Project Name: Rural Integrated Behavioral Health & Primary Care Services

County: San Diego

Date: 11/19/08

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

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	☒	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☒	☒
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☐	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		
6. Underserved Cultural Populations	☒	☒	☒	☒

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

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Rural Community as one of our 10 priority focus areas. Below is a summary of stakeholder input and background information.

The following input was provided by stakeholders at several community forums, including those held in five rural community sites:

- Educate/train community residents and service workers (postal carriers, beauticians, law enforcement, pet groomers, food delivery, and visiting nurses) to recognize at-risk warning signs (overfull mailbox) and provide written resource information to at risk individuals;
- Link with exiting rural organizations (Planning, Community Emergency Response Team "CERT," Senior Centers, Community Centers, Fire Protection, and Faith-Based) to promote and engage the community in PEI activity;
- Provide mobile services or tag-along with existing mobile services (book mobile, food services) to outreach, educate, and engage at-risk persons and their families/friends at locations where they live/work/visit (e.g. trailer parks, restaurants, churches, libraries, hair salons);
- Utilize community locations to advertise services such as the post office, community bulletin boards, and back country newspapers to provide prevention information and information about community prevention events;
- Develop in-home screening and assessment;
- Provide short-term intervention with information on follow-up resources and services to reach the population where they reside;
- Team mental health service provider staff (may be on-call) with Sheriffs Deputies to assist in responding to situations that are traumatic or involve persons with behavioral health problems;
- Initiate regular (monthly, quarterly) meetings with rural behavioral health service provider staff and first responders (fire and Sheriff) to improve collaboration through joint training and information sharing;
- Educate/train community members to identify at-risk neighbors and help them access services, "neighbors-helping-neighbors;"
- Co-locate PEI services with other services to address the shortage of suitable facilities and to reduce stigma;

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Community input received at the Child/Youth and Family Forum:

- Serve children/families in communities (where they are),
- Develop outreach and screening services for children and families,
- Bring outreach services to neighborhoods, and
- Develop marketing and outreach to general population on developmentally specific mental health issues.

Community input received at the Co-occurring Disorders Forum:

- Create mobile teams and fixed centers to provide outreach and engagement and as needed, immediate response to trauma (suicide, death, domestic violence) or disaster (fire, flood, accident);
- Mobile teams to attend community events, casinos, and “go-to” locations;
- Expand public access to mental health information, self-screening tools, and lists of appropriate resources such as County on-line resources (Network of Care) and public TV;
- Advertise access in high traffic locations;
- Use creative arts (music, art, poetry) to engage at-risk persons;
- Educate/train staff of organizations in contact with specialized populations such as community organizations (e.g. meals on wheels), faith-based, businesses (hairdressers, native food stores), public systems (schools, law enforcement), and physical health service providers to be sensitive/accepting, identify at-risk persons, and help them build resilience to stress and trauma and access services;
- Educate/train community members to be peer counselors/mentors and trainers of other community members and non-community service providers; and
- Develop and distribute public service announcements to reduce stigma and help the public identify at-risk persons and help them access services.

Other data supporting this program include:

- 2006 American Psychiatric Association Report – Behavioral Health Outreach: Integrating Medical and Behavioral Health Care. There is a high co-morbidity of depression and chronic medical disorders that has led to the development of depression management programs that integrate mental health services into primary care settings.

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- September, 2006 United Behavioral Health Report – Improving Total Health & Well-Being: An Innovative Approach That Integrates Behavioral Health Across the Health Care Continuum. “The prevalence of depression, anxiety, and substance abuse in the population with chronic conditions is two to three times that in the general population and has a dramatic impact on the clinical and financial outcomes of these conditions,” said David Whitehouse, M.D., Chief Medical Officer for strategy and innovation for United Behavioral Health.
- 1998 American Psychiatric Association report – Linking Primary Care and Rural Psychiatry: Where Have We Been and Where Are We Going? A National survey identified 53 successfully linked programs, ranging from small local efforts to sophisticated multipoint networks. A concern in rural areas is how to improve access to mental health care. Limited access stems from problems in the availability and acceptability of mental health care. Rural areas are considered medically underserved communities and that includes behavioral health services. Generally, few mental health providers, particularly psychiatrists, work in rural areas. Rural persons are often unwilling to seek mental health care from available providers because of the stigma that may result from being identified as a mental health consumer. In general, stigma may be more strongly experienced in rural areas where people know whose vehicle is parked by the mental health center. Policy makers have promoted linking primary care with mental health care for more than 30 years to improve access to mental health care in rural areas.
- San Diego County has twice implemented a Federal Emergency Management Agency (FEMA)/Substance Abuse and Mental Health Services Agency (SAMHSA) grant to provide outreach and support to wildfire survivors after two devastating wildfires within the County. The Wildfire Recovery Project model of outreach and supportive counseling has been highly successful in providing preventative services to reduce the trauma effects of the wildfire losses. The model includes outreach workers that are hired from the community. These community workers have knowledge and relationships within their community, which facilitates engagement of the community members in prevention and early intervention services. The community members are also able to identify community residents at risk for behavioral health issues.
- Poverty and lack of access to services is an extreme issue in the unincorporated rural Mountain Empire of San Diego. Of the 11,708 residents, Census 2000 shows at least 63% are at or below the 200% federal poverty level. The California Department of Education shows the Mountain Empire Unified School District as having 69% of its students eligible for free or reduced price lunch, higher than the average for the both the state and county. Access to care in these communities is limited due to a lack of facilities and transportation, thus posing a greater need for adequate mental health care to be serviced in the area. Native Americans comprise 4% of the population in this isolated rural mountain region with several reservations and 17 tribes represented. The entire rural ethnic/cultural makeup in San Diego County is predominantly white (75%) with Hispanic (16%), Asian/other (5%; this includes Native American), and African American (4%) residents.

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- Access to appropriate healthcare is an ongoing problem for the rural mountain empire and mental health services are nearly non-existent. In 2000, the Scripps Hospital East closed its doors resulting in a 45 to 90 minute drive to access the nearest emergency medical facility. Public transportation consists of one bus to service a portion of the area making a stop early in the morning and again in the late evening.

A PEI workgroup began to construct and facilitate a program design based upon community need and response. Group members included Juvenile Probation, Child and Adolescent Services Research Center (CASRC), Adult Mental Health, Children's Mental Health, Alcohol and Drug Services, and representatives from both East and North Inland regions of HHSA. Stakeholder and community input was reviewed and indicated that behavioral health prevention and early intervention services were needed for all age groups in rural underserved communities. As a result of this process, the Rural Integrated Community Behavioral and Primary Care Services plan was formulated to provide mobile outreach to underserved populations. This model is consistent with the PEI Community Needs, Priority Populations and principles.

3. PEI Project Description:

The focus of this PEI Plan is to establish fully integrated, behavioral health/primary care services for children, adolescents, transitional age youth, adults, and older adults in a rural community clinic. The plan model supports early intervention of individuals with risk of mental health and drug and alcohol use issues within a primary care context before their condition worsens and they could require specialty services. The plan is designed to implement a seamless integration of medical and behavioral health care that will reduce the stigma associated with seeking help for a range of behavioral health issues. Addressing behavioral health is increasingly recognized as an important aspect of dealing with overall physical health and well-being of individuals. The model will be transformational, enhancing services to patients, and will promote environmental/cultural change within the clinic. Community clinics offer a natural setting for promotion of optimal mental health. The program will increase the provider's capacity to offer effective mental health guidance and early intervention treatment through implementation of routine screening, education, consultation, and referral. The Group Health Collaborative of Puget Sound has had, for more than a decade, a similar successful model for integrated behavioral health within the primary care setting. In that model, behavioral health professionals with special skills in consultation and primary care liaison are actually integrated within the primary care team.

The proposed program will implement services that prevent patients within the community clinic from developing an increased level of behavioral health issues, severe mental illness, or addiction by addressing behavioral health needs early. Primary care patients with risk factors can benefit from a psycho-educational intervention to manage mental and

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emotional stress and unhealthy behavioral patterns, including those associated with various medical conditions. The plan will also include a mobile outreach component for prevention and early intervention through the use of a team of licensed behavioral health staff and para-professional outreach specialists who will engage clinic patients and the broader rural communities.

The model for identification of risk shall be the universal Screening Brief Intervention and Referral (SBIR) tool. The SBIR model is a method for identification of persons at risk for a behavioral health condition. SBIR shall be implemented routinely within the clinic(s) for patients who have not been screened within the past sixty days. The goal of the brief screening is to identify behavioral health issues as a routine part of medical care. SBIR includes screening plus immediate feedback, which serves as an intervention and is tailored to the patient's level of illness or risk. Brief intervention feedback raises awareness of risks and seeks to motivate the patient toward acknowledgement of the problem. It offers a menu of change options and places the responsibility to change on the patient. Critical to brief screening is the incorporation of five basic steps:

- o Introducing the issue in the context of the patients health;
- o Screening, evaluating, and assessing;
- o Providing feedback, talking about change, and setting goals;
- o Summarizing and reaching closure; and
- o Follow up care management contacts.

Brief intervention and prevention typically last one to three sessions and not more than five sessions. It utilizes a motivational interviewing style that incorporates a readiness to change model based upon the work of Prochaska and DiClemente. Their stages of change model tailors brief interventions to patient needs and the current stage of change. Brief intervention is low cost, low intensity, and of short duration. Using the results of a screening questionnaire, an individual may receive brief intervention(s) or be referred to specialized treatment. A key concept in the delivery of brief intervention is respect for the patient and confidentiality. Interventions need to be in a space with privacy and no interruptions.

An integrated model will include licensed behavioral health specialist(s) as part of the primary care team. The licensed behavioral health specialist(s) shall provide consultation and professional development to primary care providers and participate in team meetings to address integrated patient care. The integrated model shall increase the competence of primary care teams to recognize early signs of at-risk behaviors and early psychiatric illness and/or addictions through the screening of clinic patients. Healthcare staff shall utilize evidence-based, age-appropriate, and culturally sensitive screening instruments that identify alcohol and drug issues, gambling issues, early mental health risk factors, and the

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strengths of the patients. Examples of such tools are depression screening tools, brief version of the Parent Stress Index, Alcohol Use Disorder Identification Test (AUDIT), CRAFFT, and the brief screening developed by the Behavioral Health Co-occurring Initiative to identify either drug and alcohol or mental health issues. Time shall be allocated for the primary care physicians to consult with behavioral health specialists and participate in ongoing education in order to develop a holistic approach to prevention and to intervention treatment of uncomplicated serious psychiatric illness.

Priority risk factors to be targeted by SBIR include, but are not limited to, depression; suicidal ideation; impact of stressors on daily life; post-partum depression; isolation, caregiver burden, problems with substances and other conditions of older adults; drug and alcohol use; mental illness; early signs of behavior problems in children; stress level related to parenting, unhealthy lifestyle choices including poor nutrition and lack of physical activity; and problem gambling.

Behavioral health specialists shall model a strengths-based approach to instill a sense of optimism and hope in the patients and their ability to overcome the risk factors and stresses they are experiencing.

Integrated licensed behavioral health specialists shall provide consultation with the primary care team(s). The licensed behavioral health specialists shall train and supervise paraprofessional outreach behavioral health specialists to provide preventative and early intervention services within the clinic or through outreach in rural communities. All healthcare staff may screen and provide brief intervention in order to promote healthy living choices, good problem solving skills, and emotional wellness. The licensed behavioral health and outreach specialists shall assist primary care providers in understanding the range of alternative healing modalities that may be utilized, especially by Latino and Native American patients, such as use of herbal remedies. The licensed behavioral health specialists shall be available on-site to provide additional assessment if needed, referral, and linkage to services for those patients identified as needing treatment. Referrals of patients for assessment and linkage may also be made through other community services and schools.

A culture shall be created where primary care physicians shall provide early intervention treatment of mentally ill patients before their condition worsens to avoid the need for specialty mental health services. Psychiatric consultation and consultation with the licensed behavioral health specialists on the team shall promote the capability of primary care physicians to provide these early intervention services. A liaison will be established between community clinics, county mental health clinics and Alcohol and Drug Services (ADS) personnel in order to improve linkage and referral between the community clinics and the traditional mental health and alcohol and drug service systems. A structure shall be developed to coordinate care, cross refer, and provide consultation between traditional mental health and ADS primary care team.

Due to transportation issues in rural communities, access to services is limited. To improve access to service for patients at risk of behavioral health conditions, the plan includes a mobile outreach component. Community liaisons shall be hired from the rural communities and reflect the cultural/ethnic composition, language needs, gender, and generational needs of

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the targeted population. Community liaisons shall be trained in brief screening by licensed behavioral health staff. They may provide screening and brief intervention services that focus on fostering resiliency and wellness. They shall design interventions that are tailored to the individual's current stage of change, sensitive to the various cultural norms of patients, and that reduce the stigma associated with behavioral health issues. The community liaisons may conduct follow up with patients through telephone contact or in-home visits to reinforce the intervention strategies resulting from early screening.

While the community liaisons shall target clinic patients, they shall also develop public awareness activities that promote wellness and healthy living choices for the broader community in which patients reside. Community liaisons shall work with community partners to assess community needs in relation to such activities. Activities may include the following:

- Psycho-educational classes on parenting, stress management, dealing with loss, healthy relationships, teen relationship violence, drug and alcohol use, promotion of abstinence, and good nutrition;
- Psycho-educational information to families and individuals experiencing first onset of psychosis;
- Promotion of healthy recreational activities such as yoga or other physical fitness activities;
- Use of expressive arts and crafts with children activities to reduce mental health stigma;
- Support groups for caretakers of older adults or family members with chronic illness;
- Activities to prevent children and adolescents from engaging in risk taking behaviors such as under age drinking or early sexual activity;
- Focused skill building and problem solving groups with children and youth; these psycho-educational groups may be provided for clinic patients at the school; and
- Parent/child interaction such as playing interactive games to help parents learn and understand their child's emotional cues.

Outreach services to reduce stigma may be in the patient's home, or other community locations such as community centers, libraries, and faith organizations. Intervention activities shall be developmentally age appropriate for the entire age range of patients served.

Another component of the plan is for the program to develop a structure to include other community residents as volunteers. This strategy may be a means of sustaining the project as well.

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As part of a brief intervention, healthcare staff shall provide written wellness materials at the clinic site(s) and community venues. Resource materials may also be distributed to law enforcement and other first responders who interact with at-risk individuals. Community liaisons shall function as gatekeepers to identify community residents in need of prevention services. A community liaison may identify changes in behavior by observing the appearance of older adults: their mental and emotional state, personality changes, physical changes, social problems; potential problems with substance use, condition of the home, domestic violence, caregiver burden, financial hardship and suicide risk. Community liaisons and others involved in the community, such as postal workers or law enforcement, may be trained in a model such as the Gatekeeper Training Manual developed by Raschko, Raymond, and Francie Coleman of Spokane, WA (Spokane Mental Health, Elder Services, 1998).

The PEI plan shall target a community clinic(s) that could include a Native American health center in one of the rural areas of San Diego County. The prospective service provider shall propose the rural geographical area to be served. These areas will have a high concentration of ethnic minorities, older adults, and low income residents. Screening, brief intervention services, and outreach shall be available evenings and weekends to meet the needs of the working population.

The incorporation of information technology and healthcare, known as telemedicine, has set the stage for an innovative and effective way of delivering healthcare across large geographical areas and increases access to care. The PEI plan must link patients to treatment, but treatment services are not part of the PEI plan. Telemedicine may be utilized for psychiatric consultation to primary care physicians. The community clinic may also utilize telemedicine as part of any treatment services they provide separate from PEI. Another component for workgroup to consider is a website to access wellness information or that links patients to other sites.

Key dates and milestones include:

- Receive California DMH approval for Plan – Month 1
- RFP developed and competitive procurement process completed – Month 8
- Contract Awarded – Month 8
- Hire Staff – Month 8 – 9
- Begin development of policies and procedures – Month 8
- Draft policies and procedures submitted to County for approval – Month 9
- Develop program materials - Month 9
- County approval of outcome tools and tracking systems – Month 9

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- Begin delivery of services – Month 9
- County approval of satisfaction surveys – Month 12

4. Programs (program is not starting until July 1, 2009). The number of patients served through prevention and prevention/early intervention is duplicated. The patients receiving intervention other than screening are a sub-set of the total number of patients served

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Rural Integrated Community Behavioral Health and Primary Care Services – East, North Inland, Mountain Communities	Individuals: 3800 (all TAY, Adult, & OA) Families: 2020 (all children <18)	Individuals: 1550 (40% of individuals) Families: 808 (40% of families)	
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 3800 Families: 2020	Individuals: 1550 (duplicated) Families: 808 (duplicated)	

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

Clients shall be screened for priority risk factors including, at a minimum, mental health, alcohol and drug use; domestic violence; elder abuse; and problem gambling. Children and parents shall be screened for risk factors related to family stress and transitions. A portion of the patients screened may be identified as needing treatment services. Patients may be linked to regional treatment providers with support from a liaison to traditional mental health, as well as drug and alcohol services. The clinic is also able to provide direct treatment services through Mental Health Services Act (MHSA)

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and Medi-Cal. With the establishment of internal behavioral health consultation, as well as linkages to traditional mental health clinics, the primary care providers will be better able to serve all clients with mental illness, including Seriously Mentally Ill (SMI) individuals whose condition is stable and who do not yet meet Medi-Cal criteria for specialty mental health services.

Licensed behavioral health specialists hired through the PEI plan may conduct an assessment to determine if more intensive services are needed and to make appropriate referrals. Provider will establish partnerships with community based organizations, as well as County programs. Key members of the community will be used to help assist in identifying at risk individuals.

The provider shall identify community partners. The role within the partnership shall be described including the leveraging of resources and matching funds. The provider may also seek other grant and funding opportunities to enhance this integrated effort.

The activities of this PEI Plan also fit into the San Diego County Health and Human Services Agency public health and regional activities looking at environmental approaches to chronic disease prevention.

Individuals in need of resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues. While the County-funded Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services.

6. Collaboration and System Enhancements:

A mental health provider could partner with a rural community clinic to provide the services described in the PEI plan or a rural clinic could provide these services directly. The program shall collaborate with local leaders in the community in order to recruit outreach workers. These community leaders and organizations may promote PEI activities in their community(s). Examples of partners might be faith based leaders, Community Emergency response Teams (CERT), or community organizations such as Kiwanis. Collaboration is vital to identify community needs in relation to building individual and community resilience/wellness. Other collaborative partners may include local law enforcement, and first responders such as fire departments and California Department of Forestry (CDF) who may have firsthand knowledge of

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the community. The program may provide training and resource materials for these first responders to offer to community members.

The provider shall liaison with Child and Adult Mental Health clinics, Alcohol and Drug Services (ADS) and public health to facilitate referral for patients in need of treatment services. The provider shall also partner with other county programs such as Aging and Independent Services (AIS), child Welfare Services (CWS), and other regional County Health and Human Services Agency (HHSA) services. Currently the rural Public Health Nurses conduct home visits and these home visits are another opportunity for linkage and outreach.

A liaison relationship will be established between the primary care clinic(s) and geographically proximate traditional mental health clinics and drug and alcohol programs for the purpose of providing mutual support and consultation. This will enhance the ability of mental health clinics to have the medical needs of their clients addressed. In turn, the primary care providers will have easier access to mental health and drug and alcohol providers for consultation regarding early intervention in emerging, uncomplicated mental illness prior to development of more severe symptoms and for referral of their client.

Partnerships will be developed with the other community-based agencies in rural areas and schools to provide brief mental health wellness education. Other community partners may include Senior Centers and self help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

The liaison position between the community clinic and traditional mental health and ADS treatment programs will strengthen mutual referral and begin to integrate community clinics into the mental health system. The program will expand the continuum of behavioral health care by funding positions to provide prevention and early intervention services to community clinic patients within an integrated model. It will strengthen the ability of primary care to identify risk factors and intervene early to avoid or alleviate the need for specialty mental health services or alcohol and drug treatment.

Within San Diego County there are several existing rural collaborative groups that meet on a regular basis including the San Diego County Rural Health Network (RHN), which covers the rural communities of East, North Coastal, and North Inland regions. This network is currently developing a webpage for the RHN to increase collaboration and communication among rural providers. PEI information on the webpage could be an avenue for outreach and wellness information.

The rural health clinics are also involved in the broader California State Rural Health Association (CSRHA) and the Southern California Rural Roundtable, which covers all counties in Southern California.

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It will be the responsibility of the organization providing the service in this PEI plan to identify primary partners and ways in which they will leverage resources. One expectation is that they will need to provide in-kind resources such as space, share supplies etc.

The County will continue to fund this PEI program if it achieves the outcomes established for the service. The service provider may also seek other grants geared toward enhancing the integration of the behavioral health and primary care model. Enhancing the program with volunteers to do outreach and community education is an example of sustainability.

7. Intended Outcomes

Individual and Family Outcomes

- Primary care providers shall actively identify mental health risk factors;
- Report the number of patients who are screened for risk factors;
- Report the number of patients who receive brief interventions by licensed behavioral health specialists and community liaisons;
- Report the number of referrals made for behavioral health services and where they were referred to;
- Report the percentage of patients of each age group who were referred to more intensive services;
- Primary care and behavioral health staff shall report their satisfaction with the integrated model and the impact on patient care and clinic functioning;
- In the first year, collect and report data on the number of psychotherapeutic drugs prescribed in the clinic;
- Administer satisfaction surveys for staff in the community clinic and at traditional mental health and drug and alcohol clinic services regarding mutual referral;
- Report satisfaction of patients on the integrated approach to behavioral health care;
- Increase access to mental health wellness information by increasing the number of mental health wellness events; report the number and type of events provided;
- Implement or support a collaborative informational website that provides resource information or links to prevention resources; and
- Demonstrate improved awareness of primary care providers in early intervention treatment of mentally ill patients by utilizing appropriate survey instruments.

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System/Program Outcomes

- The primary prevention/early intervention services in a rural community clinic shall broaden the continuum of services to clinic patients and rural residents and increase access to wellness information;
- Report the number of people attending community wellness events;
- Primary health care personnel (including medical, front desk etc.) shall increase awareness of risk factors as a result of professional development offered by behavioral health specialists; and
- Clinic will screen patients for risk and provide brief intervention that demonstrates an integrated primary care behavioral health approach with patients.

8. Coordination with Other MHSA Components

This PEI Plan shall link to Community Services and Supports services through referral to treatment services in the community and within the clinic. Community clinics can link Medi-Cal patients to treatment within the clinic as they are a federally funded health clinic. They can link patients without funding to treatment within the clinic through the Council of Community Clinics CSS services for patients that meet the criteria for CSS. Patients may also be referred to the regional outpatient clinic(s) for assessment, brief treatment, psychiatric evaluation, and medication services. Patients of all ages including children, TAY, adults, and older adult, are eligible for the above referral.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County:

SAN DIEGO

Workgroup - Focus Area (Cnty PEI List):

Rural East, North Inland & Mountain Communities

Program ID/Name:

RC01 Rural Integrated Behavioral Health and Primary Care Services

Provider Name (if known):

Pending Competitive Procurement

Provider Category (DMH List):

Primary Health Care Provider

Proposed Total Number of Individuals/Families to be served:

FY 07-08

FY 08-09

0

5820

Total Number of Individuals/Families currently being served:

0

0

Total Number of Individuals/Families served through PEI Expansion:

0

5820

Estimated Months of Operation:

0

12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
Classification	FTE	Per FTE				
Program Manager	1.00	\$84,000		\$0	\$84,000	\$84,000
Licensed MH Direct Svc Staff	2.00	\$70,000		\$0	\$140,000	\$140,000
Admin Support (Admin Asst, Secr, Clrk)	2.00	\$40,000		\$0	\$80,000	\$80,000
Health Care Direct Svc Staff	6.50	\$43,000		\$0	\$279,500	\$279,500
	0.00	\$0		\$0	\$0	\$0
Total FTE	11.50	Sub-Total		\$0	\$583,500	\$583,500
b. Benefits%	@ 30.0%			\$0	\$175,050	\$175,050
c. Total Personnel/Staffing Expenses				\$0	\$758,550	\$758,550
2. Operating Expenditures						
Indirect/Administrative Costs	15.5%	\$216,450		\$0	\$216,450	\$216,450
Operating Costs (includes Facility Costs)	19.9%	\$278,000		\$0	\$278,000	\$278,000
Start-Up/One-Time Only Costs*	12%	\$168,000		\$0	\$168,000	\$168,000
c. Total Operating Expenses				\$0	\$662,450	\$662,450
3. Subcontracts/Professional Services (list/itemize)						
Consulting Psychiatrist		\$72,000		\$0	\$72,000	\$72,000
Physician	.25 FTE	\$75,000		\$0	\$75,000	\$75,000
		\$0		\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$147,000	\$147,000
4. Total Proposed PEI Program Budget				\$0	\$1,568,000	\$1,568,000
B. Revenues (list/itemize by fund source)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$1,568,000	\$1,568,000
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**

Program ID/Name: **RC01 Rural Integrated Behavioral Health and Primary Care Services**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals and improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Community Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified workers from the communities served to provide outreach and wellness activities.

Positions targeted: Program Manager (1.0 FTE), Licensed MH Direct Service Staff (2.00 FTE), Health Care Direct Service Staff (6.50 FTE), Administrative Support (2.00 FTE)

A1b Benefits - The Benefit rate (30%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate Specialized Training, and Consultant costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Specialized Training in Evidence Based Prevention Practices
- Consultants to assist Program implementation

A2 Subcontracts/Professional Services

Consulting Psychiatrist - Estimated ongoing costs of providing psychiatrist support to primary care provider physicians and staff.

Physician - Estimated ongoing costs of physician liaison and support to behavioral health staff providing services.

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

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PEI Project Name: Collaborative Native American Initiative

County: San Diego

Date: 11/19/08

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

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	☒	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☐
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☒	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		
6. Underserved Cultural Populations	☒	☒	☒	☒

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

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Native American Community as one of our 10 priority focus areas.

Stakeholder Input

While most target areas facilitated one community forum, in response to input from the Native American and community stakeholders, there were three gatherings held; two community forums and an additional community planning meeting. Concern was also expressed by the American Indian/Alaskan Native (AI/AN) stakeholders that any new services offered through MHSA Prevention and Early Intervention funding would need their involvement in order to be truly culturally competent.

The initial AI/AN Community Forum was held on February 26, 2008, a second forum was held on March 27, 2008, and an additional community planning meeting was held on May 1, 2008. Various community stakeholders were in attendance, including members from several of the county's 18 different tribes. The following themes emerged from these community meetings:

- There is a need to address family issues that may contribute to at-risk individuals behavioral health problems.
- The American Indian/Alaska Native Community (referred to as Community) has been subject to historical, multi-generational, and continuing trauma that affects the behavioral health of Community members and their trust in services.
- There is a high frequency of recidivism is the result of the lack of follow-up services.
- Centralized services with "business hours" do not address in-home family issues, cultural norms, and transportation issues.
- Transition Age Youth (TAY) ages 16-25 are hard to access and engage for services.
- A high frequency of suicide traumatizes families and communities.
- Chronic illnesses are common and are distressing for individuals, families, and the community.
- Behavioral health problems are common.
- Services are limited because of insufficient funding.
- Non-Community service providers often do not have the cultural competence to provide effective services.
- Communication using "western" medical/mental/physical health terminology and references do not reflect the culture or the culture's traditions and are not effective.
- Recent fires and subsequent flooding added stresses that increased the occurrences of behavioral health problems.
- The diversity and dispersion of urban Community members decreases the effectiveness of outreach and services.

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- Educate/train family members (including extended family) to identify high-risk individuals and assist them in accessing services.
- Assist families in making changes to "Break the Cycle" that places children at risk and influences the behavior of the children as parents.
- Develop Community-based trauma/disaster teams to address the stresses of individual and family trauma and Community disasters.
- Team behavioral health with physical health services to provide more effective, holistic, health services, and reduce stigma.
- Provide services in-home to ensure both individual and family needs are met, help resolve transportation issues, and provide opportunities for positive role-modeling.
- Engage and provide services for TAY through youth-centered projects and centers ("safe places").
- Authorize the Community to determine program/service needs, priorities, and funding allocations.
- Schedule presentation by the Community to the Mental Health Board and Board of Supervisors as part of the PEI Plan approval process.

Service Gaps Identified:

- Transportation – Long distances and travel times to centralized services are a barrier to timely access to services. Need regular (public) and reliable transportation to centralized services.
- Aftercare – Aftercare is unavailable or inadequate and persons are returning to unchanged home environments that make maintaining recovery difficult.
- Transition Age Youth (18-25 years of age) are often not able to return even to a home environment.
- Culturally competent centers – To improve the effectiveness of services, services should be provided in centers that provide culturally competent services.
- Service provider/staff turnover – Inconsistent funding, short staffing, and overworking result in significant staff turnover. Need to reduce service provider staff turnover to ensure consistency and continuity of services.
- Funding flexibility – Need funding flexibility to help ensure the continuity of successful programs.
- In-home services – In-home services are needed to help ensure that family needs and home environments contributing to behavioral health problems are more effectively addressed. In-home services also meet cultural norms and help resolve transportation-to-service problems.
- Family approach – Families need support in assisting family members with behavioral health problems including wraparound services that help meet family needs.
- Homelessness – Homelessness in urban and rural locations increases problems in accessing services and medical care, including medications.

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- Holistic/wraparound approach – Need to provide services that address all issues contributing to a person's behavioral health problems and provide whole family support.
- Elders – Need to involve Elders (especially the natural healers) in providing services.
- Service provider linkages – Native (both urban and reservation) and non-native community service providers should be linked through collaboratives to avoid service duplication, increase cultural competence, and improve communication and understanding.
- Native providers – Need more Native service providers to ensure culturally competent services.
- Case management – Need case management to help ensure appropriate and seamless services and the continuity of care from initial care at the clinics through programs providing services and into aftercare.

Services to Address Gaps:

- Family prevention programming such as:
 - o Crisis team – Create a crisis team that responds to trauma to or in families.
 - o Family education/training – Educate/train family members to identify at-risk individuals and assist them in accessing services.
 - o Family support – Support families in the return of a family member from behavioral health treatment rehabilitation/recovery.
 - o School/child care education/training – Educate/train school and child care staff to have the skills required to identify at-risk individuals and provide services.
 - o Parenting support – Assist families in making changes that “break the cycle” of negative parenting and home environments that put children at-risk and influence the behavior of the children as parents.
- Adult Prevention such as wraparound services that address all the needs of persons receiving services.
- MERIT – A San Diego County Sheriff representative proposed funding MERIT (a PERT model) services for rural communities. Sheriff Deputies are often the first responders to calls that involve persons with mental health issues. SDC Sheriff is proposing that mental health clinicians assist in those calls. Forum attendees suggested that the proposal use a trained community member (elders who are natural healers) rather than a clinician.
- Community roundtable meetings – Initiate regular meetings (at least quarterly) with representatives of community service providers, the County's community liaisons (when funded and hired), public service providers, fire protection, and law enforcement. The meetings will provide an opportunity to avoid service duplication, increase the effectiveness and continuity of care in services provided, increase cultural competence, and improve communication and understanding.

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- Support individual accountability with empathy – For success in changing behaviors, individuals need to take responsibility. Ensure that implemented programs and services support the individuals in meeting their behavioral health needs without taking away the individual's responsibility.
- Support for families and communities – Provide support for families and communities in addressing individual/family/community trauma, alcohol and other drug problems, and first-breaks with mental health. Include wraparound services to help meet family needs. Provide education and training to identify at-risk individuals and provide access to services. Provide outreach to families and communities to engage them in available programs and services.
- Isolated adults – “Bring-in” adults isolated from their families, Community, or culture to provide them culturally competent services that could better assist them in addressing their behavioral health problems.
- Case management – Provide case management to help ensure appropriate and seamless services and the continuity of care from initial care at the clinics through programs providing services and into aftercare.

Mental Health Board (MHB) Presentation, April 3, 2008. A summary of community input was presented to the MHB for their review and guidance. The Board reviewed input and concurred with Mental Health Services' assessment to develop programs based on the identified needs.

Following a recommendation from the American Indian/Alaska Native community, the County of San Diego began to collaborate with the local AI/AN tribes to develop PEI services. Four American Indian/Native American health groups representing all local tribes and urban areas came forward with the desire to work with the County and form a consortium. A PEI workgroup was subsequently formed. This workgroup reviewed the community input and conducted additional research to develop San Diego's Native American Communities Project. Due to the experience and local knowledge of the AI/AN Consortium members, the County has followed their direction in developing the PEI plan to provide culturally appropriate American Indian/Alaska Native services in the San Diego community.

The Consortium Members

San Diego American Indian Health Center (SDAIHC) has been providing health and social services to the urban community since 1975 and it will be the location for the proposed Urban Youth Center. The service area for SDAIHC includes Del Mar, Spring Valley, La Mesa, La Jolla, Imperial Beach, Ocean Beach, Pacific Beach, San Ysidro, Solana Beach, Lemon Grove, San Diego, Central San Diego, S.E. San Diego, Coronado, National City, and Chula Vista.

The *Indian Health Council (IHC)* was founded in 1970 and represents a Consortium of nine North San Diego County tribes. IHC will be the fiscal agent for the proposed PEI project. A distinguishing feature of IHC's health care and educational services is a strong emphasis on family-centered, community-based programs offering respect and consideration for the traditions and culture of California's diverse Native American populations. The member reservations within IHC's Consortium include Pala, Pauma, La Jolla, Rincon, Santa Ysabel, San Pasqual, Mesa Grande, Inaja-Cosmit, and Los Coyotes. The total area reservation-based population served by IHC exceeds 4,500 Native Americans, out of

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more than 12,000 patients who have registered since 1995 (Indian Health Council, 2008). IHC continues to be the only agency within North San Diego County that provides culturally competent child abuse treatment services for the American Indian population, the majority of which reside on or near nine area reservations. This geographically diverse service region encompasses 1,500 square miles and is home to nearly half the entire AI population reported in the 2000 U.S. Census for San Diego. Of these, approximately 41% of the population consists of children age 18 and younger.

The Southern Indian Health Council (SIHC) was established in 1982 and structured as a consortium of seven different tribes located in the rural and remote unincorporated areas of southeastern San Diego County in the state of California. One delegate from each of the seven tribes (La Posta, Ewiiapaayp, Barona, Campo, Jamul, Manzanita and the Viejas Band of Kumeyaay Indians) is the governing Board of Directors. The service area population is 9,885 American Indians as determined by the U.S. Indian Health Service. According to the 2000 US Bureau of Census data, it was revealed that 80% of the households are economically disadvantaged and fall within the very low, low, and moderate income limits as set by the Federal Anti-Poverty Income Guidelines of January 1, 2008. Four hundred twenty (420) members are children and youth between the ages of 1 and 18 years of age. According to the most recent reliable data from our Kumeyaay Family Services, 35% (120) of our children and youth are open cases in the non-Indian juvenile court proceedings. According to the Bureau of Indian Affairs' most recent Labor Statistic Report of January 2007, the unemployment rate is 9% on the reservation compared to 6% for the general population of San Diego. Nine hundred eighty-nine (989) tribal members are between the ages of 18 and 65.

The Sycuan Medical Dental Center was established by the Sycuan Band of the Kumeyaay Nation in 1978. The Sycuan Medical Dental Center provides healthcare to the Native American community and Sycuan employees and their families, as well as the surrounding community. The agency provides access to four areas of expertise in the medical field: Family Practice, Pediatrics, Internal Medicine, and Podiatry. On-site primary services include well child and infant care, preventive care, diabetes management, and treatment of acute illnesses and injuries. Specialized services include podiatry, telemedicine involving pain management, and mental health. Currently SMDC serves 1,500 patients with a cumulative 8,000 patient visits per year.

Additional Data Analysis

As part of the planning process by the workgroup members, the following additional data was reviewed in developing this PEI Project. San Diego County has the largest number of American Indian reservations and tribal governments in the nation. Due to a long history of distrust and broken treaties, many American Indians/Alaska Natives may be inclined not to disclose their tribal status during US Census surveys and, over the years, public health programs and the Indian Health Service have struggled to sort out the challenge of mis-categorizing individuals who may be of mixed heritage. In this light, although the 2000 Census may show a population of 24,337 (American Indian/Alaska Native alone or in combination), local data from the San Diego Association of Governments shows a different picture; 46,177 was the total reported in 2000. Neither of these numbers account for the fact that American Indians/Alaska Natives may have non-AI/AN partners,

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spouses, or family members, and those families may be spread across reservation and urban settings. This information is provided to increase awareness of the fact that implementing PEI activities to the AI/AN community of San Diego County encompasses a larger population than what is documented. Tribal values place an emphasis on family and community, rather than the individual, which leads to the family-centered approach of serving elders, youth, and adults.

As the recent data demonstrated more than 46,000 persons who identify as American Indians/Alaska Natives reside in San Diego County with the majority of the population concentrated in the urban/metropolitan area. Indian Health Service estimates over 9,000 of these reside in reservation areas of north and south San Diego County among 18 reservations. Because the location of the City of San Diego is in a temperate climate, the urban area attracts many AI/ANs from around the country.

According to *San Diego Child and Family Health and Well Being Report Card, 2005*:

- Urban Indians are 1% of regional population.
- Urban Indian youth under age 18 account for 50% of the Urban Indian population.
- Ten percent (10%) of urban AI/AN youth attempted suicide in the past 12 months.
- The substantiated rate of child abuse for AI/AN population is thirty-four percent (34%).
- The rate of violent crime victimization for youth ages 12-17 is 68% (per 1,000).
- The rate of youth offending is 15.4% (per 1,000).
- The teen birth rate for AI/AN ages 15-17 is 15% (per 1,000).
- The rate of AI/AN teen alcohol use is 47.2%.
- The rate of marijuana use of AI/AN youth is highest in the county and includes (25%) of 11th graders, (21%) of 9th graders, and (9%) of 7th graders.
- The high school graduation rate in San Diego for AI/AN youth is the third lowest in the county at 68.9%.

The Office of Emergency Services noted in 2004 that “except for African American children, American Indian children had the highest proportional participation in the child welfare services program and out-of-home placement at 51 per 1,000 and 39 per 1,000, compared to Caucasian children at 18 per 1,000, and 13 per 1,000 for the same child welfare services program and out-of-home placements.”

In addition, “of the 520,711 referrals made (for Child Welfare Services), 5,101 or 1% were for American Indian children. Of the 5,101 referred, 33% were for abuse, 58% for neglect, 9% for at-risk, and 1% for exploitation.” From 2005 to 2007, the overall countywide rate for substantiated reports of child abuse has remained static at 13.7 per 1,000 children under age 18. For American Indians, the rate is 33 per 1,000 (Source: San Diego County Health & Human Services, 2005 and 2007 Report Cards).

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3. PEI Project Description:

There are four main components for the Native American Communities PEI Project submitted on behalf of San Diego County. These include:

1. Urban Youth Center (UYC),
2. Elder Services/Navigator Program,
3. Suicide Prevention Program, and
4. Outreach and Prevention Education.

The overall proposed project will serve American Indians/Alaska Natives and their families in San Diego County from the rural reservation communities to the urban area in Central San Diego. The service providers for these four components will be the following: 1) Indian Health Council (IHC), 2) Southern Indian Health Council (SIHC), 3) Sycuan Medical/Dental (SMD), and 4) San Diego American Indian Health Center (SDAIHC). All four of these providers have a successful track record of serving American Indians/Alaska Natives in San Diego County and will share goals and objectives that enhance community wellness and reduce the number of AI/AN individuals who may typically be underserved/unserved.

The Consortium and their staff members will cast a broad net to educate and inform community members about PEI activities. This will be done through existing established clinics, outreach and prevention education activities that promote and support community wellness, cultural activities, support groups, and referral services. Emphasis will be placed on enhancing individual, family, and community wellness by promoting and increasing awareness and access to cultural events that are known to support resilience. These services may include: traditional health gatherings, cultural programs that maintain language, knowledge of basket weaving (a local tradition for many tribes), nutrition programs, self-esteem activities, male involvement strategies, positive parenting, exercise programs, and the promotion of overall increased medical and dental health. All of these services will have the goal of preventing the onset of serious mental health problems.

The project will be overseen by the CEO and Associate Executive Officer of the lead agency for the Consortium (Indian Health Council) to ensure coordination and uniformity of services and reporting requirements. There will be one shared credentialed mental health provider across all four agencies. This staff position will support the PEI objectives and goals and ensure continuity of services, data collection, and reporting from the Consortium's partner agencies. This PEI Coordinator/Clinician, who is familiar with the community, will work with each of the program components to develop a diagnostic survey/assessment that will determine client satisfaction, measure referral follow-through, and integrate a developmental and sequential process. The PEI Coordinator/Clinician and the Consortium workgroup will work together to identify a survey/assessment model that best fits the dynamics of the environment and utilization. In addition, this staff person will screen for risk of mental health and substance abuse issues, and assess individuals who seek assistance or are referred through outreach or other agency cross-referral systems.

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The program will include at least 1.2 FTE clinicians (PEI Coordinator/Clinician is part of the 1.2 FTE) that will be responsible for the support and implementation of the PEI objectives/goals. Both of these positions will be filled by licensed clinicians with experience in screening, diagnostic surveys/assessment, and the development of screening instrumentation. The first position is a .2 FTE part-time position. The individual who fills this position will assist in identifying and scheduling individuals who will be screened by the full-time clinician. This individual will serve as the initial contact when the participating agency makes a referral for screening. This clinician will ensure that proper referrals are made once the screening process has been completed. In addition, the clinician will be responsible for compiling all the data and information that is gathered through the screening process.

The second position is a full-time position. The clinician who fills this position will work with the four participating agencies. This clinician will receive referrals from the .2 part-time PEI FTE clinician or clinicians and/or program personnel representing one of the participating agencies. This clinician will identify the most appropriate screening instrument and/or process for each case and will conduct the screening at the local agency. This clinician will provide screening for the objectives identified in this PEI grant. He/she will also serve as a resource for parents whose children are being identified as "special needs" or who are going through an IEP process. In addition, this staff person will screen for risk of mental health and substance abuse issues and assess individuals who seek or are referred through outreach or other agency cross-referral systems. Both PEI Clinicians will work together to identify an assessment/survey model that best fits the dynamics of the environment and utilization of the services.

Due to the fact that there is a limited number of EBP models that have been developed for, or by American Indians/Alaska Natives, the Consortium has decided to use the instruments that have been successfully used by the current providers, with a long-term goal to identify and further investigate EBPs for future integration. The projects will utilize a toolbox of assessment instruments that have been useful in rural, reservation, and urban AI/AN settings, and the prevention and early intervention screening tools may be expanded beyond what is currently in use. Assessment tools being utilized across the Consortium include: Trauma Symptom Inventory, Child Behavior Checklist, Adolescent Diagnostic Interview, Millon Clinical Multiaxial Inventory, Thematic Apperception Test, Beery Visual-Motor Inventory, Clinical Assessment of Behavior for Children, Kaufman Assessment Battery for Children, Wechsler Intelligence Scale for Children, Wechsler Adult Intelligence Scale, House-Tree-Person test, Kinetic Family Drawing, and Bender Gestalt test. Additional screening tools that may be considered are in the areas of depression, suicidal ideation, anxiety, and stress.

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New & Innovative Programs

The following culturally-based approaches to enhancing community, family, and individual wellness are part of the PEI projects' effort to create new and innovative program components. These components evolved from discussions that occurred during the community forums, as well as the workgroup planning process.

The *Indian Health Council (IHC)*, serving the nine northern reservations of San Diego County, and the *Southern Indian Health Council* and *Sycuan Medical/Dental*, together serving the eight southern reservations, will offer two of the three components of this project: 1) Elder Services/Navigator Program and 2) Outreach and Prevention Education.

The *San Diego American Indian Health Center (AIHC)* will offer services to Urban AI/AN youth through the establishment of an Urban Youth Center.

Urban Youth Center:

In response to the lack of urban youth services in the area where there is the highest density of the AI/AN youth population, the San Diego American Indian Health Center will offer services to urban AI/AN youth, ages 16-25, through the establishment of an Urban Youth Center (UYC).

The UYC will provide screening/assessment for the risk for mental health needs of adolescents and young adults, including utilizing assessment tools and methods that take into account early detection indicators for mental illness such as self-mutilation and other markers. All youth who enter the program will have a bio-psycho-social assessment completed. This will give a base-line of the youth's mental health and substance abuse status. In addition, an assessment tool will be developed so that youth can complete self-evaluations (quarterly) and be equipped to self-report their own status of well being. The PEI Coordinator/Clinician will work with the UYC to develop this diagnostic survey/assessment that will determine client satisfaction, measure referral follow through, and integrate a developmental and sequential process. Individual counseling will be offered at the center by a counselor or a Spiritual Advisor.

Other services offered by the UYC will involve weekly structured activities for urban AI/AN youth including psycho-educational groups and culture classes. The UYC will serve as a central location for local tribal youth to meet, work on homework, learn about culture, and, in a structured format, learn how wellness relates to mental, spiritual, emotional, and physical health. An annual Youth Conference for all AI/AN youth in San Diego County will be planned for youth to gather, enhance awareness about culture and how culture relates to wellness and balance, and increase knowledge of other youth programs in the area. In addition, the Urban Youth center will provide access to other health care services on-site such as medical, dental, and HIV testing and counseling.

Elder Services/Navigator Program

In alignment with a family-centered approach, the Elder Services/Navigator Program will support and sustain a key population in AI/AN culture, elders. As part of prevention programming offered across all age groups, the elder project will ensure intergenerational activities so that youth can benefit from the experiences of survival and self-sufficiency the

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elders can offer. Additionally, connection to culture, language, and community are known resilience factors in the AI/AN communities. This project can best be visualized in the context of a community event, where the Elder Navigator will be present with their peers, hearing and learning about community issues and providing support to other elders, families, youth, and community members. Members of the community will be linked, through the Elder Navigator, to needed services, information, and referrals. These cultural events will include a set aside area specifically for elders, where they will be served coffee, under the shade of a canopy or a grove of trees. The Elder Navigator positions will be present and unobtrusively provide essential support and linkages in a cultural format in each of the communities. When no events are occurring, the Elder Navigator will conduct outreach in partnership with other clinic outreach workers. This will include making visits to homes and community centers and continuing their role by staying in touch with the community in a culturally-dictated manner.

The Elder Navigators, along with other clinic staff, will outreach to AI/AN elders and their families to ensure access and participation in local and community-wide wellness activities and events. Through this process, individuals may be screened and assessed for mental health risk and referred or self-referred to a menu of services. These services may include activities such as exercise classes, intergenerational activities, financial awareness, social events, cultural activities, and counseling services.

Services will be offered at established clinic locations and other sites in the AI/AN community that are known, trusted, centrally located, and accessible by public transportation. The Elder Service Navigator component will integrate with the Outreach and Prevention Education component of this PEI project in order to assist with early detection of depression, effects of trauma, and other markers for mental health issues.

Outreach and Prevention Education

Outreach and Prevention Education will promote awareness of PEI services and focus on suicide prevention and the emphasis of promoting and maintaining community, family, and individual wellness at community events, gatherings, and public relations campaigns. This will be accomplished through the use of existing Community Health Outreach Workers, the development of marketing materials and brochures, and making age and culturally appropriate presentations in the community. Marketing materials will be placed in a variety of locations including clinics, Tribal Halls, Tribal Social Service programs and schools. Efforts will be made to ensure all Consortium and community partners are aware of available PEI services. Clinic outreach will ensure awareness of services and assist in recruiting new AI/AN and their family members for Consortium agency services. These strategies will provide multiple access points for family members of all age groups to participate in wellness activities that support a well family and reduce risk.

A diagnostic survey/assessment will be created in partnership with the PEI Coordinator/Clinician for the Outreach and Prevention Education component in order to determine client satisfaction, measure referral follow through, and integrate a developmental and sequential process.

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A Suicide Prevention program will be part of the Outreach and Prevention Education component. The program will address a challenging and critical issue facing AI/AN communities in San Diego County. This component will coordinate and organize activities to increase awareness of suicide risk, identify signs of and early detection of suicide risk, and promote community wellness through the involvement in cultural and social activities known to support individual and community resilience.

During community events, outreach workers and, at times a clinician or other qualified counseling and support staff, will hand out brochures and provide presentations about the importance of Suicide Prevention by engaging in social, communal, and cultural activities. An announcement will be made that services and counseling are available for those who think they may need additional support and a promotional effort will be made to pass along the word that services are available. The Consortium members will identify those activities and events that support wellness and programs that are appropriate as preventive efforts to maintain wellness. During periods of time when events are not occurring, the staff will follow up on referrals, provide support to individuals and families who are at risk and in need of linkages to on-going services, and make referrals to a clinician for assessment and/or treatment services. All key staff will be trained to identify individuals who need additional support and who may also be at risk for suicide.

Key Milestones and Timelines

- Receive California DMH approval for plan – Month 1
- Contract and Statement of Work negotiated with lead agency (Indian Health Council) and Consortium partners – Months 1-2
- On-going meetings of the Consortium leadership and Community roundtables – At least monthly beginning in first month
- Finalize organization infrastructure for project implementation and complete MOA with Consortium partners – Months 1-2
- Hire shared PEI Coordinator/Clinician – Months 1-2
- Create and update Memoranda of Agreement and Letters of Support for referral to agencies outside Consortium – Months 2-3
- Hire other key staff that will support the project – Months 2-4
- Staff training begins – Months 2-4 (on-going for first year)
- Identify and/or develop culturally appropriate diagnostic survey/assessments for each of the PEI components – Months 3-6
- Identify location for Urban Youth Project – Month 3
- Begin PEI program services – Month 3

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- Develop PEI promotional and other educational materials – Months 4-6
- Review data for development of culturally appropriate diagnostic survey/assessment for early intervention programs – Month 6 and ongoing

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Urban Youth Center	Individuals:65 annually Families:	Individuals: 30 annually Families:	
Elder Services Program with an Elder Navigator	Individuals: 89 annually Families:	Individuals: 10 annually Families:	
Outreach and Prevention Education to San Diego American Indians/Alaska Natives	Individuals: 1700 annually Families:	Individuals: 135 annually Families:	
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 1854 annually Families: 0	Individuals: 175 annually (duplicated) Families: 0	

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

The Consortium will utilize a credentialed mental health provider that will devote time in different San Diego County locations:

- North San Diego – Indian Health Council and Pauma Valley;

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- Central/urban – San Diego American Indian Health Center and downtown; and
- East inland – Southern Indian Health Council, Alpine and Sycuan Medical/Dental, El Cajon.

During outreach and prevention education activities, agency staff will inform community members of PEI services and individuals may self-select for screening or be referred for follow up with the shared clinician, the Suicide Prevention program, the Elder Services/Navigator Program, or the Urban Youth Center. Such individuals will be screened and assessed for risk of mental health and co-occurring disorders as appropriate.

For those with higher levels of mental health needs, including clients with serious mental illness, each will be provided with referrals to treatment services that currently exist at the clinics, MHSA Community Services and Supports (CSS) programs, or additional County or tribal-funded behavioral health treatment programs. The Consortium clinics currently refer to and utilize a number of County Mental Health Services, community agencies, and other Tribal and non-Tribal programs that serve those with and at-risk for mental health issues. These include programs that address domestic violence, temporary residential services, counseling, food assistance programs, and workforce development. Agencies include the Center for Community Solutions, Child Welfare Services Indian Specialty Unit, Foster Care Training Recruitment, Home Licensing, Alcohol and Drug Services, Child and Adult Mental Health Services, Aging and Independent Services, and San Diego Hospice.

The Consortium agencies will maintain an on-going list of agencies for specialty referral and each agency will ensure Memoranda of Agreements and Letters of Support are on file. Many agencies currently make referrals in the areas of basic needs, substance abuse treatment, and community, domestic, or sexual violence prevention/intervention when these services are not available on site. In addition, Consortium agencies will become more involved with the Behavioral Health System of Care (SOC) councils (e.g., Adult, Older Adult, Children's) and meetings. As contractors, the entities will attend and participate in the quarterly Leadership Plus meetings and provide information and/or presentations on Consortium activities at various meetings in the mental health/social service arena (e.g., Commission on Children, Youth and Family; Mental Health Board).

The Consortium agencies – Indian Health Council, Southern Indian Health Council, San Diego American Indian Health Center, and Sycuan Medical/Dental – have been serving the Native American community in San Diego for over 20 years. Each agency maintains policies and procedures in accordance with HIPAA and currently offer related services on a limited basis. The proposed project will support service expansion in response to community needs and reduce mental health risk among Native Americans in San Diego County.

Individuals in need of resources will also be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues. While the Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will also

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then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services

Urban Youth Center (only):

Per our PEI screening and assessment process at the Urban Youth Center, staff will refer youth to outpatient therapy at SDAIHC's Behavioral Health Department. If youth need a more intensive level of care, such as adolescent day treatment, an intensive youth outpatient substance abuse program, or a residential substance abuse program, SD County resources will be utilized. Youth will also be referred to local Indian youth residential programs if appropriate.

Youth will also be referred to SDAIHC's medical clinic if they need medical or dental referrals. If a youth comes from a non-enrolled Indian family and they (and/or youth's family) need medical care, the parent of the youth will be offered assistance in applying for appropriate benefits by the Outreach Department.

6. Collaboration and System Enhancements

As a result of the engagement process for the MHSA PEI component planning, the four primary health providers to American Indians/Alaska Natives in San Diego County have formed a Consortium to ensure coordination, linkages, and seamless referral among providers. This approach also ensures a non-competitive process, which reduces gaps in services by enhancing coordination of PEI services to AI/ANs in the County. The Consortium process will strengthen the ability to provide a continuum of care by sharing resources across rural, reservation, and urban service areas. Subsequently, a family member in one area of the county who may have family in a different agency's service area will receive coordinated care for both the individual and the family through the Consortiums' shared goals and objectives, irrespective of their location.

Members of the Consortium maintain collaborative relationships with San Diego law enforcement, Juvenile probation, Southern California Tribal Chairman's Association-Tribal TANF and Tribal Court, Office of Education, Hospice, other providers that participate in CPT (Child Protection Team), and other case planning groups.

A recommendation through community input is to conduct community roundtables with service providers to ensure effective networking and increase referral. The Consortium will meet regularly to identify challenges and solutions in a framework of building successful collaboration.

Program staff at various levels (case managers, coordinators, outreach workers, directors) will also have an increased awareness of the menu of services available as a result of on-going community roundtable meetings and increasing networking opportunities across Tribal and non-Tribal providers. Regular meetings will also support the ability for specialty training for all providers and the opportunity to investigate the usefulness of promising practices or evidence based practices for future use.

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Consortium agencies will leverage a collective interest and some resources to support the overall success of the project. For example, the reservation-based agencies will provide transportation for youth to large youth-focused events held in the urban area and the urban program will provide transportation for youth to the reservation areas. The Consortium leadership will meet regularly to ensure successful execution and completion of proposed goals and objectives. Finally, partnerships with schools will occur for outreach, prevention, and education purposes.

7. Intended Outcomes

Elder Services Program with an Elder Navigator:

- Elders will demonstrate increased awareness of eligibility for services – measured by number of individuals reached and/or utilization of services.
- Elders will demonstrate increased knowledge of social, emotional, and behavioral issues – measured by developed assessment instruments and/or utilization of services.
- Elders will demonstrate increased knowledge of risk and resilience/protective factors – measured by developed assessment instruments and/or utilization of services.

Outreach and Prevention Education to San Diego American Indians/Alaska Natives:

- Increased awareness of eligibility for services – measured by developed assessment instruments.
- Increased awareness of Community wellness activities and PEI efforts of Consortium – measured by developed assessment instruments and/or utilization of services.
- Increased knowledge of social, emotional, and behavioral issues – measured by developed assessment instruments and/or utilization of services.
- Increased knowledge of risk and resilience/protective factors – measured by developed assessment instruments.
- Increase in the numbers screened for suicide risk – measured by tracking reports of those screened and/or utilization of services.
- Increase in the numbers participating in wellness activities – measured by an increase in attendance in such events.
- Increased social support – measured by developed assessment instruments.
- Satisfaction with linkage/referral process – measured by developed assessment instruments.
- Reduced stigmatizing attitudes towards people with mental illness – measured by developed assessment instruments.

Urban Youth Center:

- Increased school attendance and performance at school – measured by school attendance records and grades.

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- Increase of teens remaining clean and sober (not going into a residential rehab setting) – measured by developed assessment instruments.
- Increased awareness and involvement culture/community activities – measured by developed assessment instruments and satisfaction surveys to measure change in awareness of activities and/or utilization of services.
- Increased participation in cultural and self-esteem activities that support wellness and prevent severe mental illness onset – measured by attendance at events.
- Enhanced resilience and protective factors – measured by developed assessment instruments.
- Improved mental health status – measured by developed assessment instruments and/or utilization of services.
- Reduced isolation – measured by developed assessment instruments.
- Increased youth and community wellness, due to increased awareness of menu of wellness and cultural programs across urban and reservation areas – measured by the increase participation across these areas.
- Increased health and access to healthcare services, due to outreach and eligibility efforts – measured by the change in number of new clients/new patients for clinics over time.

System and Program Outcomes:

- A stronger and enhanced coordination of efforts among AI/AN providers.
- A community-wide and family-centered approach to wellness and/or utilization of services.
- Increase in number of AI/AN organizations with capacity to ensure effective linkage to services.
- Enhanced wellness and mental health promotion in partner organizations.

8. Coordination with Other MHSA Components

Members of the Consortium currently coordinate with Community Services and Supports programs and have participated in the recent federal review process. Referrals are currently made to Children's Hospital, San Diego Regional Center, County Mental Health, San Diego Hospice, Palomar Family Counseling in Escondido, County programs for residential placement for substance abuse issues, independent therapists who have experience working with Native Americans and fit with independent needs and/or insurance requirements, and The Center for Social Services.

This Plan will also benefit from the Primary and Secondary Prevention Plan (PS01) in the following ways:

- Media Campaign – The campaign will include elements that address raising public awareness about the risk factors and warning signs of suicide. The campaign will also incorporate cultural perspectives in the resulting printed materials and TV/radio/print ads.
- The Native American Consortium members shall participate on the Interagency Suicide Meeting (referenced in PS01). In being a member of this group, they will assist to develop the County's suicide action plan and ensure

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cultural sensitivity and awareness for the distinct needs of the target population that they represent and provide PEI services for.

- Suicide Prevention services offered through PEI will be included in Primary Prevention printed materials (described in PS01). This will assist to raise awareness about the availability of suicide prevention services funded under MHSA in San Diego County.

Through the Breaking Barriers project, funded with PEI planning dollars, a cultural broker has been engaged to work directly with the local AI/AN community. This individual is American Indian and is known in the local AI/AN community. This position will be used to provide outreach and engagement support with existing AI/AN agencies and will assist in communicating identified needs that arise in the community as well as recommend strategies to be addressed through PEI programming or other County programs. If successful, this position may be expanded.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): Native American Communities
 Program ID/Name: **NA01A Collaborative Native American Initiative - Elder Services Program with Elder Navigator**
 Provider Name (if known): San Diego Native American Consortium
 Provider Category (DMH List): Ethnic or Cultural Organization

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	89
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	89
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
	Classification	FTE	Per FTE			
	Manager & Supervisors	0.25	\$70,000	\$0	\$17,500	\$17,500
	Licensed Clinician	0.25	\$80,000	\$0	\$20,000	\$20,000
	Counseling & Support Staff	0.50	\$50,000	\$0	\$25,000	\$25,000
	Elder Navigator	2.00	\$38,000	\$0	\$76,000	\$76,000
	Education/Training Staff	0.25	\$30,000	\$0	\$7,500	\$7,500
	Admin Support (Admin Asst, Secr, Clrk)	0.30	\$28,000	\$0	\$8,400	\$8,400
		0.00	\$0	\$0	\$0	\$0
	Total FTE	3.55	Sub-Total	\$0	\$154,400	\$154,400
	b. Benefits% @	27.0%		\$0	\$41,688	\$41,688
c. Total Personnel/Staffing Expenses				\$0	\$196,088	\$196,088
2. Operating Expenditures						
	Indirect/Administrative Costs		\$43,689	\$0	\$43,689	\$43,689
	Operating Costs (includes Facility Costs)		\$78,235	\$0	\$78,235	\$78,235
	Start-Up/One-Time Only Costs*		\$39,000	\$0	\$39,000	\$39,000
c. Total Operating Expenses				\$0	\$160,924	\$160,924
3. Subcontracts/Professional Services (list/itemize)						
				\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$0	\$0
4. Total Proposed PEI Program Budget				\$0	\$357,012	\$357,012
B. Revenues (list/itemize by fund source)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$357,012	\$357,012
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**
Program ID/Name: **NA01A Collaborative Native American Initiative - Elder Services
Program with Elder Navigator**

Program Budget - Proposed Program services will be provided by a consortium of San Diego County Native American health service providers through contract with the County of San Diego. County staff are negotiating with the consortium to develop and implement innovative proposals that optimize performance and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on consultation of County staff with the Native American consortium using County and consortium experience and expertise and current consortium services staffing.

Clients and Family Members - Native American consortium will recruit, hire, and retain qualified mental health clients and family members.

Position(s) targeted: Counseling and Support Staff, .05 FTE and Education/Training Staff, .25 FTE.

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize differences in service needs, economies of scale, and costs of current Native American consortium programs.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

B Revenues:

The Native American consortium will leverage available other revenues to enhance or expand services.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): Native American Communities
 Program ID/Name: **NA01B Collaborative Native American Initiative - Urban Youth Center**
 Provider Name (if known): San Diego Native American Consortium
 Provider Category (DMH List): Ethnic or Cultural Organization

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	65
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	65
Estimated Months of Operation:	0	12

			Total Program/PEI Project Budget		
Proposed Expenses and Revenues	Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure					
1. Personnel/Staffing					
a. Salaries, Wages					
Classification	FTE	Per FTE			
Behavioral Health Director	0.25	\$72,800	\$0	\$18,200	\$18,200
Licensed Clinician	0.25	\$80,000	\$0	\$20,000	\$20,000
Counseling & Support Staff	1.00	\$52,000	\$0	\$52,000	\$52,000
Counselor-CADAAC Level 1	0.75	\$42,000	\$0	\$31,500	\$31,500
Youth Counselor	1.00	\$28,000	\$0	\$28,000	\$28,000
Admin Support (Admin Asst, Secr, Clrk)	0.25	\$28,000	\$0	\$7,000	\$7,000
Education/Training Staff	0.25	\$30,000	\$0	\$7,500	\$7,500
	0.00	\$0	\$0	\$0	\$0
Total FTE	3.75	Sub-Total	\$0	\$164,200	\$164,200
b. Benefits%	@ 27.0%		\$0	\$44,334	\$44,334
c. Total Personnel/Staffing Expenses			\$0	\$208,534	\$208,534
2. Operating Expenditures					
Indirect/Administrative Costs		\$76,293	\$0	\$76,293	\$76,293
Operating Costs (includes Facility Costs)		\$144,483	\$0	\$144,483	\$144,483
Start-Up/One-Time Only Costs*		\$54,000	\$0	\$54,000	\$54,000
c. Total Operating Expenses			\$0	\$274,776	\$274,776
3. Subcontracts/Professional Services (list/itemize)					
		\$0	\$0	\$0	\$0
		\$0	\$0	\$0	\$0
		\$0	\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses			\$0	\$0	\$0
4. Total Proposed PEI Program Budget			\$0	\$483,310	\$483,310
B. Revenues (list/itemize by fund source)					
		\$0	\$0	\$0	\$0
		\$0	\$0	\$0	\$0
		\$0	\$0	\$0	\$0
1. Total Revenue			\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program			\$0	\$483,310	\$483,310
D. Total In-Kind Contributions			\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**

Program ID/Name: **NA01B Collaborative Native American Initiative - Urban Youth Center**

Program Budget - Proposed Program services will be provided by a consortium of San Diego County Native American health service providers through contract with the County of San Diego. County staff are negotiating with the consortium to develop and implement innovative proposals that optimize performance and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on consultation of County staff with the Native American consortium using County and consortium experience and expertise and current consortium services staffing.

Clients and Family Members - Native American consortium will recruit, hire, and retain qualified mental health clients and family members.

Position(s) targeted: Counseling and Support Staff, 1.00 FTE; Youth Counselor, 1.00 FTE; and Education/Training Staff, .25 FTE.

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize differences in service needs, economies of scale, and costs of current Native American consortium programs.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

B Revenues:

The Native American consortium will leverage available other revenues to enhance or expand services.

PEI Revenue and Expenditure Budget Worksheet

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Form No. 4

Date: 10/31/08

County:

SAN DIEGO

Workgroup - Focus Area (Cnty PEI List):

Native American Communities

Program ID/Name:

NA01C Collaborative Native American Initiative - Outreach and Prevention Education to San Diego American Indians/Alaska Natives

Provider Name (if known):

San Diego Native American Consortium

Provider Category (DMH List):

Ethnic or Cultural Organization

Proposed Total Number of Individuals/Families to be served:

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	1700
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	1700
Estimated Months of Operation:	0	12

Total Number of Individuals/Families currently being served:

Total Number of Individuals/Families served through PEI Expansion:

Estimated Months of Operation:

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
	Classification	FTE	Per FTE			
	Manager & Supervisors	0.15	\$70,000	\$0	\$10,500	\$10,500
	Licensed Clinician	0.25	\$80,000	\$0	\$20,000	\$20,000
	Counseling & Support Staff	4.50	\$50,000	\$0	\$225,000	\$225,000
	Health Educator	0.50	\$35,000	\$0	\$17,500	\$17,500
	Education/Training Staff	0.10	\$30,000	\$0	\$3,000	\$3,000
	Admin Support (Admin Asst, Secr, Clrk)	0.25	\$28,000	\$0	\$7,000	\$7,000
		0.00	\$0	\$0	\$0	\$0
	Total FTE	5.75	Sub-Total	\$0	\$283,000	\$283,000
	b. Benefits% @	27.0%		\$0	\$76,410	\$76,410
c. Total Personnel/Staffing Expenses				\$0	\$359,410	\$359,410
2. Operating Expenditures						
	Indirect/Administrative Costs		\$77,293	\$0	\$77,293	\$77,293
	Operating Costs (includes Facility Costs)		\$58,794	\$0	\$58,794	\$58,794
	Start-Up/One-Time Only Costs*		\$54,000	\$0	\$54,000	\$54,000
c. Total Operating Expenses				\$0	\$190,087	\$190,087
3. Subcontracts/Professional Services (list/itemize)						
				\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$0	\$0
4. Total Proposed PEI Program Budget				\$0	\$549,497	\$549,497
B. Revenues (list/itemize by fund source)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$549,497	\$549,497
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**

Program ID/Name: **NA01C Collaborative Native American Initiative - Outreach and Prevention Education to San Diego American Indians/Alaska Natives**

Program Budget - Proposed Program services will be provided by a consortium of San Diego County Native American health service providers through contract with the County of San Diego. County staff are negotiating with the consortium to develop and implement innovative proposals that optimize performance and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on consultation of County staff with the Native American consortium using County and consortium experience and expertise and current consortium services staffing.

Clients and Family Members - Native American consortium will recruit, hire, and retain qualified mental health clients and family members.

Position(s) targeted: Counseling and Support Staff, 4.50 FTE and Education/Training Staff, .10 FTE.

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize differences in service needs, economies of scale, and costs of current Native American consortium programs.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

B Revenues:

The Native American consortium will leverage available other revenues to enhance or expand services.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County:

SAN DIEGO

Workgroup - Focus Area (Cnty PEI List):

Native American Communities

Program ID/Name:

NA01D Collaborative Native American Initiative - Suicide Prevention Program

Provider Name (if known):

San Diego Native American Consortium

Provider Category (DMH List):

Ethnic or Cultural Organization

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	810
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	810
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
Classification	FTE	Per FTE				
Manager & Supervisors	0.25	\$70,000		\$0	\$17,500	\$17,500
Licensed Clinician	0.25	\$80,000		\$0	\$20,000	\$20,000
Counseling & Support Staff	3.00	\$55,000		\$0	\$165,000	\$165,000
Admin Support (Admin Asst, Secr, Clrk)	0.25	\$28,000		\$0	\$7,000	\$7,000
	0.00	\$0		\$0	\$0	\$0
Total FTE	3.75	Sub-Total		\$0	\$209,500	\$209,500
b. Benefits%	@	27.0%		\$0	\$56,565	\$56,565
c. Total Personnel/Staffing Expenses				\$0	\$266,065	\$266,065
2. Operating Expenditures						
Indirect/Administrative Costs		\$52,292		\$0	\$52,292	\$52,292
Operating Costs (includes Facility Costs)		\$44,824		\$0	\$44,824	\$44,824
Start-Up/One-Time Only Costs*		\$44,000		\$0	\$44,000	\$44,000
c. Total Operating Expenses				\$0	\$141,116	\$141,116
3. Subcontracts/Professional Services (list/itemize)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$0	\$0
4. Total Proposed PEI Program Budget				\$0	\$407,181	\$407,181
B. Revenues (list/itemize by fund source)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$407,181	\$407,181
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**

Program ID/Name: **NA01D Collaborative Native American Initiative - Suicide Prevention**

Program Budget - Proposed Program services will be provided by a consortium of San Diego County Native American health service providers through contract with the County of San Diego. County staff are negotiating with the consortium to develop and implement innovative proposals that optimize performance and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on consultation of County staff with the Native American consortium using County and consortium experience and expertise and current consortium services staffing.

Clients and Family Members - Native American consortium will recruit, hire, and retain qualified mental health clients and family members.

Position(s) targeted: Counseling and Support Staff, 3.00 FTE.

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize differences in service needs, economies of scale, and costs of current Native American consortium programs.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

B Revenues:

The Native American consortium will leverage available other revenues to enhance or expand services.

PEI PROJECT SUMMARY

Form No. 3

PEI Project Name: Triple P - Positive Parenting Program

County: San Diego

Date: 11/19/08

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

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	☐	☐	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☐
3. Children and Youth in Stressed Families	☒	☐		
4. Children and Youth at Risk for School Failure	☒	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		
6. Underserved Cultural Populations	☒			

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).

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Early Childhood and Parenting as one of our 10 priority focus areas.

The following input was provided through numerous venues by a broad range of stakeholders:

- Provide support and consultant-type services to parents/families, child care providers, and physical health providers;
- Target high-risk children – parent/family incarcerated, foster care, teen mothers, child "expelled" from child care;
- Develop marketing and outreach to general population on age group mental health issues;
- Ensure transition/integration of services for child development from home to child care to schools;
- Educate/train school and day care staff to identify at-risk students and to help them access services;
- Educate parents to identify their behaviors that may put their children at-risk;
- The SD Head Start program has over 5,000 children county-wide that could benefit from PEI collaboration with screening & therapeutic play & psycho-education (with teachers & parents);
- Work with childcare providers to reduce the number of children expelled from childcare/preschool due to challenging behaviors/special needs; pre-school students are expelled at a rate three times that of K-12 students;
- Increase the emphasis/scope of developmental assessments through First Five to emphasize behavioral/emotional screening for kids ages 0-5;
- Train childcare providers to facilitate screening and behavioral interventions; use kindergarten as a first point of entry where all kids are present; universally train kindergarten teachers and parents to provide behavioral interventions;
- Link preschool to kindergarten;
- All programs should be for children AND parents so that they can all come together to prevent a family breakdown;
- Educate/train parents/families to accept accountability, identify at-risk behaviors, and help family members to access services;
- For the 0-5 population, include pro-attachment and bonding supports through multi-media and public health nursing, home visits;
- Educate/train existing community (health care providers, businesses), public (schools, family courts, law enforcement), and veterans service organizations to recognize service needs and help veterans and families access services;

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- Need services outside of existing military environments to reduce stigma, increase confidentiality, and allow active duty military personnel and their families to access services;
- Need to address family issues that may contribute to an at-risk individual's behavioral health problems;
- Military members and their families are often disconnected from their home-community support systems;
- Educate/train staff of community organizations, public systems (schools, law enforcement, justice, social services), physical health services (hospitals, physicians), family, and peers (military, faith-based organizations) to identify at-risk persons and help them access services; and develop a standardized curriculum and provide "certification."

Following the extensive community input processes, a workgroup formed to focus on the 0 to 5 age range needs. With careful attention paid to avoid conflict of interest, experts from the childcare field, mental health, drugs and alcohol, First 5 Commission, special education, outcome/research specialist, as well as courts and forensics began deliberation towards formulating a program design. Stakeholder input was reviewed, elaborated upon and researched.

Based on the assessment of need, specifically for under-served and under-represented cultural populations, the workgroup members reached out to obtain additional and specific information from local Head Start providers. The Triple P America program model was determined to be an evidenced-based model that showed strong likelihood of meeting local need and, as a result, the Positive Parenting Program was formulated.

The program will focus on providing the Triple P model in Head Start and Early Head Start centers; the federally funded child development program established in 1965. Subsequent sections will elaborate on how the Triple P model lends itself especially well to prevention and early intervention focus, as well as highlight the benefit of selecting Head Start centers as a way of reaching high-risk children due to living in poverty.

In addition to the community stakeholder input, the workgroup looked at the following additional data and research in developing a response to the community need and to inform the development of the work plan:

- The 2007 San Diego County Report Card on Children and Families references recent brain research and other studies which indicate that we must provide environments that are nurturing and enriched beginning with babies. Research demonstrates that early childhood care and education in a quality setting can improve the school readiness and overall development of young children. It also can improve their education, employment and other positive outcomes throughout life. Thus, quality early care and education from birth to five years can not only help a child, but also produce economic benefits to society that far exceed the initial investment.
- Furthermore, the 2007 San Diego County Report Card on Children and Families identifies the need for more mental health consultants to provide services to children (families) in early child care settings and work with staff to improve the quality of early care.
- Numerous publications support that the child who plays, talks, resolves disagreements, and collaborates with peers and adults strengthens his or her social competence and is therefore more likely to have better mental health,

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stronger relationships and more success in school and work. (Hartup, W.W. Having Friends, Making Friends, and Keeping Friends: Relationships as Educational Contexts ERIC Digest. Champaign, IL: ERIC Clearinghouse on Elementary and Early Childhood Education, 1992).

- Parents have a direct impact on the progress of their child's cognitive development because children learn about language through speech they hear and the activities they engage in at home. The development of language and reading skills is fundamental to a child's academic success, as well as success throughout life. Children need to have reached a certain level of cognitive development prior to entering kindergarten, as research has shown increasingly stringent expectations for academic excellence from children at a younger age (Walsh, "Changes in Kindergarten: Why here? Why now?" Early Childhood Research Quarterly, 1989, 4, 377-91).
- Direct linkage exists in showing that a parent's confidence in their parenting ability, partnered with knowledge of child development, is related to how the parent interacts with the child. (Conrad B., D. Gross, L. Fogg and P. Ruchala. "Maternal Confidence, Knowledge, and Quality of Mother-Toddler Interactions: A preliminary Study." Infant Mental Health Journal, 1992, 13.4, 353-62).

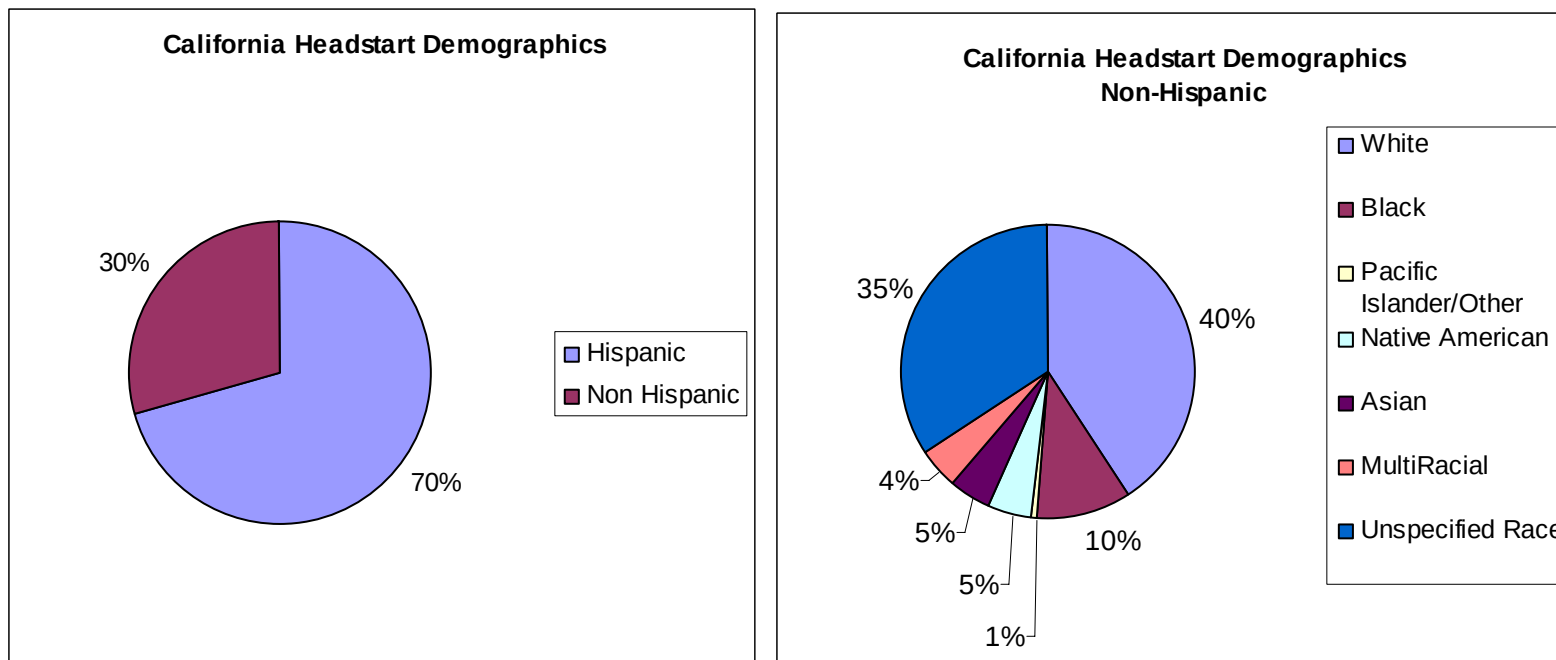
Rationale for Head Start Population

The following data and input was utilized to inform the selection of the Head Start population for this program:

- 2007 San Diego County Report Card on Children and Families discusses how living in poverty puts children at increased risk for a range of problems. The more severe the poverty or more years a child lives in poverty, the worse the outcomes. Poor children are disproportionately exposed to risk factors that may impair brain development and affect social and emotional development. This research directly supports the selection of Head Start as the target population, as it is set up to serve children in families earning income at or below the federal poverty level.
- The California Head Start Association notes total Head Start funded enrollment for fiscal year 2007 at 104,606. The majority of enrollment in Head Start is defined as 3 to 5 years old at 90,787 youth. Early Head Start for 0 to 3 years old at 7,608 youth. Migrant and Seasonal Head Start enrollment at 5,553 and Tribal Head Start enrollment at 658.
- The California Head Start Association provides the following 2007 program statistics regarding demographics:

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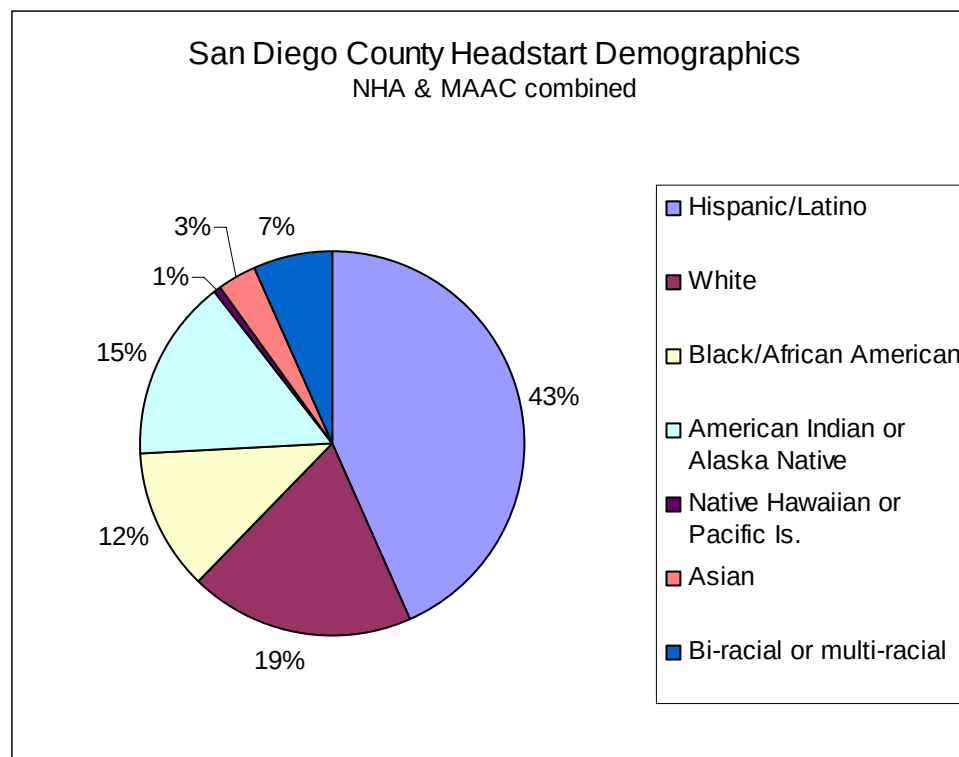
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- In 2008, the County of San Diego had two Head Start grantees being the MAAC project serving the communities of Valley Center, San Marcos, Vista, Fallbrook, and Oceanside, and Neighborhood House Association (NHA) which predominantly serves the Central, North Coastal, North Central, and North Inland regions.
- MAAC Project offered 14 Head Start Centers (HS) and 4 Early Head Start Centers (EHS).
- Neighborhood House Association operated 85 centers with roughly 250 classrooms.
- Neighborhood House Association had two delegate agencies being Episcopal Community Services serving the South Bay region and Alpha Kappa Alpha located in the East region.
- In September of 2008, a number of additional Head Start/Early Head Start providers have been incorporated including Unified School District and Children of the Rainbow.
- In 2007/2008, the two San Diego County Head Start Providers, NHA and MAAC, served approximately 9,700 children. The following chart outlines the demographic breakout of those served:

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Central Region Data

- In February 2005, the Child Care Needs Assessment in the Diamond Neighborhoods of Southeastern San Diego (known as the Central Region with zip codes 92102, 92105, 92113, 92114) assessed the need for parenting education/training classes for the 0 to 5 age group.
- Using data from SANDAG, Data Warehouse for 2000 illustrates high need in the Central Region (92103, 92113, 92115, 92105, 92114, 92116) based on families below poverty level with high Head Start and Early Head Start enrollment.
- The First 5 Commission of San Diego County 2005 Family Survey Report indicates that the Central Region had the lowest level of daily parental participation, which is linked to increased success throughout life.

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North Coastal and Military Data

- Since 2001, approximately 1.64 million U.S. troops have deployed as part of Operation Enduring Freedom (OEF, Afghanistan) and Operation Iraqi Freedom (OIF, Iraq). The pace of the deployments in current conflicts is unprecedented in the history of an all-volunteer force. Mental health conditions are emerging and, aside from direct impact on the individual, impact can lead to impaired relationships, disrupted marriages, aggravate the difficulties of parenting, and cause problems in children that may extend the consequence of combat experiences across generations. It is noted that improving access to mental health services for OEF/OIF veterans will require reaching beyond the Department of Defense and the Department of Veterans Affairs health care systems (Center for Military Health Policy Research. *Invisible Wounds of War – Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*).
- The military population in San Diego County is vast with 125,000 individuals currently on active duty [60% White, 17% Hispanic, 13% Black, 6% Asian, 1% American Indian, and 3% other (extrapolated from US census 2000 data)].
- In addition, San Diego County is home to 292,000 veterans and that number is increasing by an average of 17,000 annually. If we add the families of active duty military and veterans there are in excess of **1,000,000** Veterans, Military and their families in San Diego County.
- Civilian Veterans and Families: 627,500 (includes spouses and dependents)
- Recent news from the Pentagon states that 20% of service members returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) are dealing with mental health issues. This percentage increases the more often the member is deployed. San Diego County has services in place to assist its existing military population and families, but as OEF/OIF operations continue and the number of returning vets climbs ever higher, we are in danger of being overwhelmed by the number of veterans and their families needing reintegration and family supports.

High concentrations of military families reside in the North Coastal region of the county. According to information provided by the MAAC Project Head Start, five of the Head Start/Early Head Start centers in the region have high military involvement (Camp Pendleton, Fallbrook, and three Centers in Oceanside). Due to all of these factors, an additional emphasis will be made to serve enrolled Head Start children from military families in this project.

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3. PEI Project Description:

This program will utilize the **Triple P – Positive Parenting Program** at Head Start (HS) and Early Head Start (EHS) Centers (some of which will be located on elementary school campuses) to strengthen the skills of parents, HS/EHS center staff, and educators to promote the development, growth, health, and social competence of young children.

The 0 to 5 age group and Triple P model directs services to benefit the child by working with the parent/caregiver. The program design will be set up to work in collaboration with the Head Start staff and school personnel to promote their education and enhance their ability to work with the child as well as provide on going support to the family/caregiver once the Triple P curriculum is completed.

The prevention model focuses on reducing the risk for behavioral/emotional problems in young children. This outcome will be achieved through reducing the prevalence of coercive or inappropriate parenting behaviors that could lead to child maltreatment. Early intervention occurs by providing assistance for parents of young children who are beginning to show behavioral or emotional difficulties. The program will serve the Central and North Coastal regions of San Diego as outlined in data analysis section of this document. Potential bidders may include mental health service providers, community based organizations, universities, and schools. Selected provider will develop a Memorandum of Understanding (MOU) with Head Start providers in order to provide the Triple P model in Head Start centers.

Triple P, by design, has multiple levels of program intensity to match the differing needs of parents/caregivers. The selected provider will obtain accreditations to provide the following three levels:

Selected Triple P is a series of three, one-time positive parenting seminars delivered to large group of parents/caregivers, which is designed to introduce positive parenting principles and building blocks for raising confident and resilient children as part of providing prevention/early intervention services.

Primary Care Triple P offers 1 to 4, twenty-minute, flexible consultations with individual parents to address common developmental and behavioral problems.

Group Triple P is a parenting skills program administered to groups of parents/caregivers (5 to 12 members per group) to address a broad range of child behavioral/emotional difficulties. This active skills training is offered in 5, two-hour group sessions and 3, twenty-minute (telephone) consultations.

A Triple P team (Parent and Peer Educator) will serve a minimum of one HS/EHS Center for approximately four months, providing the Selected, Primary Care, and Group Triple P curriculum. Five teams serving a minimum of one Head Start Center for four months will result in a minimum of 15 Head Start Centers served annually.

A minimum of three (approximately 20%) of HS/EHS Centers served shall be located on a school campus. This partnership will strengthen the collaboration between mental health and schools, making the Triple P Model available to educators.

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During the four-month interval that the Triple P provider is at a selected HS/EHS Center, they will work with families, Center staff, and educators to maximize prevention through offering all families at the Center education about positive parenting, reduce stigma associated with mental health services, offer early intervention services via brief consultations and/or group sessions, as well as be available to provide referrals as needed. Services will be offered primarily at the Head Start Center, with in-home service availability when needed. Additionally, the model utilizes the use of phone contacts/consultations. Family, Head Start Center staff, and school personnel will have access to the Triple P program provider upon the conclusion of the four month track to obtain follow up consultation.

A licensed or licensed-eligible practitioner will act as the Lead Educator whose primary role will be to provide supervision/support to the Parent/Peer Educator and be a resource to evaluate the need for treatment level referrals to families.

Selection for voluntary early intervention levels offered via Primary and Group Triple P will be based on self referrals/requests by families, center staff suggestion, educators, and observation and recommendation by Triple P staff.

Program staff is to be representative of, and knowledgeable about, the client's culturally diverse backgrounds. Provider will be expected to demonstrate culturally and linguistically sensitive services and will explain how this sensitivity will be incorporated into the program's design. Materials such as tip sheets and workbooks are available in English and Spanish with language equivalent to a sixth grade reading level. The provider will be tasked with coordinating availability of resources in the County's threshold languages.

Annually, a minimum of two positive parenting seminars shall be advertised and offered to the community of parents and providers not directly affiliated with Head Start or schools.

During fiscal year 09/10, a pilot project shall be funded to provide Selected Triple P curriculum at a minimum of five schools per month. One FTE School Specialist position will be established to work with school districts and provide the prevention focused series of three, one-time positive parenting seminars to teachers and parents associated with the identified schools. Official Triple P materials shall be made available to participating schools, as well as follow up consultation as needed.

Through the competitive proposal process, potential providers will be required to outline how they will address the following issues:

- Transportation solutions for program participation,
- Child care options (i.e. for groups outside of center hours), and
- Incentives for program participation.

To address the current need or risk in the military community, a minimum of three Head Start Centers served annually will have a significant level of military family enrollment. Provider will be tasked with developing competencies in the following areas:

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- Military culture;
- Impact and challenges of deployment;
- Reintegrating family members;
- Transition of roles;
- Isolation due to frequent moves;
- PTSD, depression, brain injuries;
- Confidentiality and associated fears with accessing services; and
- Appropriate referrals.

Key Milestones and Timelines

- RFP developed, competitive procurement process completed – Months 1-6 (completed within the first 6 months)
- Contract awarded – Month 7
- Hire staff within the first two months of contract execution – Months 7-8
- Begin staff training and certification, including cultural and linguistic needs of population – Month 7-8
- The selected provider will obtain formal recognition as a Triple P accredited provider for all the direct service staff within the first 4-6 months of contract execution.
- It is expected that the initial start up phase (first 4-6 months) will be spent setting up infrastructure to work with Head Start agencies. This includes the development of policies and procedures. *Note: this may impact the total number served in the first year of the program.*
- A Memorandum of Understanding (MOU) with the appropriate Head Start delegates shall be established in the first 90 days of contract execution and the infrastructure to provide the Triple P model shall be established.
- Draft policies and procedures submitted to County for approval – Month 7
- Outcome tools identified, surveys created – Month 8-9
- Create brochures and purchase materials to be offered at each facility (including materials in multiple languages as appropriate) – Month 9-10
- The program design will include a minimum of five teams of Parent and Peer Educators. The Parent Educator will hold a BA in a related field, with the Peer Educator being a consumer or family member who holds experience as a recipient of public services or as a parent/caregiver.
- Pilot Project is expected to begin serving schools within two months of contract execution.

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4. Programs (projected totals below are based on 12 months of services)

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Early Childhood Services	Individuals: 1,125 Families: 1,125 Pilot Projects: 15,000 (students)	Individuals: 281 Families: 281	
Veterans and Their Families Children/Youth and Family Focus	Individuals: 225 Families: 225	Individuals: 62 Families: 62	
TOTAL PEI PROJECT ESTIMATED UNDULICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 1,125 Families: 1,125	Individuals: 281 (duplicated) Families: 281 (duplicated)	
TOTAL PEI PROJECT ESTIMATED UNDULICATED COUNT OF INDIVIDUALS TO BE SERVED With Pilot Project	Individuals and Families: 16,125		

Notes on Proposed Numbers Served:

Prevention:

A minimum of 15 centers will be targeted annually by five, two member teams. Each of the five teams will serve a minimum of one center per four month period. On average, 75 children are enrolled in a center. All children attending a center will be impacted by education of center staff (potentially current and future children/families making the impacted numbers indirectly larger). All families at a minimum will be welcomed to attend positive parenting seminar and offered additional services through Primary Care Triple P and Group Triple P as needed. (15 centers x 75 children/families = 1,125 children/families) (Adjusted for start up: 10 centers x 75 children/families = 750 children/families).

Additionally, military families are a targeted subgroup. Of the fifteen targeted centers, a minimum of three centers with significant military family enrollment will be served annually (3 Centers x 75 children/families = 225 children/families of 1,125 total – not impacted by start up). Head Start staff will be educated in the Positive Parenting Model and therefore

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impacting a greater number of subsequent children/families enrolled; these numbers are not reflected in the proposed numbers served.

Total Individuals: 1,125 children (975 initial year)

Total Families: 1,125 families will be exposed (975 initial year)

The pilot project will emphasize education of elementary school personnel. Adjusting for start-up time and school schedules, during a 10 month period, five schools are expected to be served monthly resulting in a total of 50 schools trained. Accounting for differences in school enrollment, a conservative estimate of 300 student enrollments per elementary school served, results in a minimum of 15,000 students and families benefiting from Selected Triple P curriculum. Positive Parenting Program provider will work with each school to determine if seminars are to include family participation.

Early Intervention:

Of the approximately 1,125 children and families (750 in initial contract year) who will be exposed to prevention efforts, a higher level of care will be made available through Primary Care Triple P and Group Triple P. Early Intervention services are projected at approximately 25% of those served in prevention component of Triple P (25% of 1125 = 281 / 25% of 750 = 188).

Military Families: Approximately 62 children/families of the total (25% of 250 = 62).

Individuals: 281 (188 initial year)

Families: 281 (188 initial year)

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

- In addition to the primary and formal linkage to Head Start and Early Head Start Grantees through a Memorandum of Understanding (MOU), the provider will be tasked with creating collaborations and partnerships with other providers throughout the County focused on the same overall goal of excellent mental health of young children.
- A strong partnership with the schools is expected through the Pilot Project, serving a minimum of 50 schools. Additionally, a portion of HS/EHS served are expected to be located on a school campus, which will necessitate on-going collaboration.
- Provider will be expected to network with the First 5 Commission of San Diego County Health and Developmental Services (HDS), whose objective is to promote children's optimal development and learning by improving access to professionals who can evaluate a child as early as possible to identify and treat health problems or delays in a

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child's ability to learn. The mission of HDS is to create stronger, more comprehensive systems of services for children's physical, developmental, and behavioral health needs that incorporate and build upon existing networks, resources, and services in each HHSA region of San Diego.

- Providers trained/accredited in the Triple P evidence-based practice will be educated in three levels of the model, which begins with focus on prevention, followed by early intervention, and, ultimately, with treatment. This sensitivity will allow provider to identify those children and families who would benefit from treatment-level interventions available through the Children's Mental Health System. There is an array of mental health services available through a number of different funding streams and service levels that the provider will be able to access. Similarly, family members will be referred through the Adult Mental Health System and Alcohol and Drug Services when additional services are deemed necessary. The programs' clinical lead, who supervises the parent and peer educators, will be available to oversee appropriate assessment and linkage to suitable mental health services.
- Triple P provider will link with the Veterans Military, Reserves, Guard and their Families (VMGRF) PEI provider (VF01) in order to collaborate around specialty needs of the military family. Families served through Positive Parenting Program, which are recognized to need services beyond parenting supports provided through Triple P model, will be provided with a referral to the VMGRF program.

Individuals requiring additional resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues. While the County-funded Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline. This will also then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services.

6. Collaboration and System Enhancements

- The partnership between Head Start and Mental Health is an exciting new opportunity to collaborate and offer prevention and early intervention to the 0 to 5 age group.
- Head Start/Early Head Start is a federally funded child development program for very low-income young children and their families. The primary target population is children between the ages of 0 to 5 from families living below the federal poverty line. The program is based on the premise that all children share certain needs and children from low-income families, in particular, can benefit from a comprehensive developmental program to meet those needs. Head Start/Early Head Start is a family oriented, comprehensive, and community based program to

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address developmental goals for children, support for parents in their work and child rearing roles, and linkage with other service delivery systems.

- Head Start / Early Head Start philosophy rests on four basic principles:
 - o A child can benefit most from a comprehensive, interdisciplinary program to foster normal development and remedy problems;
 - o Parents are the primary educators of their children and must be directly involved in the program;
 - o The well being of children is inextricably linked to the well being of the entire family; and
 - o Partnerships with other agencies and organizations in the community are essential to meeting family needs.
- In addition to serving the Head Start population, the intent is to create broader awareness of positive parenting approaches to the parenting and child development/day care community. One way to meet this goal is by offering a minimum of two parenting seminars annually, beyond the ones offered in the Head Start Centers.
- When appropriate, provider will offer consultation with identified school district where child will be transitioning to.
- On-going dollars shall be made available upon successful achievement of outcomes.

7. Intended Outcomes

- Triple P aims to promote the development, growth, health, and social competence of young children; to reduce the incidences of child abuse, mental illness, behavioral problems, delinquency, and school failure; and to enhance the competence, resourcefulness and self sufficiently of parents raising children.
- The model is both parent and child-centered and readily lends itself to education of center staff and school personal. It builds on strengths and competencies of parents and caregiver staff and extends their knowledge, skills, and confidence.
- The educative approach to promoting parental competence in Triple P views the development of a parent's capacity for self regulation as a central skill. This involves teaching parents skills that enable them to:
 - o Become independent problem solvers,
 - o Select developmentally appropriate goals,
 - o Monitor a child's or the parent's own behavior,
 - o Choose an appropriate method of intervention for a particular problem,
 - o Implement the solution,
 - o Self monitor their implementation of solutions via checklists relating to the areas of concern,
 - o Identify strengths or limitations in their performance, and
 - o Set future goals for action.

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- The provider will utilize the standardized Triple P outcome measures, available upon purchasing of training curriculum.
- The Eyberg Child Behavior Inventory is one of the measures utilized in the model.
- The provider will utilize a pre and post evaluation measure, as well as administer a satisfaction measure, to both family participants and center staff.

8. Coordination with Other MHSA Components

- Upon exposure and involvement with the Triple P Program, which is being set up to be non-intrusive and stigma free, it is hypothesized that families will begin to develop trust and see the benefits of services rendered. Through this process, some children and families are likely to emerge as being eligible for a higher level of intervention such as those programs provided through MHSA-CSS. Through the establishment of a relationship with a provider, referrals can be made or, at minimum, families can be educated about additional supports they may be eligible to receive.
- The Triple P program design is conducive to being delivered by Bachelor and Associate level staff. This allows an employment opportunity for a broader array of individuals who may have experience as consumers or family members of individuals served by the behavioral health system. Some of the program's service staff will be individuals with experience as recipients of services. In fiscal year 08/09, such staff will be eligible for training and on-going support/education through the newly executed contract in the MHSA Workforce Education and Training component, titled Family/Youth Employment Education Training Academy.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 9/8/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): **Early Childhood Services (0-5)**
 Program ID/Name: **EC01 Positive Parenting Program (Triple P)**
 Provider Name (if known): **Pending Competitive Procurement**
 Provider Category (DMH List): **Other**

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	16125*
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	16125
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
Classification	FTE	Per FTE				
Program Manager	1.00	\$70,000		\$0	\$70,000	\$70,000
Licensed/Eligible - Lead Educator	1.50	\$53,000		\$0	\$79,500	\$79,500
Parent Educator (BA)	5.50	\$44,000		\$0	\$242,000	\$242,000
Peer Educator (Para Professional)	5.50	\$34,500		\$0	\$189,750	\$189,750
Office Manager	1.00	\$30,000		\$0	\$30,000	\$30,000
Total FTE	14.50	Sub-Total		\$0	\$611,250	\$611,250
b. Benefits%	@ 27.0%			\$0	\$165,038	\$165,038
c. Total Personnel/Staffing Expenses				\$0	\$776,288	\$776,288
2. Operating Expenditures						
Indirect/Administrative Costs		\$188,500		\$0	\$188,500	\$188,500
Operating Costs (includes Facility Costs)		\$304,500		\$0	\$304,500	\$304,500
Start-Up/One-Time Only Costs*				\$0	\$162,000	\$162,000
c. Total Operating Expenses				\$0	\$655,000	\$655,000
3. Subcontracts/Professional Services (list/itemize)						
Annual Triple P Training and materials		\$80,712		\$0	\$80,712	\$80,712
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$80,712	\$80,712
4. Total Proposed PEI Program Budget				\$0	\$1,512,000	\$1,512,000
B. Revenues (list/itemize by fund source)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$1,512,000	\$1,512,000
D. Total In-Kind Contributions				\$0	\$0	\$0

Budget Notes: *Individuals/Families Served - Includes 1st year Pilot, 15,000, & Ongoing 1,125

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**

Program ID/Name: **EC01 Positive Parenting Program (Triple P)**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals and that improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

Position(s) targeted: Parent Educator (BA), 5.50 FTE and Peer Educator (Para Professional), 5.50 FTE.

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate One-time Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Specialized Training in Evidence-Based Practice
- Consultants to assist Program implementation

A2 Subcontracts/Professional Services

Training - Estimated ongoing costs of providing Triple P training and will include training development, trainers, training facilities, and materials.

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

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PEI Project Name: School-Based Program

County: San Diego

Date: 11/19/08

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

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	☐	☐	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☐
3. Children and Youth in Stressed Families	☒	☐		
4. Children and Youth at Risk for School Failure	☒	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☐		
6. Underserved Cultural Populations	☒			

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

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI School Aged Kids and Youth as one of our 10 priority focus areas. Below is a summary of our planning process.

A PEI workgroup was formed with members from San Diego County Children's Mental Health Administration, Therapeutic Behavioral Services, Special Education Services, Forensics, San Diego County's First Five Commission, Juvenile Probation, and Child and Adolescent Services Research Center (CASRC). All community input informed the workgroup process which met five times for two hours each to develop the work plan.

- San Diego County stakeholders from a broad range of programs have identified the need for K-3 school-age prevention/early intervention programs that combine both a community component and a school-based component.
- This model is consistent with the PEI Community Needs, Priority Populations and principles.

Input From Community Forums:

- Localize services; use existing school organizations to allow parents/families/care givers to identify local issues and to address issues at neighborhood, community and regional levels.
- Integrate and coordinate programs and agencies to better leverage all available resources to meet child and family needs.
- Serve children/adolescents/families in schools, neighborhoods and communities (where they are).
- Provide culturally competent/sensitive services.
- Educate/train key neighborhood and community members.
- Enhance and expand services within existing school and community programs.
- Integrate programs to build community/regional/County networks of services.
- Leverage non-traditional mental health resources.

Input From the Education Sub-Committee of the Children's System of Care Council:

- "A universal intervention at the Kindergarten level aimed at identifying any children showing early signs of social/emotional difficulty." This intervention will provide basic social-emotional skills for young children and their families. Examples are Second Step, Incredible Years, and PATHS.
- "A selected intervention for identified at-risk individuals throughout elementary school who will be tracked and followed." Examples are Second Step, Incredible Years, and PATHS.

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- A selected intervention for improving school climate – supporting the emotional needs of students at all grades in the schools. Possible options include Positive Behavioral Interventions and Supports (PBS), Caring School Community or Strengthening Families.
- “The creation of a more seamless system of services in a familiar setting developed through school relationships and extended to community mental health services will contribute to integrating a service system that could be more easily accessed by families. The opportunity to transform school settings to support a broader view of the school as addressing the need of the ‘whole’ child is created and brings the chance to impact many adults to extend the emotional support system to many children.”

Input From the County Office of Education:

- Implement mental health programs for younger students, specifically universal prevention and screening for mental health needs.
- Expand programs for all students that encourage positive behaviors and provide support when there are early signs of mental and behavioral needs.

Input From San Diego Local School Districts:

- Interventions for universal prevention and response to school-wide intervention activities including Second Step.
- Use resources to enhance the skills and knowledge base of school multi-disciplinary teams and school staff to include knowledge of mental health and illness, screening techniques, youth development, risk reduction and resiliency strategies.
- Leverage existing school resources and staff to help create a continuum of services, not silos, for students and families.

Input From Community/Family Liaison:

- Use of the multi-system model; coordinating public schools, children, families and community providers.
- “All programs should be for children AND parents so that they can all come together to prevent family breakdown.”
- Youth identified school and teachers/counselors who don’t care or understand as a cause for continued stress. We should have services in different areas and engage the people of that area.
- There is apprehension around being labeled at school or in the community, as it may be a cause for isolation and/or stigma.

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San Diego County Multi-system Proposal (Collaborative effort):

- Multi-system approach to prevention and early intervention includes public child-serving systems (CWS, Juvenile Justice and Behavioral Health Services, schools, First Five) and faith-based organizations, providers and the community - blended funding.
- School-based prevention and early intervention services can potentially address every child in the focus population.
- Universal program standards that are evidence based.
- Schools will have the flexibility to develop their programs to meet their needs and sub-contract with Community Based Organizations (CBO's) as needed.

3. PEI Project Description:

The opportunity to provide prevention services to school age youth through Proposition 63, PEI component, broadens the range of mental health activities offered by the System of Care. Research has shown that youth involved in the juvenile justice system evidenced at-risk behaviors that could be identified by the third grade. Since all children attend school, this setting allows for efficient use of public dollars and provides education and skill development for the adults who are involved with children.

The PEI plan proposes a family-focused approach that engages families in their child's school success and reduces family isolation and the stigma associated with seeking behavioral health services. Schools are more effective and caring places when they are integrated into the community. Equally, families and other community entities can enhance parenting and socialization and strengthen the fabric of family and community life through collaboration with the schools.

The proposed prevention and early intervention plan for school age children and their families is family-focused and shall include four components: 1) Positive Behavioral Support (PBS) implemented through the BEST model or another evidence-based practice that achieves similar outcomes; 2) an evidence-based practice focusing on prevention that primarily targets pre-school through third grade children, but should also include all children in the elementary school; 3) screening and early identification for at-risk children at the elementary schools; and 4) a family component that focuses on resiliency and provides intervention through community outreach specialists. The planned interventions at the school and with the family shall be coordinated and designed to increase resiliency and protective factors for children by improving child/parent social and emotional skills and reducing parental stress. The plan will minimize barriers to learning while supporting children in academic and personal success.

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The school-based universal prevention program will utilize Positive Behavioral Support (PBS), which is listed in the PEI Resource Materials, or another evidence-based practice that includes the elements of the PBS model. The prevention and early intervention program will be chosen by the successful bidder, but must be evidence-based. Examples are: Incredible Years, Second Step, and PATHS, which are all listed in the Resource Materials and were recommended by the Education Sub-Committee of the Children's System of Care Council.

The community-based outreach program is based on a promotora model, which reaches out to underserved populations through parent-peer psycho-educational intervention and support. Research suggests that promotora programs can have a positive effect on communities and on the promotoras themselves. A study conducted by the University of Arizona found that because their outreach focuses on the individual, services are provided in a cost-effective and culturally sensitive manner that eliminates many barriers to services. (The University of Arizona, 1998, *The National Community Health Advisor Study*, p. 3). In this PEI plan, the promotora position will be called a Community Outreach Specialist.

Community Outreach Specialists live in the communities that they serve and their expertise is based in their knowledge of the community. This program was chosen based on the PEI Logic Model, specifically: community input - serving children in communities, training neighborhood and community members, and leveraging non-traditional mental health resources; priority populations - children/youth in stressed families, at risk of school failure and at risk of juvenile justice involvement; short-term outcomes - increase protective factors with children by improving child/parent social and emotional skills and reducing parent stress and reduce isolation of families by increasing child and family connections to school and community.

The combination of a school-based intervention and a community-based component will support parent and family engagement. Focusing on parent education and the home environment, as well as the schools, fosters a holistic approach that is ultimately more effective in achieving outcomes. In addition, community outreach specialists have an opportunity to connect with families outside of the school environment and potentially reach the at-risk children who may not be identified by teachers.

The PEI plan shall have prospective service provider(s) propose and justify the geographical area(s) and schools where services will be implemented. The program(s) shall be located in two or more of the six HHSA regions including, though not limited to, the East urban region. The PEI plan shall target a minimum of five elementary schools that also have existing mental health services on site and a pre-school located on the campus. The target population shall have a high concentration of ethnic minorities including underserved Asian and Pacific Islanders and Latinos of low socio-economic status living in high-risk communities.

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This School Age Youth PEI project shall include, at a minimum, an established or planned collaborative partnership between a school district(s) (and individual schools), community based provider(s) and families. The lead direct service provider(s) in this program could be school district(s) in partnership with community-based provider(s); or community based provider(s) who partner with school districts. The PEI plan may be implemented by one or more lead providers. Services may build on existing school (district) prevention efforts and school and community based provider(s) shall demonstrate ability to provide additional in-kind funding to enhance the program. The service provider(s) shall develop a specific plan to evaluate the PEI Plan components and outcomes required for the plan as approved by the County.

School-Based Universal Component:

One of the most effective, evidence-based models of mental health prevention and early intervention in schools is *Positive Behavioral Supports*. Positive Behavioral Supports (PBS – Hillwalker/Sprague) is a systems-oriented, data driven approach for establishing the social culture and behavioral norms needed for a school to be an effective learning environment for all students.

The goal of PBS is to achieve effective behavior support for all members of the school community to achieve academic success. PBS is a universal implementation that transforms the culture of a school from one that takes a reactive approach to managing problem behavior to one that takes a preventive, positive, and supportive approach that will enhance student learning. While several models of implementation are suggested, one of the most well known and researched models is Building Effective Schools Together (BEST), which is a way to shift the school culture to PBS. This program will be the primary focus for the school-based PEI implementation during the first year.

Successful BEST implementation is a multi-year process of school-wide systems transformation. Program implementation involves a 6-12 member school site team that, at a minimum, consists of an administrative leader, teachers, other school staff, mental health/other service providers, and parents. In the first year of implementation, the team works with a coach trained in the BEST model and the school staff develop an implementation plan that 1) reviews baseline behavioral data and clearly identify behavioral outcomes for the program, 2) analyzes and prioritizes issues to be addressed at the school, 3) defines and teaches behavioral expectations, 4) implements ways of acknowledging positive behavior among students, and 5) ensures on-going use of data collection for informed decision-making and plan modifications. In the second and third years, the team focuses on on-going data and outcome-driven improvements to the program, as well as implementing evidence-based practices to support the students who struggle despite the school climate improvements. Once BEST is fully implemented, the team continues to meet regularly for on-going monitoring of the program.

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While San Diego County recommends the Positive Behavioral Support model, an alternative evidence-based universal practice and subsequent implementation model that targets the school environment would be considered.

Screening and Evidence-Based Practice Implementation

It is anticipated that after the first year of a school-wide implementation of PBS, an evidence based universal intervention will be initiated with at least pre-school through 3rd graders, but could be implemented throughout the elementary school grades. In addition, other selected evidence based interventions shall be utilized throughout all elementary school grades for at-risk children. The service provider shall propose a method of screening or screening tool that would be approved by the County to identify these at-risk children. Early prevention/intervention services shall be implemented to support these students who continue to struggle behaviorally despite school climate improvement.

The population targeted for prevention involves the entire elementary school through PBS with additional emphasis on universal prevention strategies for at least the pre-school through third graders.

Early intervention shall be implemented for 1) children at risk of school failure; 2) children beginning to exhibit behavioral issues; and 3) children whose families are experiencing transitions such as: parents separating or divorcing, parent(s) or siblings who are incarcerated, other loss, parents involved in substance use or in recovery, exposure to community or domestic violence, or those in need of social skill building. At-risk children served shall be identified, tracked and monitored. The provider shall work closely with the school personnel within the structure established at the school to monitor children at risk. Services to families shall be provided on a year-round basis. If the school is not year-round, an explanation of the limits to school based services shall be submitted. Examples of evidence based intervention practices that may be utilized are Second Step, PATHS, Incredible Years and Families and Schools Together (FAST).

Family Outreach Component:

The community-based outreach program for families is based on a promotora model, which reaches out to ethnic minority, underserved populations through parent-peer, psycho-educational intervention and support. Although functioning independently, the outreach program will collaborate and form a partnership with schools. A goal of the outreach is to involve parents in their child's education and reduce isolation by making community connections. This component will improve child and family connections to school and community and increase protective factors for children by improving child/parent social and emotional skills, reducing parent stress and reducing isolation of families. The service provider shall describe how the various components of the PEI Plan will be coordinated and establish effective communication.

Families may be referred by the school, self referred, or may be engaged through the community outreach specialists. The outreach specialists shall work in the community to determine needs and provide a variety of primary prevention and early intervention services that focus on family wellness, strengthening resilience, goal setting and helping parents make

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connections with other services and support in the community. The outreach specialists shall be hired from each of the school neighborhoods and reflect the diversity of the targeted families including gender and age diversity. The community outreach program shall utilize a parent screening tool with all families to identify strengths and risk factors for more serious mental health and alcohol and substance use issues. The program shall utilize a tool to gauge improvement with the families such as the Parent Stress Index or other measure(s).

Community outreach specialists shall take a positive approach with families to instill a sense of optimism and hope in overcoming the risk factors and stresses they are experiencing. Possible services may include but not be limited to

- Parent education and training using an evidence-based model such as Incredible Years, Second Step, Strengthening Families, Triple P, and/or FAST;
- Family assessment and linkage to behavioral health and other services that will increase protective factors and resilience of the family;
- Stress management techniques including physical activities;
- Information and education about early signs of child problems and ways to manage them;
- Activities to build resilience and reduce isolation; and
- Flex funds will be available to the program to support families with needs related to mental health wellness.

Frequency and duration of key activities:

- School-wide universal component in elementary schools beginning the first year – Three year implementation
- Targeted prevention with an evidence based universal and/or selected intervention for pre-school through 3rd graders – 2nd year and on-going.
- Identification of targeted at-risk children requiring additional services for pre-school through 6th graders – 2nd year and on-going.
- Family outreach component – begins 1st year and on-going

Key dates and milestones include:

- Receive California DMH approval for Plan – Month 1
- RFP developed and competitive procurement process completed – Month 8
- Contract Awarded – Month 8
- Hire Staff – Month 8 – 9
- Begin development of policies and procedures – Month 8
- Draft policies and procedures submitted to County for approval – Month 9

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- Develop program materials - Month 9
- County approval of outcome tools and tracking systems – Month 9
- Begin delivery of services – Month 9
- County approval of satisfaction surveys – Month 12

4. Programs

Following is a rough estimate of the number of children and families to be served through this PEI Plan. Actual numbers will depend upon the school size, number of children at the school in pre-school through 3rd grade, and an estimated 20% of total school census requiring some sort of early intervention. The 3-tier approach is: 3100 students receive universal prevention (620 students per school x 5 schools, 310 families screened per school); 1550 of those 3100 students receive targeted early intervention activities (310 per school x 5 schools); and 620 of the 1550 students receive additional early intervention programs (124 per school x 5 schools, 124 families per school).

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
School-Age PEI Program	Individuals: 3100 Families: 1550	Individuals: 1550 Families: 620	
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED:	Individuals: 3100 Families: 1550	Individuals: 1550 (duplicated) Families: 620 (duplicated)	

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

The school-based model includes not only PBS or a similar model that addresses environmental change in the school, but also screening and early intervention for those children who demonstrate higher needs. These children may be referred directly or through a student study team (a group of school staff who regularly interact with the child) to an on-site school based mental health provider or other children's mental health service providers for assessment and treatment. Each school will have a liaison to make referrals, families may self-refer, or the community outreach specialists may refer.

Individuals in need of resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues.

While the County-funded Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will also then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services.

6. Collaboration and System Enhancements

The PEI plan shall be implemented at a minimum of five elementary schools and the provider will be expected to provide the following information:

- **Identification of program partners** – partnerships may include school district(s), community based organizations providing services at the school, family resource centers, existing school intervention programs, mental health providers, special education programs, Evidence Based Practice (EBP) consultants, Alcohol and Drug Services, First Five, Probation and Child Welfare Services and other community services.
- **The Roles of partners/service sites** – the provider would define collaboration and what roles each of the partners would have in the overall PEI plan. Service sites must meet the criteria defined in the program description. A description of how the partnerships will be coordinated will be required.
- **Qualifications and justification of partners** – The potential providers will be asked why they are selecting the partners chosen and what their experience is in the continuum of care for children.
- **Preliminary letters of intent** – from the school(s), district and other partners.
- **Demonstration of blended funding** – this will include match and resource leveraging. Resource leveraging includes how the provider may build on existing prevention efforts within the district(s) and schools.

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- **Juvenile probation** – Juvenile probation was represented on the PEI workgroup. They have suggested the possibility of engaging low-end, non-violent status offenders as a way for them to complete their community service part of the program.

Partners involved in the PEI Plan will be required to provide a sustainability plan. The PEI dollars dedicated to this plan will be available on going, as long as outcomes are successfully achieved and funding is available. The PEI Plan will further strengthen the mental health/educational partnership within the County. The program capacity broadens the range of mental health activities offered by the system and the outreach component initiates on-going community engagement and relationships.

7. Intended Outcomes

Client outcomes

- Increase protective factors with children by improving child/parent social and emotional skills and reducing parent stress.
- Improve academic performance.
- Minimize barriers to learning and support students in developing academic and personal success.
- Increase school attendance and decrease office referrals.
- Reduce isolation of families by increasing child and family connections to school and community.

System and program outcomes

- Increase teacher satisfaction.
- Develop positive behavioral supports that are universally implemented in a minimum of three elementary schools.
- Increase school staff understanding of mental health needs.

8. Coordination with Other MHSA Components

Over the past eight years, Children's Mental Health Services (CMHS) has expanded outreach and treatment services to over 300 schools throughout the County. The school-based services target low-income, ethnically diverse schools. The school-based providers offer treatment services to Medi-Cal and unfunded children and each school-based provider also has case management/rehabilitation services. The implementation of school-based services has resulted in an increase in the number of Latino children and families served. Schools identified for the PEI services are recommended to have a

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school-based mental health provider on-site. Children identified through the PEI program in need of services beyond primary intervention can be referred for brief treatment to a provider at their school.

- CMHS has a MHSA Full Service Partnership (FSP) program that specializes in providing culturally competent services to Latino and Asian-Pacific Islanders – High-need families could be referred to this partnership.
- Beginning July 1, 2008, the parent outreach specialists may be trained through a new parent-partner training program available through Community Services and Supports (CSS) Workforce Education and Training (WET).

9. Additional Comments (optional)

A unified prevention strategy will be brought into the schools that will increase the number of adults promoting social/emotional wellness for children and youth. The culture of schools will become more positive and inclusive, which in turn is more conducive to student learning and social/emotional development. The goal of the early interventions is to prevent more serious problems from developing that will impact school success. Through the parent intervention, parents will be better able to support their children and the efforts of the schools. The outreach services will reduce parent isolation and engage them with the school.

As a result of the PEI program, the above outcomes will be achieved including increased protective factors with children, increased academic performance, increased school attendance, decreased office referrals and increased teacher satisfaction.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3
Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
Workgroup - Focus Area (Cnty PEI List): Children/Adolescent School-Aged Services
Program ID/Name: **SA01A School-Based Program**
Provider Name (if known): Pending Competitive Procurement
Provider Category (DMH List): PreK-12 School

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	3100
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	3100
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
	Classification	FTE	Per FTE			
	Program Manager	2.00	\$85,000	\$0	\$170,000	\$170,000
	Positive Behavioral Support Coaches	3.50	\$55,000	\$0	\$192,500	\$192,500
	LCSW Evidence Based Practice Clinician	4.00	\$70,000	\$0	\$280,000	\$280,000
	Admin Support (Admin Asst, Secr, Clrk)	2.00	\$42,000	\$0	\$84,000	\$84,000
		0.00	\$0	\$0	\$0	\$0
	Total FTE	11.50	Sub-Total	\$0	\$726,500	\$726,500
	b. Benefits% @	40.0%		\$0	\$290,600	\$290,600
c. Total Personnel/Staffing Expenses				\$0	\$1,017,100	\$1,017,100
2. Operating Expenditures						
	Indirect/Administrative Costs		\$149,500	\$0	\$149,500	\$149,500
	Operating Costs (includes Facility Costs)		\$241,500	\$0	\$241,500	\$241,500
	Start-Up/One-Time Only Costs*			\$0	\$168,000	\$168,000
c. Total Operating Expenses				\$0	\$559,000	\$559,000
3. Subcontracts/Professional Services (list/itemize)						
	Evidence-Based Materials and Training (On-Going)		\$200,000	\$0	\$200,000	\$200,000
	Program Evaluation		\$90,050	\$0	\$90,050	\$90,050
	Evidence Based Practice Consultant		\$50,000	\$0	\$50,000	\$50,000
a. Total Subcontract/Professional Svcs Expenses				\$0	\$340,050	\$340,050
4. Total Proposed PEI Program Budget				\$0	\$1,916,150	\$1,916,150
B. Revenues (list/itemize by fund source)						
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$1,916,150	\$1,916,150
D. Total In-Kind Contributions				\$0	\$174,815	\$174,815

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**
Program ID/Name: **SA01A School-Based Program**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals and improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Any program specifications to be issued as part of the competitive procurement and service provider selection criteria will be provided in a Request for Proposal.

Position(s) targeted: Positive Behavioral Support Coaches, 3.50 FTE

A1b Benefits - The Benefit rate (40%) is based on the anticipated benefit rate.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one time Specialized Training, and/or Consultant costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Specialized Training in Evidence Based Practice(s)
- Consultants to assist Program implementation

A2 Subcontracts/Professional Services

Training - Estimated ongoing costs of providing training for school and provider staff including training development, trainers, training facilities, and materials.

Evidence Based Practice Consultant - Estimated ongoing costs of a consultant to assist in research, development, analysis, and recommendations for continuing improvement in program effectiveness.

Program Evaluation - Estimated ongoing costs of data collection and analysis.

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3
Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
Workgroup - Focus Area (Cnty PEI List): Children/Adolescent School-Aged Services
Program ID/Name: **SA01B School-Based Program - Family Outreach**
Provider Name (if known): Pending Competitive Procurement
Provider Category (DMH List): Ethnic or Cultural Organization

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	1550
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	1550
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
	Classification	FTE	Per FTE			
	Program Manager	2.00	\$45,000	\$0	\$90,000	\$90,000
	Community Outreach Specialist	7.00	\$35,000	\$0	\$245,000	\$245,000
	Admin Support (Admin Asst, Secr, Clrk)	2.00	\$35,000	\$0	\$70,000	\$70,000
		0.00	\$0	\$0	\$0	\$0
		0.00	\$0	\$0	\$0	\$0
	Total FTE	11.00	Sub-Total	\$0	\$405,000	\$405,000
	b. Benefits% @	27.0%		\$0	\$109,350	\$109,350
c. Total Personnel/Staffing Expenses				\$0	\$514,350	\$514,350
2. Operating Expenditures						
	Indirect/Administrative Costs		\$143,000	\$0	\$143,000	\$143,000
	Operating Costs (includes Facility Costs)		\$316,000	\$0	\$316,000	\$316,000
	Start-Up/One-Time Only Costs*		\$168,000	\$0	\$168,000	\$168,000
c. Total Operating Expenses				\$0	\$627,000	\$627,000
3. Subcontracts/Professional Services (list/itemize)						
	Flex Funds		\$78,500	\$0	\$78,500	\$78,500
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$78,500	\$78,500
4. Total Proposed PEI Program Budget				\$0	\$1,219,850	\$1,219,850
B. Revenues (list/itemize by fund source)						
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$1,219,850	\$1,219,850
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**

Program ID/Name: **SA01B School-Based Program - Family Outreach**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals and improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified community workers and if appropriate, mental health clients and family members for Program positions.

Position(s) targeted: Community Outreach Specialist, 7.00 FTE

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

A2 Subcontracts/Professional Services

Flex funds - Estimated ongoing costs of funding items (within the scope of PEI funding) required to assist families in meeting needs and reducing mental health risks for a child and the family.

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

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PEI Project Name: School-Based Services -- Suicide Prevention

County: San Diego

Date: 11/19/08

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

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	☐	☐	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☐
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☒	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒		
6. Underserved Cultural Populations	☒	☒	☐	☐

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

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI School Aged Kids and Youth as one of our 10 priority focus areas.

In 2004, suicide ranked as the third leading cause of death for young people aged 10 – 24 years (Center for Disease Control [CDC], 2007). While suicide accounted for 1.4% of all deaths in the U.S (annually), it comprised 12.9% of all deaths among 15 – 24 year olds (American Association of Suicidology, 2006). Suicide rates for children, youth and Transition Age Youth (TAY) had been steadily declining since 1990, however, these rates increased for three age groups in 2004 (females aged 10 – 14 years & 15 – 19 years and males aged 15 – 19 years). The California Suicide Prevention Fact Sheet (Suicides, 1999-2003) notes that the number of suicide attempts for 15 – 19 year olds is close to 100 per 100,000, far above other age groups. There are some estimates that purport as many as 200 attempts are made for every completed suicide by youth (Youth Risk Behavior Surveillance Survey, YRBSS, 2003).

According to the report “Suicide in San Diego County: 1995-2004” issued by Community Health Improvement Partners (CHIP), suicide now ranks first among causes of non-natural death in San Diego County, exceeding deaths by motor vehicle crashes, homicide, drug overdose, and other non-natural causes. From 1995 through 2004, suicide took the lives of more than 3,000 San Diegans, outnumbering homicides by more than 2 to 1.

Over the past decade, suicide has been a leading cause of death for San Diego County children and youth over the age of 10, with about 10-12 San Diego youth committing suicide each year. Attempts are tracked annually in the San Diego County Child and Family Health and Well Being Report Card, which is a series of reports that provides a snapshot of the overall health and well-being of San Diego County’s children and families. The document is intended as a tool to be used by policymakers, advocacy organizations, community members and service providers. It is produced by a partnership of the San Diego County Board of Supervisors, Chief Administrative Officer and the Health and Human Services Agency. The multi-year project is authored by the Children’s Initiative and funded by the California Endowment, the County of San Diego Health and Human Services Agencies as well as several foundations. The report card includes a section on youth suicide. These data are collected and reported on Module G, part of the California Healthy Kids Survey, which is administered in secondary schools on an annual basis. Beginning in 2004-2005, 12 of the 18 unified and high school districts in San Diego County administered Module G as part of the survey. The 2007 Report shows that about 11% of

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students between the ages of 13-18 reported having made one or more suicide attempts within the past 12 months. In 2006-2007, 7th graders were twice as likely to report a suicide attempt as students in grades 9 and 11.

One of the three recommendations in the most recent Report Card with respect to suicide prevention is to "Provide education for families, caregivers, health care providers, educators, school staff, mental health providers, and peers about the warning signs and risk factors of depression and suicide, as well as protective factors that reduce the likelihood of suicide."

During the MHSA Prevention and Early Intervention planning process, clients, family members, and stakeholders in discussions at community forums and focus groups affirmed that in their experience this is a critical issue for San Diego youth. MHSA staff also attended dozens of meetings each month to discuss the Prevention and Early Intervention Component, where additional input was gathered (such as the Educational Advisory Committee; Commission on Children, Youth and Families; Consumer club houses, and Suicide Prevention Advocacy Network-SPAN). The information received from the various venues included:

Youth focus recommendations:

- Need for a youth-focused, culturally competent, and engaging media campaign to reduce stigma and increase awareness including: health relationships, signs of depression, risk for suicide, and psychiatric breaks;
- Public awareness (needed) to reduce stigma, trauma, suicide, and co-occurring disorders;
- Education to parents and community members on identifying at-risk behaviors in youth and helping them access services;
- Educate/train staff of community organizations, public systems (schools, law enforcement, justice, social services), physical health services (hospitals, physicians), and family and peers (military, faith-based organizations) to identify at-risk persons and help them access services; develop a standardized curriculum and provide "certification;"
- Provide activity centers and activities to meet youth recreational/entertainment needs on non-school/non-work days and hours;
- PEI should focus on adolescents ages 7 to 18 within the following areas: alcohol/drug and mental health (co-occurring/**suicide prevention**);
- Serve adolescents in schools and communities (where they are);
- Develop peer-to-peer outreach teams to schools; and

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- Intervention with primary level students.

Education/School Venue recommendations:

- Educate/train grade school, high school and college staff and counselors to identify at-risk behaviors and help students access services;
- Many youth are disconnected and they need opportunities to be connected to programs on school campuses, including social skills, mentoring, etc.;
- Incorporate community suicide prevention education into local programs;
- Expand existing school prevention programs and activities;
- Use existing parent involvement to support further involvement in PEI education/training and spread information to community;
- Build on existing school relationships with service providers in the communities;
- 1) Schools first to identify at-risk children (3-5 at-risk kids in each kindergarten class); 2) Target suicide prevention; 3) Schools are used to participating in community collaborative;
- Educate/Train school staff to identify service needs and initiate access to services; school-based programs reduce stigma ("normalize" services as part of other school-based services), schools are focus of age group activities, schools have permanency (always there), school staff often identify health/behavioral and family problems early;
- Identify service needs as early as possible and, at minimum, at school transition points; child entry into school (including new immigrants), grade school to middle school, middle school to high school;
- Serve children/families in schools, neighborhoods, and communities (where they are);
- Enhance and expand services within existing school and community (including sports) programs;
- Establish school-based PEI programs for children. Use older high school peer mentors and staff;
- Target services (positive life transition skills) at youth and their families at youth transition points (start school, school change, and graduation);
- Need classroom and small group models;
- Services need to be integrated into educational program;
- Provide school-based services (including preschool) to identify at-risk behaviors/children and work with the families;

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- Integrate mental health services and blend PEI funding with other agencies serving children into school-based services;
- Provide PEI funding to schools for allocation of funds to expand existing school-based programs supporting prevention and early intervention for at-risk children and families;
- Build on successful school-based programs;
- Educate/Train school staff to identify service needs and initiate access to services;
- School-based programs reduce stigma ("normalize" services as part of other school-based services), schools are focus of age group activities, schools have permanency (always there);
- School staff often identify health/behavioral and family problems early; and
- Localize services – use existing school organization levels to allow parents/families/care givers to identify local issues and, subsequently, to address issues at neighborhood, community, and regional levels.

Over the past decade, suicide has been a leading cause of death for San Diego County children and youth over the age of 10, with about 10-12 San Diego youth committing suicide each year. Attempts are tracked annually in the San Diego County Child and Family Health and Well Being Report Card, which is a series of reports that provides a snapshot of the overall health and well-being of San Diego County's children and families. The document is intended as a tool to be used by policymakers, advocacy organizations, community members and service providers. It is produced by a partnership of the San Diego County Board of Supervisors, Chief Administrative Officer and the Health and Human Services Agency. The multi-year project is authored by the Children's Initiative and funded by the California Endowment, the County of San Diego Health and Human Services Agencies as well as several foundations. The report card includes a section on youth suicide. These data are collected and reported on Module G, part of the California Healthy Kids Survey, which is administered in secondary schools on an annual basis. Beginning in 2004-2005, 12 of the 18 unified and high school districts in San Diego County administered Module G as part of the survey. The 2007 Report shows that about 11% of students between the ages of 13-18 reported having made one or more suicide attempts within the past 12 months. In 2006-2007, 7th graders were twice as likely to report a suicide attempt as students in grades 9 and 11.

One of the three recommendations in the most recent Report Card with respect to suicide prevention is to "Provide education for families, caregivers, health care providers, educators, school staff, mental health providers, and peers about the warning signs and risk factors of depression and suicide, as well as protective factors that reduce the likelihood of suicide."

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While children, youth and TAY of all ages could benefit from suicide prevention education, research indicates that gay, lesbian, bisexual, transgender, and questioning (GLBTQ) students are particularly vulnerable to contemplating suicide. As a result, this population will be an emphasis for outreach in this program. A University of California survey found that based on the number of reported attempts and reported suicidal ideation between 2000 and 2005, the two highest risk categories for completing suicide are graduate students and GLBTQ students.

The *California Strategic Plan on Suicide Prevention* (2008) concurs that this is a high-risk population. Data from multiple national studies (including the National Longitudinal Study of Adolescent Health, National Lesbian Health Care Survey, National Latino and Asian American Survey, and the Urban Men's Health Study) have demonstrated that lesbian, gay and bisexual individuals, particularly adolescents and young adults, have significantly higher rates of suicidal ideation and suicide attempts than their heterosexual counterparts (Silenzio et. al., 1998; Bradford et. al., 1994; Cochran et. al., 2007).

The *California Strategic Plan* also recommends utilizing the educational system, stating, "Integrate suicide prevention programs into kindergarten through grade twelve (K-12) and higher education institutions," (1.12, Recommended Actions); and, "promote and provide suicide prevention education for community gatekeepers" (3.9 RA). The proposed project hopes to begin that attempt.

3. PEI Project Description:

The County of San Diego is proposing to develop a school-based suicide prevention program to serve children, youth and TAY in school settings, including middle school, high school and post-secondary.

The *National Strategy for Suicide Prevention* (NNSP) "is designed to be a catalyst for social change with the power to transform attitudes, policies, and services." (2004). The NNSP employs the public health approach when addressing prevention. A multi-level public health approach 1) reduces risk factors and 2) enhances protective factors. This is different from the traditional, clinical-based approach that rests on identifying and treating individual risk factors when evidence of disease is present. The Public Health approach interventions are broad, multi-layers and occur well before a problem arises, as well as at various phases after it is present. Here are five key steps:

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1. Define the problem
2. Identify causes
3. Develop and test interventions
4. Implement interventions
5. Evaluate interventions

Steps may be sequential or can overlap. A key component of this approach is conducting a community needs assessment. This is a requirement for the project and will be expected to occur in all identified schools and/or communities.

Services

We will expect the provider to inform us of the services and strategies they will employ in this program. However, the *Draft California Strategic Plan on Suicide Prevention* (April 2008) recommends several targeted approaches to suicide prevention, all of which could be considered when developing the school-based program. As this project will go through a competitive procurement process, potential applicants will be directed to utilize the *Strategic Plan* when developing their proposal. Some of the recommendations include:

- The use of suicide prevention hotlines,
- Provide population-specific interventions,
- Implement training and workforce enhancements,
- Educate the public to take action to prevent suicide, and
- Improve program effectiveness and system accountability.

School programs must be comprehensive and address all levels of the organization (American Association of Suicidology, 1999). The successful applicant will propose services to three primary target populations: students, school staff and gatekeepers, and families and caregivers. Subsequently, services will include:

- Education/training to Gatekeepers,
- Outreach and education for students,
- Outreach and education for families/caregivers,
- Screening of at-risk students,

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- Referral and linkage to mental health resources,
- Crisis response training, and
- Short-term early intervention for high risk children, youth, and TAY.

Additional services and programs may be proposed to enhance this list.

Strategies

Numerous effective strategies are recommended by research groups and experts in the field of youth suicide prevention. "Comprehensive suicide prevention programs are believed to have a greater likelihood of reducing the suicide rate than are interventions that address only one risk or protective factor," (Suicide Prevention Resource Center). From 1994 to 1999, the Australian Institute of Family Study conducted an analysis of suicide-prevention efforts in that country. Two common themes found in the most effective youth programs were 1) strategies to enhance the identification of suicidal youth and referral to existing mental health resources and 2) strategies designed to directly address the risk factors for youth suicide (National Youth Suicide Prevention Strategy for the Commonwealth of Australia, 2000).

Training and/or education must contain the following:

- Identifying risk factors and efforts to reduce those risk factors,
- Identifying protective factors, and
- Responding when someone is at-risk.

After completing a needs assessment addressing the various age groups in the specific region(s) identified, the provider will review and select age-appropriate strategies and curricula. Applicants are also encouraged to use recommended approaches from the *Youth Suicide-Prevention Guidelines for California Schools* (2005). Primary strategies outlined are below:

- Enlist the support of administration,
- Develop and adopt a school/district/community wide youth suicide prevention policy,
- Institute training for faculty and all school staff,
- Institute a school crisis response team,
- Institute parent/guardian education regarding youth suicide,

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- Institute community “gatekeeper” training,
- Implement skills training and social support programs for students,
- Implement school activities that increase students’ connection to the school, and
- Develop supportive school/community partnerships.

Key Milestones and Timelines

The following are key milestones and their anticipated timeline:

- Receive California DMH approval for Plan – Month 1
- RFP developed, competitive procurement process completed – Month 4
- Contract awarded – Month 5
- Hire staff – Month 6
- Staff training begins – Month 7
- Begin development of policies and procedures – Month 6
- Draft policies and procedures submitted to County for approval – Month 7
- Outcome tools identified, surveys created – Month 7
- Create brochures and purchase materials – Month 6
- Gatekeeper education and training begins – Month 8
- Conduct prevention groups/program for children – Month 10
- Begin family/caregiver educational presentations/groups – Month 11

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4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Suicide Prevention Education & Training for Children, Youth and TAY	Individuals: 1500 Families: 200	Individuals: Families:	
Gatekeeper and Family/Caregiver Training	Individuals: 500 Families:	Individuals: Families:	
Early Intervention	Individuals: Families:	Individuals: 100 Families:	
TOTAL PEI PROJECT ESTIMATED UNDULICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 2000 Families: 200 (duplicated)	Individuals: 100 (duplicated) Families:	

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

Youth may be referred to existing MHSA/CSS existing programs such as the integrated primary care and mental health program, family youth & peer support services, family and youth information and education program, school based mental health services, mobile adolescent services team, enhanced mental health services for TAY, full service partnership and

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clubhouses. Additional PEI programs focusing on community and domestic violence and co-occurring disorders may also be available.

Individuals in need of resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues. While the Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will also then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services.

6. Collaboration and System Enhancements

The County recommends that the contracted provider(s) consider the following:

- **Identification of program partners:** partnerships may include school district(s); community based organizations providing services at the school; family resource centers; existing school prevention/intervention programs; mental health providers; special education programs; Evidence Based Practice (EBP) consultants; Alcohol and Drug Services; and other community services.
- **The Roles of partners/service sites** – the provider will define collaboration and what roles each of the partners will have in the overall PEI plan (if applicable). A description of how the partnerships will be coordinated will be required.
- **Qualifications and justification of partners** – The potential providers will be asked why they are selecting the partners chosen and what their experience is in the continuum of care for children.
- **Preliminary letters of intent** from the school(s), district and other partners.

7. Intended Outcomes

Outcomes for children/youth/TAY that receive education and/or participate in project services may include:

- Increased knowledge of risk and resilience/protective factors,

PEI PROJECT SUMMARY

- Reduced risk factors,
- Decreased # of suicide attempts at schools where students receive education,
- Reduced stigma about seeking treatment or help for problems,
- Improved well being and hopefulness,
- Increased school connectedness,
- Increased social supports/reduced isolation,
- Improved knowledge in how to access care, and
- Increased skills in problem solving, help-seeking, etc.

Outcomes for gatekeepers and caregivers will include at a minimum:

- Increased knowledge and awareness of at-risk behaviors and features,
- Improved early detection and identification of at-risk behaviors and features, and
- Ensure cultural competency in dealing with referrals.

Information may be gathered through interviews, surveys, standardized assessment tools, or other appropriate measures.

8. Coordination with Other MHSA Components

Over the past eight years, Children's Mental Health Services (CMHS) has expanded outreach and treatment services to over 300 schools throughout the County. The school based services target low-income, ethnically diverse schools. The school-based providers offer treatment services to Medi-Cal and un-funded children and each school-based provider also has case management/rehabilitation services. The implementation of school-based services has resulted in an increase in the number of Latino children and families served. Schools identified for the PEI services are recommended to have a school-based mental health provider on site. Children identified through the PEI program in need of services beyond primary prevention can be referred for brief treatment to a provider at their school.

CMHS also has a MHSA full service partnership (FSP) program that specializes in providing culturally competent services to Latino and Asian-Pacific Islanders. High-need families could be referred to this partnership.

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This Plan will also benefit from the Primary and Secondary Prevention Plan (PS01) in the following ways:

- Media Campaign – The campaign will include elements that address raising public awareness about the risk factors and warning signs of suicide. The campaign will also incorporate cultural perspectives in the resulting printed materials and TV/Radio/print ads.
- The contracted service provider of the SA02 project shall participate on the Interagency Suicide Meeting (referenced in PS01). As a member of this group, they will assist in developing the County's suicide action plan and ensure cultural sensitivity and awareness for the distinct needs of the target population that they represent and to which they provide PEI services.
- Suicide Prevention services offered through PEI will be included in Primary Prevention printed materials (described in PS01). This will assist to raise awareness about the availability of suicide prevention services funded under MHSA in San Diego County.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): **Children/Adolescent School-Aged Services**
 Program ID/Name: **SA02 School-Based Suicide Prevention**
 Provider Name (if known): **Pending Competitive Procurement**
 Provider Category (DMH List): **Other**

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	2000
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	2000
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
	Classification	FTE	Per FTE			
	TBD	0.00	\$0	\$0	\$0	\$0
		0.00	\$0	\$0	\$0	\$0
		0.00	\$0	\$0	\$0	\$0
		0.00	\$0	\$0	\$0	\$0
		0.00	\$0	\$0	\$0	\$0
	Total FTE	0.00	Sub-Total	\$0	\$0	\$0
b. Benefits%	@	27.0%		\$0	\$0	\$0
c. Total Personnel/Staffing Expenses				\$0	\$0	\$0
2. Operating Expenditures						
	Indirect/Administrative Costs	0.0%	\$0	\$0	\$0	\$0
	Operating Costs (includes Facility Costs)	0.0%	\$0	\$0	\$0	\$0
	Start-Up/One-Time Only Costs*	12%	\$99,000	\$0	\$99,000	\$99,000
c. Total Operating Expenses				\$0	\$99,000	\$99,000
3. Subcontracts/Professional Services (list/itemize)						
	Program/Services		\$817,596	\$0	\$817,596	\$817,596
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$817,596	\$817,596
4. Total Proposed PEI Program Budget				\$0	\$916,596	\$916,596
B. Revenues (list/itemize by fund source)						
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$916,596	\$916,596
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**
Program ID/Name: **SA02 School-Based Suicide Prevention**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals and improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries will be determined through the competitive procurement with negotiation process. The services and strategies proposed by the selected service provider and negotiated with the County will determine program staffing.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs will be determined through the competitive procurement with negotiation process. The services and strategies proposed by the selected service provider and negotiated with the County will determine Operating Expenditures.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

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PEI Project Name: First Break of Mental Illness – Cool Program

County: San Diego

Date: 11/19/08

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

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	☐	☐	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☐	☐
3. Children and Youth in Stressed Families	☐	☐		
4. Children and Youth at Risk for School Failure	☒	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒		
6. Underserved Cultural Populations	☐	☐	☐	☐

PEI PROJECT SUMMARY

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B. Summary of Stakeholder Input and data analysis that resulted in the selection of the priority population(s).

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Transitional Age Youth First Break of Mental Illness as one of our 10 priority focus areas. Below is a list of venues and opportunities offered to community stakeholders to participate in planning and to provide their valuable input.

Transitional Age Youth First Break Forum – January 23, 2008: Expert guest speakers presented material on mental health needs of TAY experiencing the onset of psychosis to a forum of community members. The forum was well attended by the TAY community, providers, experts, and other key stakeholders.

Input from the community included the following:

- Public and provider education and training to reduce stigma;
- Increase access to care to at-risk TAY and their families;
- Provide a family and strength-based approach;
- Early detection through screening by frontline gatekeepers;
- Peer support and mentoring that provide role modeling;
- Support and outreach to at-risk youth;
- Increase self-sufficiency and resilience by providing life skills training and positive life transition skills to youth and their families at youth transition points and by providing support to clients and families at high risk of first break or at time of first break;
- Improve access to care by providing comprehensive, seamless programs for individuals at high risk and their families;
- Provide a uniform screening process and improve transportation to and from services;
- Link mental to physical health and co-locate physicians with mental health clinicians;
- Linkage with existing community services;
- Add first onset mental health services to alcohol and drug treatment centers;
- Utilize community based settings; and
- Provide culturally competent safe places for at-risk youth and a peer or trusted person to whom they may speak.

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Mental Health Board (MHB) Presentation, April 3, 2008. Community input was presented to the MHB for their review and guidance. Board reviewed inputs and concurred with Mental Health Services' assessments to develop programs based on the identified needs.

First Break PEI Workgroup, April – May 2008. Subsequent to the community forum, a PEI workgroup was formed consisting of County staff and community members in order to develop first break programs. The workgroup met four times. Its members included representatives from Children's Mental Health Services, Alcohol and Drug Services, Client and Family Liaison Services, San Diego County Psychiatric Hospital, the Clinical Director for San Diego County Behavior Health Services, and Adult/Older Adult Systems of Care representatives. The workgroup helped to refine the community and MHB inputs and developed project concepts for development.

The workgroup project concepts were:

- Utilize gatekeeper model,
- Focus on family and education,
- Incorporate mobile outreach for assessment,
- Must include a treatment component,
- Include foster care youth children, and
- Utilize a three-pronged approach of outreach, intervention, and disposition to Cool clinical component or other services.

Furthermore, the First Break PEI draft workplan was presented to the Cultural Competence Resource Team (CCRT) and to the TAY Committee for input and comment. Their input and recommendations were considered in the final development of the plan.

Additional Data Analysis:

The gap analysis conducted in San Diego for CSS planning in fiscal year 05-06 demonstrates that TAY (18 to 24 y/olds) are an age group that is unserved and underserved and are often found in the juvenile justice system and in foster care, especially Latino and Asian/Pacific Islander TAY. The San Diego County Mental Health Services fiscal year 06-07 Databook demonstrates that 30% of TAY receiving mental health services are Latino and 12% are African American. Approximately 633 youth were served in the San Diego County Emergency Psychiatric Unit (EPU) and 211 (16 to 17

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y/olds) were served in the Emergency Screening Unit (ESU) during fiscal year 06-07. Approximately 694 TAY (ages 18 to 24 y/o) were receiving some type of outpatient mental health services in the justice system while in detention.

This program will be provided in the Central Region of San Diego. The region has approximately 79,082 youth ages 14 to 24 y/olds. The ethnic composition of this region is approximately 41% Latino, 28% Caucasian, 14% African American, and 13% Asian/Pacific Islander [San Diego County Association of Governments (SANDAG) data warehouse, 2007]. This region has the largest population of African Americans and Asian/Pacific Islanders and the second largest Hispanic population in San Diego County.

The Children's Mental Health Services Eighth Annual System of Care Report for Fiscal Year 2005-2006 states that 24.6% of youth receiving mental health services also had an opening in the Child Welfare System during the year. San Diego County data is consistent with national data demonstrating that the median age of onset for an anxiety disorder is age 11 (*Lifetime prevalence and age-of-onset distribution of DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 2005*). Schizophrenia often appears in men in their late teens or early twenties, while women are generally affected in their twenties or early thirties (*Psychiatric disorders in America: the Epidemiologic Catchment Area Study*).

The San Diego Child Welfare Services (CWS) Fiscal Year 2006/2007 Annual Report demonstrates that 17.2% of youth referred to the Child Abuse Hotline are 15 to 17 y/o. Based upon the CWS Monthly Children's Statistics for fiscal year 06-07, the ethnic composition of this age group is 51% Hispanic, 24% Black, 10% White, 0.5% Asian, 0.04% Native American, and 15% Other. The Central Region had the most referrals for children and youth, including over 2,000 youths aged 15 to 17 y/o.

The First Break PEI work group reviewed and evaluated the following evidence-based practices (EBP) for consideration in this program: Portland Identification and Early Referral (PIER) Program model, early Treatment and Identification of Psychosis (TIPS) Program, Personal Assessment and Crisis Evaluation (PACE), and the Structured Interview for Prodromal Symptoms (SIPS). The County participated in the State's TAY PEI webcast. Research has confirmed that the SIPS tool is utilized as a community standard for prevention and early intervention programs such as PIER, PRIME, and UCSD's Cognitive Assessment and Risk Evaluation (CARE) program. The SIPS will be utilized in this program.

This program was designed for youths who are at risk for developing a psychotic illness and are experiencing signs or symptoms that are indicative of high risk for psychotic illness (ARMS), which is usually a period of one to two years. The California Department of Mental Health Resource Material Enclosure 6 RM-3 states that "specialized intervention during this one to two year period of time may delay or prevent the transition to onset of full psychotic illness; prevent the loss of

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community, vocational, and social functioning; and decrease the length of time that the illness goes untreated.” The Cool component of this program provides intensive services to youths who are at risk for psychotic illness.

3. PEI Project Description:

Stakeholders expressed that there is “a great need for services in schools and jails” and a need to develop peers and paraprofessionals that will outreach to at-risk youth. Stakeholders expressed the importance of including families and educating them about their TAY/youth who are at risk of first break. Stakeholders also emphasized utilizing gatekeepers in areas such as high schools and colleges. Based on stakeholder input and the available research literature on the subject, San Diego County is proposing a first-break program that has a three-pronged approach to early detection of at-risk and high-risk children and TAY, ages 14 to 24 y/o. This program will focus on prevention, early intervention, and At Risk Mental State (ARMS) services, hereafter referred to as the Cool program in this work plan, in the Central region of San Diego County.

Program Details

The **Prevention** component of the program will utilize gatekeepers who may have contact with TAY and youth in general community settings. This component will target gatekeepers in the San Diego Unified School District, specifically high schools and colleges; community health centers; primary care physicians specializing in adolescent and young adult medicine (pediatricians); family resource centers; churches with youth ministries; substance abuse programs; mental health programs such as the Emergency Screening Unit (ESU) for children/youth and the San Diego County Emergency Psychiatric Unit (EPU); as well as Child Welfare and Justice System (juvenile and young adults) providers in this region. These gatekeepers will be provided education and information on early detection of at-risk behaviors and features of TAY and youth. Once trained, they will return to their various community settings prepared to identify and assess at-risk youth and TAY. Each Gatekeeper will utilize a screening tool to determine at-risk behaviors and features and will be provided information on how to refer and link to the Cool program for further assessment and intervention.

Actions that will be performed to carry out the **Prevention** “phase” include:

- During the first 3 to 6 months of the program, psychoeducation of gatekeepers and families on at-risk behaviors and features and screening of at-risk behavior; and

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- Information, referral, and linkage to Cool component for further evaluation and assessment if needed.

Staffing of this component includes:

- Gatekeeper Educators – 2 FTEs licensed Master's level clinicians will provide prevention and intervention education for gatekeepers, referral, and linkage to Cool/ARMS component program, other MHSA/TAY Services, or other appropriate community-based, non-mental health program.

The **Early Intervention** component will provide an in-depth integrated assessment for potential mental health and/or substance abuse issues, domestic/community violence, physical/sexual/emotional abuse, and physical health needs. TAY/youth and their families will be referred and linked for further assessment by a trained gatekeeper. TAY/youth will be provided with opportunities for family psychoeducation and social, educational, and employment support services, as well as information and linkages to extended treatment for mental illness or emotional disturbance, substance abuse, community or domestic violence services, and other basic need services such as food, housing and employment services, and social services. This program will also provide services for individuals experiencing At Risk Mental State (ARMS), which is explained below in the Cool component. The research literature on first break programs has demonstrated that TAY family involvement and participation is key in the early identification of at-risk behaviors of their youth. To this extent, families will be engaged to actively participate in the program services to include psychoeducation classes, support services, and treatment interventions.

Actions that will be performed to carry out the **Early Intervention** "phase" include:

- Early detection screening and integrated assessment will be provided during the first 3 to 6 months and ongoing as needed.
- The gatekeeper will link the TAY/youth and their family with the Cool-Mobile team, who will then outreach and engage the TAY/youth and their family for services.
- Mobile outreach and engagement by Cool staff.

Staffing for this component includes:

- Unlicensed Mental Health Counselors – 2 FTEs who will provide Cool-Mobile outreach and engagement to identified TAY/youth and their families at their residence or selected sites of choice to engage at-risk TAY/youth in the Cool Program or other appropriate services.

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The **Cool** component addresses a community concern that ARMS education is not available and that education should be provided to community gatekeepers, health care providers, and families so they may recognize at-risk behaviors and features that TAY/youth are experiencing. This intensive service component is envisioned to provide mobile outreach and engagement; TAY/youth, family, and parent psychoeducation classes/groups to assist in the identification and management of at-risk behaviors and features; consultation and care coordination with integrated primary care, mental health and substance abuse treatment; in-home services and support, crisis intervention and transportation for approximately 100 TAY/youth and families. **Cool** services for At Risk Mental State (ARMS) TAY/youth provides short term services (up to 18 months) for identified and eligible TAY that meet the criteria for Cool services. Services may include outreach and engagement, integrated mental health services, crisis intervention, in-home supportive services, peer support services, family psychoeducation and supported education/employment (SE/E). Psychosocial interventions include evaluation/assessment, peer support and mentoring and re-integration in the community. The program will use the Structured Interview for Prodromal Syndromes (SIPS) and the Positive and Negative Syndrome Scale (PANSS) and other to-be-determined tools. This program may be considered as a potential research site for the existing CARE research protocol for TAY.

Actions that will be performed to carry out the Cool component include:

- Outreach, engagement, evaluation and assessment; and
- Mobile and site-based short term treatment, intervention, and support services for the first 3 to 9 months until capacity of services are reached.

Staffing of the Cool Program includes a clinical and research and evaluation team composed of:

- Psychiatrist with a specialization in TAY/youth,
- Psychiatric nurse,
- Licensed clinicians,
- Peer Counselors, and
- Employment and education service staff.

Flexible program staff adjustments will be made once the gatekeeper education, outreach, and engagement phases wind down and as program capacity in the Cool Program is achieved.

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The research component at this time is under negotiations with Dr. William McFarlane, MD, psychiatrist and researcher at Maine Medical Center, and will be finalized within the next three to six months.

It is envisioned that this program will be procured via a Request for Proposal (RFP). There are a number of non-profit organizations, mental health providers, and community health centers that potentially can bid for the services outlined. The settings where these services can be provided include community health centers, designated schools, recreational youth centers, justice system settings, and in the TAY/youth home.

The target population for this program is TAY/youth aged 14-24 y/o in the Central Region of San Diego County including Hispanic, African American, and Asian/Pacific Islander communities, as well as LGBT TAY.

This new program will provide prevention, early intervention, and a Cool component for TAY and youth experiencing At Risk Mental State (ARMS) behaviors and features.

Note: The MHSA Prevention and Early Intervention standards for low intensity and short duration do not apply to services for individuals experiencing ARMS or first onset of a serious psychiatric illness with psychotic features.

Key Milestones and Timelines

The following are key milestones and their anticipated timeline:

- Receive California DMH approval for plan – Month 1
- RFP developed, competitive procurement process completed – Month 5
- Contract awarded – Month 6
- Hire staff – Month 6
- Begin development of policies and procedures – Month 7
- Additional outcome tools identified, surveys created – Month 7
- Staff training begins (including cultural and linguistic needs of population) – Month 7
- Outreach to potential gatekeepers – Month 7
- Education of gatekeepers – Month 7, ongoing
- Draft policies and procedures submitted to County for approval – Month 7
- Create brochures and purchase materials to be offered at each facility (in multiple languages as appropriate) – Month 7
- Assessment tool education for clinicians – Month 8
- Outreach and engagement begins – Month 9

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- Cool Program implemented – Month 10
- Referrals to program – Month 10

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operations through June 2009
	Prevention	Early Intervention	
Cool Program	Individuals:350 Families:	Individuals:100 Families: 100	
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 350 Families:	Individuals: 100 Families: 100 (duplicated)	

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

TAY/Youth who are deemed appropriate for further mental health assessment/treatment and services will be transitioned and linked to existing MHSA Child (under 18 y/o) or MHSA TAY (18 to 24 y/o) outpatient mental health programs. TAY will also be linked to primary care physicians, substance abuse services, and other appropriate social and recreational services in the community. TAY with prodromal symptoms and/or features not previously diagnosed will be linked to the PEI/Cool program, a component of this proposed program.

Once screened, the TAY/youth and family members will be referred and linked to other needed services based on their reported needs. Information will be provided on how to access family resource centers, primary care, or other health providers, and support services in the community, which will include school-based counseling services, counseling

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services for domestic violence, and Alcohol and Drug Services (ADS) programs for substance abuse issues. The PEI program staff will identify these and other resources by compiling a resource guide for the TAY/youth and their families.

The Cool program and its components of prevention, early intervention, and ARMS services will impact the system by:

- Increasing awareness and knowledge of gatekeepers in the Central region by providing education on at-risk symptoms and features in TAY;
- Utilizing an integrated assessment, TAY and their families will be provided linkages to existing public and community services available in churches, schools, gang prevention groups, substance abuse programs, mental health programs, and employment and housing services; and
- Providing education to client and family.

Individuals in need of additional resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues. While the Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline. This will also then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services.

6. Collaboration and System Enhancements:

Partnerships and collaborations will be reinforced and/or developed with community health centers, primary care, mental health, alcohol and drug services, San Diego Unified School District and its high schools, San Diego City College, San Diego State University, Family Resource Centers in the Central region, local social service agencies, foster care and justice system sector for youth and TAY, other TAY non-profit organizations such as the Access Center, serving LGBT, and the Monarch High School for TAY homeless. Gatekeepers will be identified within these organizations. The Program will establish memorandums of agreement (MOAs) with external agencies to delineate roles and responsibilities to include gatekeeper education, mutual referrals, linkages, care coordination and consultation, communication, and technical consultation.

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The roles and activities with the above partners will include gatekeeper education of at-risk mental state (ARMS) behaviors and features for TAY/youth, referral, and information for further assessment.

The primary and mental health care system will be strengthened and built upon by increasing community, provider, and family awareness and education of at-risk behaviors and features in TAY/youth. It is envisioned that the primary care sector, particularly primary care physicians in pediatrics and adolescent medicine, will be able to do a preliminary screening of at-risk TAY and youth and provide care coordination through a “smooth hand-off” to the Cool program mobile staff who will further assess the TAY/youth.

Program resources will be leveraged by collaborating and partnering with existing TAY/youth service providers in the community and linking TAY/youth and their families to existing MHSA Child and TAY programs described in the “Linkages” section above. In addition, TAY/youth who are interested in participating in UCSD’s Cognitive Assessment and Risk Evaluation (CARE) program and research protocol will be linked to the CARE program for additional assessments to determine eligibility. The primary goal of the CARE program is to identify and assess adolescents and young adults who are experiencing changes in their thoughts, behavior, or emotions that might be associated with developing serious and/or disabling mental problems.

This program will be sustained with MHSA/PEI funds.

7. Intended Outcomes:

Outcomes will be measured by tracking and trending of baseline information into a database; issuing pre- and post-surveys assessing level of knowledge acquired; and tracking and trending outcomes at 6, 12, and 18 month intervals on different measures, which includes the SIPS. The SIPS is a structured diagnostic interview used to diagnose the three prodromal syndromes and may be thought of as analogous to the Structured Clinical Interview for DSM-IV (SCID). The SIPS includes the SOPS (Schizotypal Personality Disorder Checklist and a version of the Global Assessment of Functioning scale (GAF). The SIPS also includes operational definitions of the three prodromal syndromes [Criteria of Prodromal Syndromes (COPS)] and an operational definition of psychosis onset [Presence of Psychotic Syndrome (POPS)].

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Individual level outcomes include:

- Increase in education and awareness of at-risk behaviors and features;
- Early detection and identification of at-risk behaviors and features;
- Improved well being and hopefulness;
- Management of behaviors, symptoms, and features;
- Family education and involvement;
- Reduction of prolonged suffering;
- Reduction of untreated mental health needs;
- Increase in timely access to services;
- Diversion from incarceration; and
- Avoidance of school failure or dropout.

System level outcomes include:

- Collaboration and partnership development,
- Ongoing education with primary care and other gatekeepers,
- Reduction of hospitalizations, and
- Reduction of incidence and prevalence of psychiatric disorders.

Program level outcomes include:

- Increased number of outreach and engagement attempts to gatekeepers and identified TAY and their families;
- Demographics, diagnosis, types of services provided, referrals to extended and other services;
- Reduction of untreated mental health problems;
- Reduction of stigma associated with seeking mental health services;
- Improved knowledge in how to access care;
- Early identification and prevention of untreated mental health issues;
- Reduced family stress and burden;
- Increase of family support systems (through education);
- Diversion from incarcerations; and
- Continuation in school or employment.

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Other proposed methods to measure success will be gauged through the number of screenings, mental health assessments, and short term interventions administered through each component of the program.

8. Coordination with other MHSA Components:

San Diego County has a broad array of MHSA/CSS programs for children, youth, and young adults that provide services to unserved and underserved clients and their families. Referring and linking eligible youth/young adults and their family to these services is key to the early identification of untreated mental health issues that, without intervention, may develop into long term mental health illnesses. The program staff will have a resource directory of core mental health services and MHSA/CSS programs in the Central region, as well as a broad directory of resources for TAY (TAY Resource Provider Directory) and their families. The TAY Resource Directory includes services provided by the faith community, domestic violence, substance abuse, primary care, employment and housing resources, and family resource centers. Youth may be referred to existing MHSA/CSS programs such as the Council of Community Clinics (CCC) integrated primary care and mental health program, family youth & peer support services, family and youth information and education programs, school-based mental health services, mobile adolescent services team, enhanced mental health services for TAY, full service partnerships, and clubhouses. Additional PEI programs focusing on community and domestic violence and co-occurring disorders may also be available.

This workplan will also benefit from the Primary and Secondary Prevention Plan (PS01) in the following ways:

- Media Campaign – The campaign will include elements that address raising public awareness about the risk factors and warning signs of suicide. It will incorporate cultural perspectives in the resulting printed materials and TV/Radio/print ads.
- The contracted service provider of the FB01 Project shall participate on the Interagency Suicide Meeting (referenced in PS01). In being a member of this group, they will assist to develop the County's suicide action plan and ensure cultural sensitivity and awareness for the distinct needs of the target population that they represent and provide PEI services for.

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- Suicide Prevention services offered through PEI will be included in Primary Prevention printed materials (described in PS01). This will assist to raise awareness about the availability of suicide prevention services funded under MHSA in San Diego County.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): **First Break of Mental Illness**
 Program ID/Name: **FB01 Cool Program**
 Provider Name (if known): **Pending Competitive Procurement**
 Provider Category (DMH List): **Mental Health Treatment/Service Provider**

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	450
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	450
Estimated Months of Operation:	0	12

			Total Program/PEI Project Budget		
Proposed Expenses and Revenues	Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure					
1. Personnel/Staffing					
a. Salaries, Wages					
Classification	FTE	Per FTE			
Program Manager - Licensed	1.00	\$78,200	\$0	\$78,200	\$78,200
Peer Counselor/Support Staff	3.00	\$29,500	\$0	\$88,500	\$88,500
Registered Nurse	0.50	\$74,400	\$0	\$37,200	\$37,200
Admin Support (Admin Asst, Secr, Clrk)	0.50	\$24,893	\$0	\$12,447	\$12,447
Licensed Clinical Social Worker (LCSW)	2.00	\$46,900	\$0	\$93,800	\$93,800
Other Unlicensed MH Direct Svc Staff	2.00	\$40,000	\$0	\$80,000	\$80,000
Occupational Therapist	1.00	\$65,000	\$0	\$65,000	\$65,000
Supported Education/Employment Staff	1.00	\$36,700	\$0	\$36,700	\$36,700
Psychiatrist, Child/Adolescent	0.50	\$175,000	\$0	\$87,500	\$87,500
Total FTE	11.50	Sub-Total	\$0	\$579,347	\$579,347
b. Benefits% @ 27.0%			\$0	\$156,424	\$156,424
c. Total Personnel/Staffing Expenses			\$0	\$735,770	\$735,770
2. Operating Expenditures					
Indirect/Administrative Costs		\$150,666	\$0	\$150,666	\$150,666
Operating Costs (includes Facility Costs)		\$243,500	\$0	\$243,500	\$243,500
Start-Up/One-Time Only Costs*		\$156,000	\$0	\$156,000	\$156,000
c. Total Operating Expenses			\$0	\$550,166	\$550,166
3. Subcontracts/Professional Services (list/itemize)					
Research & Evaluation (Consult, Training)		\$120,064	\$0	\$120,064	\$120,064
Flex Fund		\$50,000	\$0	\$50,000	\$50,000
		\$0	\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses			\$0	\$170,064	\$170,064
4. Total Proposed PEI Program Budget			\$0	\$1,456,000	\$1,456,000
B. Revenues (list/itemize by fund source)					
		\$0	\$0	\$0	\$0
		\$0	\$0	\$0	\$0
		\$0	\$0	\$0	\$0
1. Total Revenue			\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program			\$0	\$1,456,000	\$1,456,000
D. Total In-Kind Contributions			\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**
Program ID/Name: **FB01 Cool Program**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals and improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

Position(s) targeted: Other Unlicensed MH Direct Service Staff, 2.00 FTE and Supported Education/Employment Staff,

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

A2 Subcontracts/Professional Services

Research and Evaluation - Estimated ongoing costs for a consultant to assist in research, development, analysis, and recommendations for continuing improvement in program effectiveness and the estimated ongoing costs of data collection and analysis.

Flex funds - Estimated ongoing costs of funding items (within the scope of PEI funding) required to assist clients in meeting needs and reducing mental health risks.

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

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PEI Project Name: Co-occurring Disorders – Bridge to Recovery

County: San Diego

Date: 11/19/08

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

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	☐	☐	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☒	☒	☒
3. Children and Youth in Stressed Families	☐	☐	☐	☐
4. Children and Youth at Risk for School Failure	☐	☒	☐	☐
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☒	☐	☐
6. Underserved Cultural Populations	☐	☐	☐	☐

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

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Co-Occurring Disorders as one of our 10 priority focus areas. Below is a summary of community feedback and supporting background data.

In 2002, San Diego County Health and Human Services Agency adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) model to improve services for persons with co-occurring disorders. This model outlines four “Quadrants,” the broad parameters of responsibility of Alcohol and Drug Services (ADS) programs and Mental Health (MH) programs for persons with co-occurring disorders. Individuals are designated as having either “high” or “low” substance abuse or mental health issues, respectively. Typically, persons with high MH issues **and** either low or high SA issues (Quadrants II & IV) are eligible for specialty MH services (which serve persons with SMI). Persons with low MH issues **and** either low or high SA issues (Quadrants I & III) usually do not meet criteria for specialty MH programs.

Co-Occurring Disorders Forum – February 2008

“**Quadrant III**” (Kenneth Minkoff, 1991) individuals are identified as persons with **high substance abuse issues/treatment needs and low mental health issues/treatment needs** and are considered at-risk for serious mental illness (SMI) if not treated early on in their addiction. The needs of Quadrant III individuals were specifically addressed by community stakeholders at the County’s Co-Occurring Disorders Forum. Additional needs and concerns identified by the participants of the forum included:

- Access to care
 - o Screening and assessment
 - o Provide transportation or mobile units to outreach, engage, assess, refer, and increase access to services
- Integration and coordination of services
 - o Collaborate with community identified gatekeepers
 - o Augment existing Alcohol & Other Drug (AOD) services with MH services
 - o Mobile trauma services
- Peer support, mentoring, and advocacy
- Education and training to reduce stigma
 - o Provider education and training
 - o Law enforcement training

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Members of the San Diego County Mental Health Advisory Board also recommended training for law enforcement personnel around the overlap of substance abuse and mental health issues. While the PEI planning process brought many key strategies to the forefront around co-occurring disorders, this serious need was first identified by the community during the CSS planning process, and it was subsequently placed in the “Parking Lot” for later consideration with enhanced funding or via another MHSA component.

A variety of compelling information and statistics continue to highlight the need in the area of co-occurring disorders. Over 6,000 adults (ages 25-59), more than 1,000 transition age youth [TAY] (ages 18-24), and over 300 older adults (ages 60+) were served in the San Diego County Psychiatric Hospital's (SDCPH) Crisis Recovery Unit (CRU), the County-run Emergency Psychiatric Unit (EPU), and the County's Crisis (Walk-in) Clinic in fiscal year 2006-2007. Together, these individuals made almost 16,000 visits that year – a number that has been expanding annually.

To help develop proposed PEI programs to address co-occurring disorders, a workgroup of various experts was convened, including a Board-Certified psychiatrist in Mental Health and Addiction Psychiatry; Adult, Older Adult, and Children's Mental Health staff; Juvenile Forensics; Probation; and Alcohol and Drug Services (ADS) senior staff trained and experienced in co-occurring issues. They collaborated to develop this work plan based on the community input and available data. They determined that while Quadrant III individuals may be found in other venues, the opportunity to strategically engage these individuals at the SDCPH and the adjacent EPU location could also be an opportunity to reduce their suicidal risk at a critical juncture.

Substantial numbers of clients, who are under the influence of drugs and/or alcohol, present in crisis at these facilities and often with suicidal ideation (SI) at intake. At the time of discharge, from a few hours to a few days later, the SI appears to clear, possibly as a result of sobering. Efforts are already in place to link clients who meet criteria for serious mental illness (SMI) or for co-occurring substance abuse (SA) and serious mental illness to MH programs via transition case management.

However, individuals with primary SA, while given referrals for SA treatment, often do not receive significant follow-up or case management. Many of these individuals are at risk, as they may have experienced trauma or emerging/low MH issues that, if left untreated, could develop into serious mental illness or even death over time, especially if they continue to abuse drugs and/or alcohol. These are the individuals who are considered “**Quadrant III,**” a category of persons with **high substance abuse issues and low mental health needs.**

In fiscal year 2006-2007, a spike in the numbers of persons who successfully completed suicide, who had been served at the San Diego County Psychiatric Hospital CRU, EPU, and Crisis Clinic, was observed. That year, 12 individuals

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completed suicide, which represented almost a two fold increase in the annual number of suicides typically observed from this population. While any instance of suicide is always a tragedy, it is especially concerning when the individual had previously made contact with a mental health service or system. Case reviews revealed that substance abuse was a common theme for these individuals. Although some of the identified patients had experienced recent periods of sobriety, relapse had occurred. Patients being released often professed a resolve to attend substance abuse outpatient services or AA/NA groups, but minimal follow-up occurred.

The data below is from the University of California, San Diego (UCSD) Health Services Research Center (HSRC) San Diego County Mental Health Services (SDCMHS) Data book for 2006-2007. It is delineated by age groups served at the SDCPH units:

- **8,389** unique individuals visited the SDCPH units for a total of **15,907** visits.
- Of the 8,389 served:
 - o **3,259** (39%) were determined to have some type of substance use disorder,
 - o **5,271** (63%) were uninsured,
 - o **4731** (56.4%) were males, **3643** (43.4%) were females, and 15 (>1%) were other/unknown

<u>AGE</u>	<u>#UNIQUE</u>	<u>#VISITS</u>
Age <18-24	1,366 (16%)	2,094 (13%)
Age 25-59	6,672 (80%)	13,362 (84%)
Age 60+	351 (4%)	451 (3%)
Total	8,389 (100%)	15,907 (100%)

RACE/ETHNICITY

White	4,745 (57%)
Hispanic	1,824 (22%)
African-American	1,186 (14%)
Asian	367 (4%)
Native American	52 (1%)
<u>Other/Unknown</u>	<u>215 (3%)</u>
Total	8,389 (100%)

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3. PEI Project Description:

The goal of this work plan is to provide screening, brief intervention, education, linkages, and referrals to at least 1,800 TAY (Est: 250), adult (Est: 1,300) and older adult (Est: 250) individuals accessing the SDCPH CRU, EPU, and Crisis Clinic. The program will also offer follow-up short-term assertive peer case management support to link at least 840 clients to needed treatment or other problem-solving resources to instill hope, reduce stigma about seeking treatment through the use of peer mentors, and reduce suicidal risk factors.

A further component will be a monthly training for law enforcement around co-occurring SA and MH issues and related topics as requested, initially offered to law enforcement who chiefly utilize the SDCPH and EPU; the San Diego Police Department divisions and the Sheriff substations in the unincorporated areas of San Diego County.

The agency selected to implement this work plan must employ staff that have completed one of the CCISC Cadre Training series within a year of contract execution. The agency must also be actively pursuing "Dual Diagnosis capable" status as defined by ADS Administration from the CCISC initiative.

Services

The Substance Abuse and Mental Health Services Administration (SAMHSA) Screening, Brief Intervention, Referral, and Treatment (SBIRT) model has been used successfully in trauma centers nation wide to reduce trauma recidivism by 50% using the "teachable moment" to implement an effective prevention strategy such as alcohol counseling for problem drinking (From *"Resources for Optimal Care of the Injured Patient: 2000"* by the American College of Surgeons Committee on Trauma). Currently, San Diego County has implemented the California SBIRT (CASBIRT) in trauma centers, emergency departments, and a community health center via a SAMHSA grant for this purpose.

For the Quadrant III individuals this model will provide:

- Screening – quickly assesses the severity of substance use and identifies the appropriate level of treatment. Three of the most widely used screening instruments are AUDIT, ASSIST, and DAST.
- Brief intervention – focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment – provides those identified as needing more extensive treatment with access to specialty care such as referrals to AA, NA, Dual Anonymous or other support groups; substance abuse detox, substance abuse residential or outpatient services; individual, marital, divorce or family counseling; and other services.

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This work plan proposes to adopt CASBIRT model as a best practice approach of screening, brief intervention, and referral to treatment. This model will use brief treatment in the form of short-term assertive peer case management to educate and engage at-risk individuals with substance abuse and/or trauma issues at the SDCPH CRU, EPU, and Crisis Clinic who appear to have low mental health needs but would benefit from peer mentoring and/or case management so that they may be effectively linked to needed services. For clients who are brought in by police pending criminal charges, screened at EPU, and deemed as fitting criteria for Quadrant III, but released to jail for booking, some additional efforts to follow-up and engage these clients into appropriate services within a reasonable time frame will be expected by the contract provider.

Proposed Staffing:

- The Program Manager shall be a licensed mental health professional OR have comparable work experience providing services to individuals with co-occurring issues
 - o The PM will be certified in alcohol and other drugs counseling such as CA Association of Alcoholism and Drug Abuse Counselors (CAADAC) certification.
- Seven, two-person teams composed of an Alcohol or Other Drug (AOD) Certified counselor and an AOD-Certified peer mentor would rotate 10am-6pm weekdays and weekends at SDCPH CRU, EPU, and Crisis Clinic. It should be noted that weekend coverage is especially important, as there is a significantly higher volume of individuals on weekends that are seen for services related to substance abuse.
 - o All team members will be AOD-certified or achieve such certification within one year of contract execution.
 - o All team members will be CCISC trained or familiar with and actively employing the philosophy of the CCISC initiative of the County.
 - o To be culturally competent, the teams will reflect the ethnicity of the population served (57% White, 22% Hispanic and 14% African-American).
 - o All teams will receive cultural competence training, in particular to develop sensitivity to LGBT individuals of all ages served.
- Two of the seven teams will have knowledge and expertise in age and developmentally appropriate services as follows:
 - o One team will specialize in outreach and assertive peer case management for TAY (18-24) population.
 - o Another team will specialize in outreach and assertive peer case management for transition age older adults [TAOA] (55-59) and older adults [OA] (60+). In fiscal year 2006-2007, 351 older adults were served at the SDCPH units. Based on this data, it is estimated that approximately 15-20 older adults will be provided services by this program on a monthly basis from this location.

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- o Based on ADS data, about one-third of patients (over 10,000 individuals) currently being screened in trauma medical centers in the County (via the ADS CASBIRT SAMHSA grant) are 55 and older; sixty-two percent of them (6,410) are 65+. The specialized TAOA/OA team will also conduct assertive outreach to the TAOA/OA referred from that project for short-term assertive case management to assure that this population is properly served.

Prior to the implementation of this model at SDCPH CRU, EPU, and Crisis Clinic, there will be multiple orientations about the model with staff at the sites, especially the psychiatrists, so that they are fully informed partners of this program. In many cases, a physician “prescription” or referral to meet with the peer/counselor team will be advantageous to the engagement of at risk individuals.

Proposed Services:

- Active outreach will be conducted to patients and family members waiting to be seen in the lobbies of the EPU and the Crisis Clinic.
 - o They will be offered education and/or 1:1 screenings through interview or self-report using an accepted screening instrument such as the AUDIT, ASSIST, DAST, or MAST-G. The MAST-G is an elderly specific screening instrument that will be utilized with the TAOA and OA population.
 - o Various means to educate the clients and accompanying family members will be employed such as looping videos on the lobby’s television and providing instructional literature. A brochure describing the programs services will be developed and distributed.
- Individuals self-identified or referred by family members or medical personnel at SDCPH will also be screened with tools described above.
 - o From all outreach, educational efforts, and screenings, those individuals identified as needing follow-up short-term assertive peer case management will be offered it.
 - o Motivational interviewing techniques will be employed to engage persons who are in the pre-contemplative or contemplative stages of change and thus hesitant to engage in this service.
- Psycho-educational/evaluation groups (pre-contemplation/contemplation stages) will be conducted a minimum of 3X weekly at SDCPH CRU, 2X weekly at EPU, and 3X weekly at the Crisis Clinic.
- Screening tools as above will be used during group.
 - o Those who attend group will be assessed for need of referral to short-term assertive peer case management. Staff will approach those so identified to engage them for this service utilizing motivational interviewing techniques as mentioned above.

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- o Pre and post surveys will be conducted for each group to assess skills learned and knowledge gained.

From the efforts described above, individuals (at least 840 – TAY 120, Adults 600, Older Adults 120) would be engaged to accept short-term assertive peer case management. These follow-up services would include:

- A plan of action would be developed based on the individual's most immediate needs and priorities as they identify them;
- Each counselor/peer team would have a monthly active caseload of 30 individuals;
- Staff would assist linkage to substance abuse treatment, residential and non-residential rehab programs; detox; AA/NA or other relevant self-help groups; sober living homes, domestic violence resources, relationship counseling, housing, educational, vocational, medical, legal, benefits, or other services, including psychiatric services, if indicated;
- Suicide risk factors would be assessed as on-going basis with case management clients; How their suicide risk factors are being minimized will be documented;
- Clients will be supported with frequent calls or visits as needed until linked to services or resources;
- Transportation would be provided as needed to the initial interview/application appointments; and
- A 90 day maximum of services with length of services dependent on availability of the treatment resources to which the individual is linked and their readiness to accept help.

Law Enforcement Training

The various San Diego Police Department Divisions and Sheriff Substations will be polled regarding what mental health and substance abuse topics would be of interest to their officers. Coordinating with law enforcement and an offer of 12 trainings (Est: 100 Officers) annually at a different location each month is planned. An orientation for law enforcement about the program's role at the SDCPH and services offered will be part of any training that is developed. Additionally, brochures describing the programs services will be offered to any law enforcement officers visiting the SDCPH.

Key Milestones and Timelines

The following are key milestones and their anticipated timeline:

- Receive California DMH approval for plan – Month 1
- RFP developed, competitive procurement process completed – Month 4
- Contract awarded – Month 5
- Hire staff – Month 6
- Staff training and certification (including cultural and linguistic needs of population) begins – Month 7-8

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- Begin development of policies and procedures – Month 5
- Draft policies and procedures submitted to County for approval – Month 6
- Outcome tools identified, surveys created – Month 6
- Create brochures and purchase materials (including materials in multiple languages) – Month 7
- Place screening and assessment teams – Begin in Month 8
- Conduct psycho-educational/evaluation groups (3/week) – Month 8
- Training of law enforcement begins (monthly) – Month 10
- Training in CCISC completed – Month 17

4. Programs

Program Title Bridge To Recovery	Proposed number of individuals or families through PEI expansion to be served annually by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
"Bridge to Recovery" SDCPH/CRU/EPU/Crisis Clinic SBIRT	Individuals: 0 Families: 0	Individuals: 1800	
"Bridge to Recovery" Assertive Short-term Peer Case Management [<i>Individuals from the SBIRT program</i>]	Individuals: 0 Families: 0	Individuals: 840	
"Bridge to Recovery" Law Enforcement Training	Individuals: 100	Individuals: 0 Families: 0	
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 100 Families: 0	Individuals: 1800 Families: 0	

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

Some anticipated linkages are listed below. Additional linkages are expected to be identified in the County's process to competitively select a contractor to provide the proposed program and services.

Linkages would be provided to all appropriate service providers including residential and non-residential rehab programs; detox; self-help groups; sober living homes; counseling resources; benefits, housing, Domestic Violence services; medical and legal resources. In addition, individuals meeting the medical necessity for specialty mental health services will be linked to existing outpatient MHSA programs in the system of care for children, TAY, adults, and older adults.

Individuals in need of resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues.

While the County-funded Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will also then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkages to non-traditional mental health related services.

6. Collaboration and System Enhancements

Anticipated collaborations and system enhancements are listed below. Additional collaborations and system enhancements are expected to be identified in the County's process to competitively select a contractor to provide the proposed program and services.

While this project has been developed as an early intervention program targeting at-risk substance abusing populations across the adult spectrum, the expectation of an intimate collaboration between an ADS provider and a significant and traditional Mental Health provider (SDCPH) promises to advance San Diego County's CCISC Initiative to a new level. While some ADS programs have incorporated a part-time or a full-time Mental Health professional into their programs, this is the first time that numbers of Alcohol or Other Drug certified counselors and peer mentors will be working shoulder to shoulder with Mental Health professionals, including psychiatrists, and on their territory. This collaborative project hopefully will be a model for Behavioral Health Services programs working cooperatively.

PEI PROJECT SUMMARY

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Collaboration and partnerships with alcohol and drug services will result in improved linkage of appropriate clients to these services so that they may begin their recovery process as soon as possible.

Collaborations with social service agencies will be sought so these programs can provide assistance in stabilizing the individuals' life in the areas of employment, housing, benefits, and other family needs.

The contractor will develop collaborations and partnerships with TAY and Older Adult programs such as Teen Centers, Senior Centers, and health care providers such as community health clinics, so that these individuals can be provided treatment and services that are age and developmentally appropriate.

Services and quality of care at the SDCPH CRU, EPU, and Crisis Clinic will be enhanced by offering these services to hundreds of individuals who otherwise would be unlikely to follow through on their own to needed care.

7. Intended Outcomes

Outcomes may include, though are not limited to, the anticipated outcomes listed below. Specific program outcomes are expected to be identified as a result of the County's process to competitively select a contractor to provide the proposed program and services. Outcomes will be re-evaluated annually by the County and service provider and, if necessary, revised to improve service provider performance.

Intended outcomes will demonstrate:

- Increased problem-solving skills and resilience,
- Increased coping skills ,
- Improved positive attitudes and behaviors,
- Reduced recidivism at the SDCPH units,
- Reduced stigma about seeking treatment or help for problems,
- Reduced suicidal risk factors, and
- Reduced # of suicides for this population.

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The program will track and/or conduct the following:

- # Screening and Brief Intervention contacts: estimated 150 per month with estimated 1800 unique clients served annually.
- Utilize a short survey for each brief intervention contact such as:
 - o “As a result of our discussion, would you know where to call when you need help?”
 - o “As a result of our discussion, could you name resources that are available to you for assistance?”
- # clients served in psycho-educational/evaluation groups and # of such groups occurring monthly: estimated **720** served annually (minimum of 30 groups monthly X 2 clients minimum X 12 months = 720).
- Utilize a short survey for each psycho-educational/evaluation group such as:
 - o “As a result of this group, I know where to call when I need help.”
 - o “As a result of this group, I understand safe drinking limits.”
 - o “As a result of this group, I am not ashamed to seek help for my issues.”
 - o “As a result of this group, I feel I am safer.”
- Utilize a short survey for each case management client who is served whether or not successfully linked to a service (they may decline linkage) with such questions as:
 - o “As a result of this program, I feel more hopeful” and other survey items such as above.
- Of those clients initially assessed, # and % that are followed up in assertive short-term case management: Each team seeing a minimum of 30 individuals every 90 days - 120/year X 7 teams = **840** individuals served.
- Of those clients successfully followed up, # and % successfully linked to a service program/housing/other defined immediate need: Contractor to establish baseline and improve on it over time.
- Numbers of clients served that are TAY, Adult, TAOA, and OA who have **not** received substance abuse treatment or mental health treatment and stipulate reasons.
- Of all identified clients who received SBIRT and assertive peer case management services under this work plan, # and % who did not return to any SDCPH unit in 60 days, 90 days, and 180 days.
- Of all identified clients who received services under this work plan, suicide risk factors were decreased as evidenced by: no suicides in group served, measurable improvement in positive behaviors, or info on survey as showing patient notes decrease in risk factors or case review.
- Track and trend suicide rate to assess if there was a decrease of suicide as a result of this intervention.

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8. Coordination with Other MHSA Components

Anticipated coordination with other MHSA components and their programs are listed below. Coordination with additional MHSA Components may be identified in the in the implementation of the proposed PEI projects and programs and the County's process to competitively select a contractor to provide the proposed program and services.

Quadrant III clients identified in this program qualify as Priority 4 among those who seek substance abuse treatment in ADS programs. (The Federal Priorities are 1: Pregnant women who are Injection Drug Users (IDU), 2: Pregnant women, 3: All other Injection Drug Users, and 4: HHSA referrals). ADS programs funded from the PEI Co-occurring Issues (CO2) work plan will have enhanced mental health services enabling them to work more effectively with persons who have co-occurring issues.

This pan will also benefit from the Primary and Secondary Prevention Plan (PS01) in the following ways:

- Media Campaign – The campaign will include elements that address raising public awareness about the risk factors and warning signs of suicide. It will incorporate cultural perspective in the resulting printed materials and TV/Radio/print ads.
- The contracted service provider of the CO01 Project shall participate on the Interagency Suicide Meeting (referenced in PS01). In being a member of this group, they will assist to develop the County's suicide action plan and ensure cultural sensitivity and awareness for the distinct needs of the target population that they represent and provide PEI services for.
- Suicide Prevention services offered through PEI will be included in Primary Prevention printed materials (described in PS01). This will assist to raise awareness about the availability of suicide prevention services funded under MHSA in San Diego County.

9. Additional Comments

Future expansion of this program might include soon to be released individuals from juvenile detention facilities and/or outreach to recently released jail inmates.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): **Co-Occuring Conditions**
 Program ID/Name: **CO01 Bridge to Recovery**
 Provider Name (if known): **Pending Competitive Procurement**
 Provider Category (DMH List): **Mental Health Treatment/Service Provider**

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	1900
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansio	0	1900
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
Classification	FTE	Per FTE				
Certified Drug and Alcohol Counselor	6.00	\$35,700		\$0	\$214,200	\$214,200
Certified Drug and Alcohol Counselor-Licensed	1.00	\$52,550		\$0	\$52,550	\$52,550
Certified AOD Peer Mentor	6.00	\$28,400		\$0	\$170,400	\$170,400
Certified CADAAC Supervisor	1.00	\$59,000		\$0	\$59,000	\$59,000
Certified AOD Asst. PM/Educator	1.00	\$54,300		\$0	\$54,300	\$54,300
Support Staff	3.00	\$25,000		\$0	\$75,000	\$75,000
Lead Peer Specialist	1.00	\$31,300		\$0	\$31,300	\$31,300
Total FTE	19.00	Sub-Total		\$0	\$656,750	\$656,750
b. Benefits%	@ 27.0%			\$0	\$177,323	\$177,323
c. Total Personnel/Staffing Expenses				\$0	\$834,073	\$834,073
2. Operating Expenditures						
Indirect/Administrative Costs		\$247,000		\$0	\$247,000	\$247,000
Operating Costs (includes Facility Costs)		\$418,927		\$0	\$418,927	\$418,927
Start-Up/One-Time Only Costs*		\$315,000		\$0	\$315,000	\$315,000
c. Total Operating Expenses				\$0	\$980,927	\$980,927
3. Subcontracts/Professional Services (list/itemize)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$0	\$0
4. Total Proposed PEI Program Budget				\$0	\$1,815,000	\$1,815,000
B. Revenues (list/itemize by fund source)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$1,815,000	\$1,815,000
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**
Program ID/Name: **CO01 Bridge to Recovery**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals and improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

Position(s) targeted: Certified AOD Peer Mentor, 6.00 FTE and Lead Peer Specialist, 1.00 FTE.

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

PEI PROJECT SUMMARY

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PEI Project Name: Co-Occurring Disorders – Screening, Community Based Alcohol & Drug Service (ADS) Programs

County: San Diego

Date: 11/19/08

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

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).

Consistent with MHSa guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSa PEI Co-Occurring Disorders as one of our 10 priority focus areas. Below is a summary of stakeholder input and background information.

In a PEI Community Forum (2/20/08), Individuals Exposed to Community & Domestic Violence, a common theme began that was to be heard in subsequent forums, "Integrate screening, assessment, and engagement with existing substance abuse programs/services."

There appeared to be consistent stakeholder input on the need for specialized mental health assistance for clients with co-occurring conditions who are currently receiving treatment in the County of San Diego Alcohol and Drug Services contracted programs.

A Community Forum (November 2007) focusing on older adults also included ideas on strategies to address substance abuse issues for those 60 and above. Specific comments of participants included

- "Screening for older adults (60+) is difficult and issues frequently include prescription misuse,"
- "(It is) tough to screen older adults," and
- "There are no co-occurring services specific for this population and therefore, programs to address mental health and substance abuse issues together need to be developed."

A Co-occurring Issues Community Forum was held to gather specific input on needs of individuals with co-occurring substance/alcohol abuse and mental health issues. Impacts to all age populations – children, youth, transition age youth, adult and older adult – were discussed, including the following specific comments from forum participants:

- "Provide early intervention services using Cognitive Based Therapy (CBT) and Motivational Interviewing (MI);"
- "Trauma informed services for adolescents simultaneously with substance abuse services provides a more solid foundation for permanent recovery;"
- "Trauma interventions for veterans returning from combat simultaneously with substance abuse services;"
- "Assist with establishing linkages to essential services, developing life skills, and being able to maintain longer periods of sobriety;"

PEI PROJECT SUMMARY

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- “Augment Alcohol and Drug Services (ADS) programs with trained mental health counselors;”
- “Augment ADS services with staff and resources to screen, assess, and provide mental health interventions/services to children of substance abusers;”
- “Provide funding to already well-established Regional Recovery Centers, Teen Recovery Centers, and other ADS residential and outpatient treatment services throughout the County;”
- “Provide ‘recovery services’ for the families of those in treatment, self help groups, and family groups;
- Normalize and support treatment/recovery for a family member, allow for support for those around them;”
- “Expand public access to mental health information, self screening tools, and lists of appropriate resources;”
- “Establish peer support groups to engage/assist at-risk individuals pending assessment or admission;” and
- “Educate/Train staff of community organizations, public systems.”

Integration of alcohol and drug services with existing mental health services has been a reoccurring theme for more than six months at the ADS providers’ meetings. Many individuals in the (substance abuse) treatment system may have experienced prior trauma and emerging or existing mental health issues. If left untreated, these issues will impact the individual’s ability to maintain on-going sobriety and could develop into serious mental illness or even death over time.

Of the 12,158 persons served in Alcohol and Drug Services in San Diego County in Fiscal Year 2006-2007, 3,285 or 27% received services from both ADS and Mental Health. Yet these individuals did not self-report a mental health diagnosis, prescription medication use for MH problems, or use of psychiatric hospital/24hr. facility for mental health needs, nor were they served in an ADS program targeting co-occurring disorders (COD). This indicates a significant percentage of individuals in ADS treatment programs who warrant the screening and educational services intended by this program to avert more serious mental health issues from developing (“Behavioral Health Outcomes Report Establishing Baselines Fiscal Year 2006-2007,” DRAFT 08/28/08; Data from Child and Adolescent Services Research Center (CASRC), University of California, San Diego (UCSD), and the County’s Alcohol and Drug Services (ADS)).

Demographic profile of 12,000 clients served in County of San Diego, Alcohol and Drug Services treatment system in FY 2006-07 (Based on data from the San Diego Web Infrastructure for Treatment Services/California Outcome Measurement System):

- 15% or 1,800 are adolescents (12-17 years),
- 18% or 2,160 are TAY (18-25 years),
- 67% or 8,040 are adults or older adults (26+ years),

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- 50% or 6,000 receive non-residential services,
- 34% or 4,080 receive residential services, and
- 16% or 1,920 receive detoxification services.

A workgroup of various local experts, including a Board-Certified psychiatrist in Mental Health and Addiction Psychiatry; Adult, Older Adult and Children's Mental Health staff; and Alcohol and Drug Services senior staff trained and experienced in co-occurring issues, collaborated to develop this work plan based on the community input and corresponding data.

Priority populations for this plan include individuals who receive services through the ADS treatment system and who generally have low mental health needs. The opportunity to screen, educate, and counsel these individuals about co-occurring issues is seen as an opportunity to lessen the development of serious mental health disorders and to reduce their suicidal risk as they recover from substance abuse.

Additionally, many residential substance abuse treatment programs allow children of the recovering person to reside with them. These children are considered to be an at-risk group who could be targeted for prevention activities to build their resilience skills so that future choices do not take them down the path of substance abuse or other self-destructive lifestyles that could eventually lead to serious mental illness and/or death.

This work plan will provide:

- Prevention activities targeted to children and youth who are placed with their parent in residential treatment programs in order to build resiliency skills;
- Mental health and substance abuse screenings to children and youth of recovering parents and the siblings of youth in recovery;
- Family assessments for families of youth or TAY in treatment;
- Family assessments when the parent or parents are in recovery;
- Information and education for parents about early signs of problems with their children and ways to manage them;
- Mental health screenings, assessments, brief interventions, education, and referrals for youth (12-17), transition-age youth (18-24), adults (25-54), transition age older adults (55-59) and older adults (60+) who are in residential or outpatient substance abuse treatment programs; and
- A specialty focus on LGBT youth and teens in recovery.

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Each agency selected to implement this work plan must employ staff who have completed one of the CCISC Cadre Training series or is scheduled to have staff complete the training series within a year of contract execution and is actively pursuing “Dual Diagnosis Capable” status as defined by Alcohol and Drug Services Administration from the CCISC initiative.

3. PEI Project Description:

Services

This prevention project proposes to add mental health counselors to a minimum of nine ADS residential and outpatient treatment programs to identify and screen clients (Est: Total 720 – children & youth 160, TAY 80, adult 400, older adult 80) who exhibit mental health concerns, prior to their development of a mental health diagnosis. The program will operate in existing ADS contracted substance abuse treatment programs, as requested in specific community forums and monthly ADS provider meetings. Interventions applied will be best practices that are age appropriate, integrated, accessible, culturally competent, and strengths based.

While addressing the needs of children, siblings, and families of individuals in AOD treatment, the project will address the needs of the following PEI priority/target populations:

- Youth (15% of overall ADS treatment population),
- Transitional age youth (18% of overall ADS treatment population), and
- Adult/older adult (67% of overall ADS treatment population).

Program staff (mental health counselors) will:

- Conduct mental health screenings at assigned ADS treatment sites, including developmentally appropriate screenings for children and older adults;
- Perform assessments;
- Provide education, debriefings, and brief counseling to reduce risk factors or stressors;
- Provide linkages to additional mental health services such as psychiatry when indicated;
- Assist with establishing linkages to essential services;
- Assist clients to develop pertinent life skills to help them maintain longer periods of sobriety;
- Provide mental health information, self screening tools and lists of appropriate resources;

PEI PROJECT SUMMARY

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- Conduct prevention groups for children of parents in recovery that build protective factors & communication skills;
- Support treatment and recovery for family members and allow for support for those around them;
- Provide consultation to ADS staff in team meetings to enhance recovery treatment;
- Conduct family assessment and linkage to behavioral health and other services that will decrease stress and increase the protective factors of the family; and
- Information and education for parents will be provided about early signs of problems with their children and ways to manage them.

This project will ensure that clients within the selected target populations, who are experiencing mental health problems with their substance abuse issues, are supported in their efforts to attain and maintain an alcohol and drug free style of living and will receive services that comprehensively address both issues. Selected programs will have staff trained about co-occurring issues of substance abuse and mental health and their interplay. They will be versed in Motivational Interviewing (MI) techniques and stage specific treatment planning. Engagement, outreach, and motivational techniques to encourage and assist clients are an expectation.

Screening tools for children and adolescents that may be utilized include: GAIN-SS, Problem Oriented Screening Instrument for Teenagers (POSIT), San Diego Resiliency Checkup, Substance Abuse Subtle Screening Inventory (SASSI), and Adolescent Drinking Index (ADI).

Prevention and education groups for high-risk children ages 6-12 yrs and their parents may include Incredible Years and/or other appropriate evidence-based practices that have demonstrated success with persons experiencing co-occurring issues. As an example, Incredible Years improves parenting skills, child social behavior, and family relationships.

Key Milestones and Timelines

The following are key milestones and their anticipated timeline:

- Receive California DMH approval for Plan – Month 1
- RFP developed, competitive procurement process completed – Month 4
- Contract awarded – Month 5
- Hire staff – Month 6
- Staff training and certification (including cultural and linguistic needs of population) – Month 7

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- Begin development of policies and procedures – Month 6
- Draft policies and procedures submitted to County for approval – Month 7
- Outcome tools identified, surveys created – Month 7
- Create brochures and purchase materials (including materials in multiple languages) to be offered at each facility – Month 6
- Begin mental health screenings at assessments at treatment sites – Month 8
- Conduct prevention groups for children – Month 8
- Provide consultation to ADS teams – Month 8
- Parent education/groups – Month 9

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served annually through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Screening, Community Based Alcohol and Drug Service (ADS) Programs	Individuals: 720 Families: 100 (associated with individuals)	Individuals: Families:	
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 720 Families:	Individuals: Families:	

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

Some anticipated linkages are listed below. Additional linkages are expected to be identified in the County's process to competitively select a contractor to provide the proposed program and services.

Linkages will be provided to all appropriate service providers including psychiatric services, detox, self-help groups, sober living homes, benefits, housing, domestic violence services, medical and legal resources, and other residential and non-residential substance abuse rehab programs if needed.

Individuals in need of resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues.

While the County-funded Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will also then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkages to non-traditional mental health related services.

6. Collaboration and System Enhancements

Anticipated collaborations and system enhancements are listed below. Additional collaborations and system enhancements are expected to be identified in the County's process to competitively select a contractor to provide the proposed program and services.

This program will collaborate with Co-occurring Issues plan "Bridge to Recovery" (CO01) by accepting referrals of persons who apply for substance abuse treatment and have been identified with possible mental health issues. Collaborations with social service agencies will be sought so these programs can provide assistance in stabilizing the individuals' life (e.g., in the areas of employment, housing, benefits, and other family needs).

PEI PROJECT SUMMARY

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7. Intended Outcomes

Outcomes may include, though are not limited to, the anticipated outcomes listed below. Specific program outcomes are expected to be identified as a result of the County's process to competitively select a contractor to provide the proposed program and services. Outcomes will be re-evaluated annually by the County and service provider and, if necessary, revised to improve service provider performance. Intended outcomes will demonstrate:

- o Increased problem-solving skills and resilience,
- o Increased coping skills,
- o Improved positive attitudes and behaviors,
- o Reduced stigma about seeking treatment or help for problems, and
- o Reduced suicidal risk factors.

The program will track and/or conduct the following:

- # of ADS clients, by age, provided with mental health service, specify service;
- # of children of ADS clients provided with mental health or prevention service, specify service;
- # of clients who identified and achieved mental health goals as evidenced by positive responses to statements such as:
 - o "I reached my goals;"
 - o "I am satisfied with the services I received;"
- # clients served in Psychoeducational Co-occurring groups and # of such groups occurring monthly;
- # of children of AOD clients who attend skill building groups and # of group sessions provided monthly;
- Utilize a short survey for each Psychoeducational Co-occurring group such as:
 - o "As a result of this group, I understand more about my mental health issues;"
 - o "As a result of this group, I am not ashamed to seek help for my mental health issues;"
 - o "As a result of this group, I feel I am safer;"
- Utilize a short survey (or design an activity to observe improved skills of problem-solving or conflict management) that is age-appropriate for children/youth with questions such as:
 - o "Because of what I learned, I feel friendlier;"
 - o "Because of what I learned, I play with my friends more without arguing or swearing;"
 - o "Because of what I learned, I play with my friends more without hitting;"
 - o "Because of what I learned, I am not so sad;" and
 - o "Because of what I learned, I am not so shy."

PEI PROJECT SUMMARY

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8. Coordination with Other MHSA Components

Anticipated coordination with other MHSA components and their programs are listed below. Coordination with additional MHSA Components may be identified in the in the implementation of the proposed PEI projects and programs and the County's process to competitively select a contractor to provide the proposed program and services.

This program will coordinate with other MHSA Components such as CSS by referring those persons who need specialty MH treatment to the age appropriate program, such as Adult Outpatient Enhancement (CSS-A8), TAY Outpatient Enhancement (CSS-TAY4), or the TAY Co-Occurring Residential Treatment (CSS-TAY3). Conversely, persons who do not meet criteria for specialty MH treatment and are referred for ADS treatment will be more appropriately served in the ADS system in which MH staff are available to provide services for low-level MH needs.

This Plan will also benefit from the Primary and Secondary Prevention Plan (PS01) in the following ways:

- Media Campaign – The campaign will include elements that address raising public awareness about the risk factors and warning signs of suicide. The campaign will also incorporate cultural perspectives in the resulting printed materials and TV/Radio/print ads.
- The contracted service provider of the CO02 Project shall participate on the Interagency Suicide Meeting (referenced in PS01). In being a member of this group, they will assist to develop the County's suicide action plan and ensure cultural sensitivity and awareness for the distinct needs of the target population that they represent and provide PEI services for.
- Suicide Prevention services offered through PEI will be included in Primary Prevention printed materials (described in PS01). This will assist to raise awareness about the availability of suicide prevention services funded under MHSA in San Diego County.

9. Additional Comments:

Future expansion of this program may include adding a mental health staff to additional AOD programs until every AOD program is so staffed.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): Co-Occuring Conditions
 Program ID/Name: **CO02 Screening, Community Based Alcohol and Drug Services (ADS) Programs**
 Provider Name (if known): Pending Competitive Procurement
 Provider Category (DMH List): Other

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	720
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	720
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
	Classification	FTE	Per FTE			
	Licensed Mental Health Counselor	9.00	\$52,550	\$0	\$472,950	\$472,950
	Certified CADAAC Supervisor	0.25	\$59,000	\$0	\$14,750	\$14,750
	Support Staff	1.00	\$25,000	\$0	\$25,000	\$25,000
		0.00	\$0	\$0	\$0	\$0
		0.00	\$0	\$0	\$0	\$0
	Total FTE	10.25	Sub-Total	\$0	\$512,700	\$512,700
b. Benefits%	@	27.0%		\$0	\$138,429	\$138,429
c. Total Personnel/Staffing Expenses				\$0	\$651,129	\$651,129
2. Operating Expenditures						
	Indirect/Administrative Costs	13.3%	\$133,250	\$0	\$133,250	\$133,250
	Operating Costs (includes Facility Costs)	21.6%	\$215,621	\$0	\$215,621	\$215,621
	Start-Up/One-Time Only Costs*	15%	\$150,000	\$0	\$150,000	\$150,000
c. Total Operating Expenses				\$0	\$498,871	\$498,871
3. Subcontracts/Professional Services (list/itemize)						
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$0	\$0
4. Total Proposed PEI Program Budget				\$0	\$1,150,000	\$1,150,000
B. Revenues (list/itemize by fund source)						
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$1,150,000	\$1,150,000
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**

Program ID/Name: **CO02 Screening, Community Based Alcohol and Drug Services (ADS)**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals and improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

Position(s) targeted: Licensed Mental Health Counselor, 9.00 FTE.

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

PEI PROJECT SUMMARY

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PEI Project Name: Elder Multicultural Access and Support Services (EMASS)

County: San Diego

Date: 11/19/08

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

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	☐	☐	☐	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☒
3. Children and Youth in Stressed Families	☐	☐		
4. Children and Youth at Risk for School Failure	☐	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		
6. Underserved Cultural Populations	☐	☐	☐	☒

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).

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Older Adult (OA) Populations as one of our 10 priority focus areas. Below is a list of venues and opportunities offered to community stakeholders to participate in the PEI planning process and to provide valuable input for the selection of the proposed program.

Aging and Mental Health Summit: June 2006

The Aging Summit is an Aging and Independent Services event. The Summit was sponsored by AOAMHS and the Aging and Mental Health Workgroup. This event offered the opportunity to gather input into the future planning of PEI programs and services. Recommendations from stakeholders included:

- Program should include Senior Peer Counseling “to provide culturally competent/linguistically appropriate Senior Peer counseling training and services to reduce social isolation and promote socialization and community participation of older adults of diverse ethnic/culturally background and to target Hispanic and Asian populations.”
- One stakeholder mentioned the need for very specific Senior Peer Counseling. The “Santa Monica Senior Peer Counseling-Adapted” was recommended as “an intervention in place in many other jurisdictions [and] is an effective way to work with older adults. Seniors are paired with an individual who is old enough to be a peer and to have experienced many of the same life events. Peer counselors are trained and certified as volunteers. Seniors have found that talking with someone from their own age group has made a tremendous difference in working through issues of emerging mental illness or life changes that they face during the aging process. Volunteers are also enriched by being able to directly contribute to the increased well being of a member of their generation.”
- Senior Peer training topics need to include Senior Peer/Promotora definition; characteristic, role, and environment and cultural issues; outreach, engagement, education, community resources, linkages, information and referral with older adults; senior peer counseling skills and confidentiality; aging as a process; older adult mental health; medications use and misuse/substance abuse; wellness, rehabilitation, recovery and self-sufficiency; care management and record keeping; and family/caregiver support.
- Stakeholders would like to see a “partnership with community-based organizations/individuals providing and/or interested in providing peer-counseling services to Hispanic and Asian communities.”

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OA PEI Stakeholder Forum: November 2007

This forum was hosted by the Older Adult Mental Health Council and the Older Adult PEI Committee of the Council, and it was the first of the scheduled PEI Planning venues in San Diego. The forum brought together close to 100 individuals. The key issues related to late onset identified at this event were:

- Stakeholders identified senior peer counseling as a need of the community.

Outreach to Special Populations Focus Groups: December through February 2008

Following Dr. Aguilar-Gaxiola's model for outreach and engaging of special populations in the PEI planning process and in partnership with community based organizations, the County of San Diego Mental Health Services staff conducted outreach to African American, Hispanic, Pacific Islander and African Refugee communities. Special population focus groups were hosted and facilitated by community-based organizations and their staff and were conducted in the preferred language of the participants. The following is a summary of input provided by these special focus groups.

African Refugees:

- "Provide services to elderly through a combination of peer counseling, mentorship, support group and intergenerational activities. This would encourage them to be active through employment, volunteer and ESL. This could be done through collaboration of faith-based institution, community elders, social services and clinics."
- "These populations are at high risk for mental health issues because they have experienced trauma and suffered torture - Service should focus on acculturation, goal setting through group formats - Need for staff training and collaborative efforts with existing refugee centers are an essential component - Extra targeted support re: functional goals (education, employment), in-home and interagency intervention and strengthening links to the community resources - Need to collaborate with Refugee Health Assessment Program and Survivors of Torture International -- Need to educate caseworkers to understand and identify Mental health symptoms in clients - Need referrals for education and treatment and prevention services - Need to build a support system of refugee resettlement programs in San Diego and it would be the perfect readiness point to provide intervention for preventing Mental illness and associated disorders - Need to reach newly arrived refugees when they arrive in our communities - Non-profit grass-roots organizations that help bridge the gap for African refugees living in San Diego - Providers need specialized knowledge and skills (cultural/ethnic competence, language) and survivors need education/information, trust in institutions (including medical), acceptance of mental health problems and reduction of stigma, improved transportation. Male and females issues need to be addressed separately due to cultural needs."

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African Americans:

Use existing resources and client base from George L. Stevens Community Center to implement the following services:

- Social services advocacy training for trusted community gate keepers to establish more positive communication/trusting relationships with helping agencies;
- Provide educational opportunities/support groups for positive parenting, support for caregivers, anger management, respite care, and positive grieving;
- Interactive workshops/seminars on appropriate use of prescriptions and other substances including training on positive interventions for misuse;
- Positive communication training between generations using storytelling;
- Life retraining support for widowers/widows; and
- Faith-based educational programs to help reduce stigma.

Hispanic Community:

Feedback included suggestions for the following:

- Support to older adults experiencing stress due to migration and acculturation;
- Socialization and social support to older adult immigrants;
- Services by providers of the same ethnic/cultural group of the older adult immigrant;
- Sufficient resources to older adult immigrants;
- Employment opportunities for older adult immigrants;
- Language training for older adult immigrant;
- Disruption of social relationships – lonely because children at work all day;
- Barriers to accessing services - insurance, culture and language barriers;
- Provide outreach staff in sufficient numbers to cover San Diego County immigrant populations; and
- Improve transportation to/from services – Need non-priority transportation that is available as needed (currently long waits) – Need transportation available all-day for shopping, socialization, groups. Current transportation limited to-from specific facility (Joslyn Center in North County).

Pacific Islander Community:

Feedback included suggestions for the following:

- Need for advocacy – someone to accompany older adult when applying for services;

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- Service providers that are culturally competent;
- Non-priority transportation that is available as needed;
- Have access to support for nutrition, technology, services, self-esteem activities, medications; and
- Provider facilities that are centrally located.

Adult Day Health Care (ADHC) Focus Group:

This focus group was conducted at an adult health care center in North County that currently serves 265 older adult clients. Feedback included suggestions for the following:

- Provide culturally appropriate care within the community;
- Listen to consumers;
- Add more SSI advocates;
- Provide mental health education at schools and colleges to family and caregivers;
- Need more Adult Day Health Care (ADHC) facilities with holistic, socialization, and integrated services; and
- Market services through the internet, literature at churches, board and care, senior apartments mobile home parks, flyers in newspapers.

Qualitative Assessment of Need for Mental Health Services Among Older Adults in San Diego County – February 2006

San Diego Mental Health Services, in partnership with the University of California San Diego (UCSD) Geriatric Research Center completed the “*Qualitative Assessment of Need for Mental Health Services Among Older Adults in San Diego County*”. This OA Needs Assessment was done in partnership with UCSD research Center, funded by a grant from the National Institute of Mental Health (NIMH). The Older Adult System of Care Council and AOAMHS provided the impetus for this assessment with the purpose of identifying older adult needs in San Diego County. Results were and continue to be used to develop programs and services to address needs of older adults and assisted to inform the development of the PEI Older Adult Plans. The following individuals assisted with the assessment: Lawrence A. Palinkas, Ph.D.; Viviana Criado, M.P.A.; Dahlia Fuentes, M.S.W., M.P.H.; Sally Shepherd, R.N.; Hans Milian, M.P.H.; David Folsom, M.D.; and Dilip V. Jeste, M.D. The results and recommendations from this study follow.

- Eighty percent (80%) of the participants identified limited or no access to mental health services as a significant unmet need. Thirty-three percent (33%) of the participants perceived an absence of age appropriate or culturally appropriate services. Language and cultural barriers were cited as limiting access to existing services. Other

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important barriers cited by participants were the lack of information on which services are available and how to use those services.

- A lack of available appropriate and affordable transportation contributes to isolation and restricts access to health care and was identified as a significant unmet need. The need for affordable and accessible transportation was recognized by 55.5% of the participants as an important barrier and unmet need. One stakeholder stated, "Transportation - when they [older adults] lose their license or the ability to use public transportation, it is very depressing for them, it cuts them off. They can no longer visit family. They can't go to social events, and usually their friends are older." One provider stated that the lack of transportation is particularly a problem for those with mental illness or cognitive disorder. "Certainly we need to develop more transportation...for seniors whether they are mentally ill or not. Because even if they are not mentally ill, if there is no transportation they may be seen down the road with depression and affective disorders. Transportation is another factor which is key to getting that support you need, socially having some way to keep mental health."

To improve access, reduce stigma and improve services, stakeholders recommended the following:

- Educate family members of service availability, involve current and former clients and family in outreach efforts;
- Train service providers to communicate in client's language;
- Offer peer counseling, support and information on availability of services;
- Use of promotoras and incorporate services in places like senior centers where older adults frequent;
- Make available door to door transportation rather than curb side;
- Expand volunteer transportation program;
- Provide vouchers to taxi cab companies for medical appointments; and
- Escort services for older adults with physical disabilities to and from appointments.

Review of demographic data for 2007 prepared by the San Diego Association of Governments (SANDAG) data warehouse demonstrates that

- Forty-eight percent (48.4%) of County residents are other than White (who comprise 51.6% of the population). The non-White residents break down as follows: 29.3% Hispanic, 9.4% Asian, 5.4% Black, 3.2% mixed race, 0.5% Native American, 0.4% Hawaiian, and 0.2% other.

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- Fourteen percent (14% or 453,939) of the total population are older adults, 71% are white, 12% are Hispanic, 9.5% are Asian Pacific Islanders, 5% are from multi-racial groups, 4% are Native American, and 3% are African American.
- Fifty-five percent (55%) of the older adult population are females and 45% are males.
- The median income for older adults is 49,880 with 23% of these individuals receiving Social Security and 16% receiving another type of pension other than social security.
- Of those 65 and over, 9% were participating in government programs and 57% were Medi-Cal eligible.

According to Elizabeth Grieco of the Migration Policy Institute (2001) there are over one million African foreign-born in the United States. Of the African refugee arrivals in 2001, 31% were from Sudan, 26% from Somalia, 18% from Liberia and 11% from Sierra Leone. Each of these groups has unique histories, languages, cultures, and situations that produced refugees. These are older adults who have been forced to leave their home countries because of political or religious persecution. Many lived for years in refugee camps before being admitted to the United States. Local non-profit grassroots organizations have helped bridge the gap for African refugees living in San Diego. However, much more than that initial support is needed to bring seniors out of the isolation in which they live and to assist them with the transition into the larger society.

Transportation Needs Report: Aging and Independence Services (AIS), 2006

Transportation needs are pronounced among rural older adults who face longer distances to reach health care delivery sites. Transportation problems are closely correlated with poor income, self-care problems, isolation and loneliness. Reduced mobility puts an older person at higher risk of poor health as the ability to obtain the goods and services necessary for good health and welfare is reduced. In addition, independence is stifled and loss of self-sufficiency can fuel depression. There is a need to enhance access to public transit, both fixed-route and para-transit systems. Some older adults may need the additional assistance of “through the door” services to reach their destinations safely. Sensitivity awareness training should be provided for drivers in how to interact with passengers with special needs. (*Transportation Needs Report: Aging & Independence Services, 2006*)

3. PEI Project Description:

This program is multicultural outreach, education, advocacy, peer counseling support and transportation services to older adult Hispanics, African refugees, African American and Filipino seniors at senior housing, senior centers, faith-based organizations, and natural gathering places by older adult promotoras and community health workers.

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The Elder Multicultural Access and Support Services (EMASS) program was selected based on the community stakeholder input and recommendation for the development of culturally and linguistically appropriate, peer-based outreach and engagement model to support prevention activities and increased access to care. The EMASS program emphasizes the use of promotoras or “Community Health Workers” as liaisons between their communities and health and human service organizations to bring information to their communities. These Community Health Workers serve as peer-based community liaisons and will play the roles of advocate, educator, mentor, outreach worker, role model, translator and more.

The Promotora model of community outreach is based on the very successful Latin American model that reaches underserved populations through peer education, and it is currently utilized with great success in public health care systems and in community health centers throughout the country.

This program is consistent with the state established priority PEI Community Needs, Priority Populations and principles and seeks to address ethnic disparities by bringing to the table community leaders from each of the target population group and together work on adapting this culturally and linguistically appropriate peer-based promotora model to address the needs of older adults in the Asian/Pacific Islander, Hispanic, African American, African Refugee communities.

This EMASS program will enable timely identification of mental health issues and will prevent some mental health issues, reduce inappropriate utilization of service such as the emergency room (ER) and inpatient hospital admissions, enhance timely access and engagement, enhance service utilization capacity and will improve quality of care by providing culturally and linguistically effective services.

Below are the services and methods that will be used in making direct contact with and engaging older adults from the targeted communities.

- Outreach and Engagement: Senior Community Workers will provide culturally and linguistically competent behavioral health care outreach and engagement opportunities through peer-based services conducted in seniors’ home and in places in the community where seniors typically congregate.
- Education: An offering of a variety of individual and group educational opportunities to strengthen seniors’ capacity to remain independent and improve quality of their lives will be available. Topics may include adjusting to a new culture, substance abuse, how to manage stress, violence in the home, navigating the healthcare system, patient rights, ER usage, community based services, health insurance and Medi-Cal, living with disabilities, taking medications correctly, nutrition and related diseases such as diabetes, heart conditions, obesity and Senior Peer Counseling.

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- Information, Linkage and Referrals: The contractor for these services will ensure that clients are identified as needing a range of services and supports. Senior Community Workers will provide seniors and their families with appropriate referral information such as community mental health, social services, self-help, housing and employment services, healthcare and referrals to mental health and other county-operated, contracted or private services. Senior services will be coordinated through HHSA, Aging and Independence Services 24-hour Call Center.
- Benefits Advocacy: Utilizing Benefit's Check up / Online Decision Support: Senior Community Worker will screen senior for benefits eligibility and assist them with enrollment and securing federal, state and private benefits programs such as healthcare, prescription medication, affordable housing, education and energy assistance.
- Senior Peer Counseling will be available for counseling, support, and education on how to navigate the health care system.
- Socialization: The program will offer on site and in community structured and semi-structured opportunities such as weekly site-based social and recreational activities to encourage the development of interpersonal relationships, community connections and other system supports.
- Transportation: To improve access to care, reduce isolation and maintain self-sufficiency, and in partnership with local interagency collaborative that seeks to develop senior transportation, contractor shall provide integrated, door-to-door transportation services. Initially, this service is to be provided in the North County Region and will be expanded thereafter to other San Diego regions. Transportation services shall be available 7 days a week and will be tailored to meet each individual's unique transportation needs.
- Culturally and Linguistically Appropriate: All services will be provided in a culturally and linguistically appropriate way, including outreach, education and peer support. These services will be provided in senior's own language by someone from their own community with the understanding of cultural nuances. In addition program materials will be developed in languages other than English.
- Location of Services: The program services will be available in home, in community settings where seniors naturally gather and/or are most comfortable such as senior housing, ADHC, senior centers, and faith based communities. Services will be also scheduled as needed to meet older adult needs and to achieve proposed program outcomes.

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Staff:

- Community Liaison Lead will be experienced and knowledgeable about community health outreach and education with diverse communities. Under the direct oversight of contractor, the lead community liaison will manage day-to-day operation of the program and will recruit and facilitate training for all program staff.
- Older Adult Community Health Workers will be well known and accepted community leaders, male and female, age 55 and over, from each of the target communities identified by program, committed to improving quality of life of their own communities. They will be responsible for providing outreach, education, peer counseling and facilitating access to other services and support. The Community Health Workers will be carefully selected members of the communities to be served. All of these staff will be trained and certified. Mobility Lead will be experienced and knowledgeable about community-wide transportation service network and understand how it operates. The Mobility Lead will be responsible for guiding older adults through the transportation resources and services that are available. The main focus of his/her activities will be to assist consumers in choosing the best options to meet their individual travel needs.

Array of Transportation Services:

The services listed below will be made available for older adults depending on their level or need and severity of physical or mental capacities.

- Curb-to-curb service will be provided for seniors, pick up and delivery at the curb or roadside.
- Door-to-door service offers higher level of assistance by picking up passengers at the door of their homes and delivering them to the doors of their destinations.
- Door-through-door (Escort) service offers several levels of personal, hands-on assistance by driver or escort to help seniors through the doors of their residences and destinations, as needed.
- Transportation Voucher Program: Services at a reduced rate that utilizes vouchers to pay for services.

Travel Training: For seniors able to utilize public transportation, the program shall provide free, hands-on instruction to help older adults and persons with disabilities learn to travel safely and independently within public transit systems. Topics shall include, but is not limited to, best routes to take to reach various destinations, hours of service, the cost of the trip (including available discounts), and how to pay for services (such as fare cards or tokens). Demonstrations on how to ride public buses and trains shall also be provided.

The contractor selected to provide these services will demonstrate experience and/or capacity to develop relationships with diverse populations. Contractor may choose to subcontract with community-based organizations already familiar/experienced in providing services to target population. Services to be provided shall be responsive to the need

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and expressed preference of the community to be served. Senior Community Workers, Health Promoters, Peer Counselors shall be hired from these communities and trained in the areas of aging and health promotion, mental health, substance abuse, medication use and adherence, elder abuse and domestic violence. Staff will also provide education to the community on how to navigate through the healthcare system and provide advocacy, peer counseling and support.

Community and faith-based organizations will be identified as part of the program contract. The contractor for this program shall deliver services as follows: outreach, education, information, linkage and referrals, benefits advocacy utilizing Benefit's Check up / Online Decision Support, senior peer counseling, socialization, and transportation.

This program addresses needs identified in the community program planning process by providing cultural/linguistic appropriate services to outreach and effectively engage traditionally unserved and underserved older adults, and to address needs for education, transportation and social and emotional support that are not currently being addressed.

Key dates and milestones include:

- Receive California DMH approval for Plan – Month 1
- RFP developed, competitive procurement process completed – Month 6
- Contract awarded – Month 7
- Hire staff – Month 7-8
- Staff training and certification (including cultural and linguistic needs of population) begins – Month 7-8
- Begin development of policies and procedures – Month 7
- Draft policies and procedures submitted to County for approval – Month 7
- Develop program materials including materials in multiple languages – Month 7
- Outcome tools identified, surveys created – Month 7
- Delivery of Services – Month 8

PEI PROJECT SUMMARY

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4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Elder Multicultural Access and Support Services (EMASS)	Individuals: 400 North County 200 Central 200 South	Individuals: Families:	
TOTAL PEI PROJECT ESTIMATED <i>UNDULICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 800 (<i>200 will be Transportation Only clients</i>) Families:	Individuals: Families:	

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

Program staff, working with each of the targeted diverse communities in this program, will link older adults identified in need for behavioral health services to culturally and linguistically appropriate older adult county operated or contracted services, as well as to primary care community healthcare centers. The contractor for these services shall develop and maintain an up-to-date roster of appropriate resources and will participate in all County-sponsored regional providers meetings.

Individuals in need of resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues. While the County-funded Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will also then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services.

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6. Collaboration and System Enhancements

The contractor for this program will develop partnerships and cooperative agreements with community-based and faith-based organizations traditionally providing services to target community. Partners could subcontract to provide all or some of the services and/or provide services as an expansion of activities already funded by other grants.

Contractor(s) for these services, in partnership with system partners, will work on a plan for program ongoing sustainability with a final goal of integrating MHSA PEI funded activities within the existing structure of services provided by the contracted/subcontracted organization(s).

7. Intended Outcomes

Contractor for these services in coordination with the Older Adult Mental Health Coordinator will identify tools to measure and track intended outcomes and will report to the County accomplished results via the Monthly Status Report.

Individual outcomes

- Increase timely access to care
- Reduce disparities in care
- Increase and maintain individual self-sufficiency
- Increase knowledge about healthcare system
- Reduce isolation / increase socialization

System Outcomes

- Reduce inappropriate utilization of specialty and emergency room services
- Reduce inappropriate institutionalization
- Decrease no show rates for medical appointments
- Decrease emergency room utilization

As a result of the implementation of this program, barriers to access to care will be removed and there will be increased access to healthcare and other resources typically not accessed by target population. Additionally, there will be increased and timely access to services and decreased use of specialty and emergency room visits. Increased system efficiencies will be evaluated on reduction of wait times, no-show rates and ER utilization.

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8. Coordination with Other MHSA Components

Individuals identified as in need for specialty mental health and in need of more comprehensive services and supports will be linked to existent older adult MHSA funded programs (full service partnership, and field capable clinical services), and/or to existent Medi-Cal funded core services, or to fee for service providers.

Training for consumers/family advocates funded by Workforce Education and Training (WET) funds may also be considered through the stakeholder process for WET for staff and consumers /families interested on developing skills to serve their communities.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): **Older Adult Services**
 Program ID/Name: **OA01 Elder Multicultural Access and Support Services (EMASS)**
 Provider Name (if known): **Pending Competitive Procurement**
 Provider Category (DMH List): **Mental Health Treatment/Service Provider**

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	800
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	800
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
Classification	FTE	Per FTE				
Community Liaison	5.00	\$28,000		\$0	\$140,000	\$140,000
Team Leader (senior community liaison)	1.00	\$32,000		\$0	\$32,000	\$32,000
Mobility Lead	1.00	\$40,000		\$0	\$40,000	\$40,000
Administrative Support	0.50	\$35,000		\$0	\$17,500	\$17,500
	0.00	\$0		\$0	\$0	\$0
Total FTE	7.50	Sub-Total		\$0	\$229,500	\$229,500
b. Benefits%	@ 27.0%			\$0	\$61,965	\$61,965
c. Total Personnel/Staffing Expenses				\$0	\$291,465	\$291,465
2. Operating Expenditures						
Indirect/Administrative Costs		\$45,000		\$0	\$45,000	\$45,000
Operating Costs (includes Facility Costs)		\$50,688		\$0	\$50,688	\$50,688
Start-Up/One-Time Only Costs*		\$127,000		\$0	\$127,000	\$127,000
c. Total Operating Expenses				\$0	\$222,688	\$222,688
3. Subcontracts/Professional Services (list/itemize)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$0	\$0
4. Total Proposed PEI Program Budget				\$0	\$514,153	\$514,153
B. Revenues (list/itemize by fund source)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$514,153	\$514,153
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**

Program ID/Name: **OA01 Elder Multicultural Access and Support Services (EMASS)**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals and improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

Position(s) targeted: Community Liaison, 5.00 FTE.

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

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PEI Project Name: Home Based Prevention Early Intervention Gatekeeper Program

County: San Diego

Date: 11/19/08

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

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	☐	☐	☐	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☒
3. Children and Youth in Stressed Families	☐	☐		
4. Children and Youth at Risk for School Failure	☐	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		
6. Underserved Cultural Populations	☐	☐	☐	☐

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

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Older Adult Populations as one of our 10 priority focus areas. Below is a list of venues and opportunities offered to community stakeholders to participate in the PEI planning process and to provide valuable input for the selection of the proposed program.

Qualitative Assessment of Need for Mental Health Services Among Older Adults in San Diego County – February 2006

San Diego Mental Health Services, in partnership with the University of California San Diego (UCSD) Geriatric Research Center completed the “*Qualitative Assessment of Need for Mental Health Services Among Older Adults in San Diego County*”. This OA Needs Assessment was done in partnership with UCSD research Center, funded by a grant from the National Institute of Mental Health (NIMH). The Older Adult System of Care Council and AOAMHS provided the impetus for this assessment with the purpose of identifying older adult needs in San Diego County. Results were and continue to be used to develop programs and services to address needs of older adults and assisted to inform the development of the PEI Older Adult Plans. The following individuals assisted with the assessment: Lawrence A. Palinkas, Ph.D.; Viviana Criado, M.P.A.; Dahlia Fuentes, M.S.W., M.P.H.; Sally Shepherd, R.N.; Hans Milian, M.P.H.; David Folsom, M.D.; and Dilip V. Jeste, M.D. The results and recommendations from this study follow.

- There is a need to educate more than the depressed person because the depressed person cannot always ask for help – must educate advocates, family members, etc.;
- Community, waiting room, etc., should be flooded with information about depression;
- Senior Peers could be trained by clinicians to be utilized to advocate with the Primary Care Provider;
- Trainings offered monthly to Volunteer Ombudsman, should be available to the general population;
- Educate XYZ generation (about the needs of the Older Adult population) and reach and educate other cultures; cultural competency is imperative – understand how other cultures see depression;
- Mental illness is in the shadows and we do not talk about it; there is far less insurance coverage for mental health issues;

PEI PROJECT SUMMARY

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- There is a need for more education of consumers so that they rise up and demand better services;
- Need to become advocates for each other – friends and family, in both physical and mental health – and to pledge to end the stigma of mental health;
- Need for funding for private and public agencies collaboration and for neighborhood based services; and
- Culturally competent mentors are needed for the mentally ill – the training could teach through role playing, need to end stereotypes.

Aging and Mental Health Summit Recommendations June 2006

The Aging Summit was an Aging and Independence Services event. The Summit was sponsored by AOAMHS and the Aging and Mental Health Workgroup. This event offered the opportunity to gather input into the future planning of PEI programs and services. At this event a panel of experts presented on the results of the “Qualitative Assessment of Need for Mental Health Services Among Older Adults in San Diego County.” The subsequent discussion and feedback was summarized and presented to San Diego County BOS as part of set formal recommendations for implementation. The following is recommendation # 4 of the workgroup.

Development of Senior Peer Counseling:

- Strategy: Provide culturally competent/linguistically appropriate senior peer counseling training and services to reduce social isolation and promote socialization and community participation of older adults of diverse ethnic/cultural backgrounds.
- Target: Hispanic and Asian populations
- Intervention: Santa Monica Senior Peer Counseling – Adapted
- Training Topic(s): Senior Peer/Promotora definition; characteristics, role, environment and cultural issues; outreach, engagement, education, community resources, linkages, information and referral with older adults; senior peer counseling skills and confidentiality; aging as a process; older adult mental health; medications use and misuse/substance abuse; wellness, rehabilitation, recovery and self-sufficiency; care management and record keeping; and family/caregiver support.

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- Partners: Community-based organizations/individuals providing and/or interested in providing peer counseling services to Hispanic and Asian communities.

Older Adult PEI Stakeholder Forum – November 2007

This forum was hosted by the Older Adult Mental Health Council and the Older Adult PEI Committee of the Council, and it was the first of the scheduled PEI Planning venues in San Diego. The forum brought together close to 100 individuals. The key issues related to late onset identified at this event were:

- “In partnership with senior community center, behavioral health organization and MHSA-CSS older adults program contractor to enhance existent promising program that identifies and engages at-risk older adults (Multicultural Senior Mental health). Program provides prompt access to screening and assessment; links older adults and their families to social, financial, health, housing, and legal services, and provides early intervention mental health resources, by incorporating the ‘gatekeeper model.’”
- “Expand home delivered meals services to screen for at-risk behaviors (suicide factors) of isolated/home bound seniors unable to access community resources to provide in-home services. Prevention and early intervention for all older adults, not just those who fall into the poverty population.”
- “Need for early detection of depression and early intervention of late on-set conditions and suicide prevention.”
- “Need for Peer Counseling”
- “Need for education and a stigma reduction campaign, particularly focused on underserved ethnic populations of elders”
- “Early intervention in elder abuse situations with complex family dynamics “
- “Prevention and early intervention strategies should be developed in collaboration with community partners.”

Special Populations Community Focus Groups – December 2007 through February 2008

To broaden the opportunity for input from special populations, the County of San Diego Mental Health Services held a series of Community Forums at places where PEI stakeholders normally gathered, such as senior centers, libraries, low

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income housing complexes, and adult day health care centers. Individuals that participated included older adults from Hispanic, African Refugee, Asian/Pacific Islander, African American and Caucasian communities in San Diego.

Older Adult Mental Health Council Prevention Early Intervention Planning Workgroup:

The Older Adult Council PEI Committee was convened in September 2007 and given the charge to review all older adult PEI related input received by Mental Health administration and to prepare a set of recommendations to the Older Adult Mental Health Council for full Council review and approval. The following is a list of recommendations endorsed by the OAMHSOC Council that were submitted to Mental Health administration for consideration as related to this plan for older adults.

- Outreach, Assessment, Engagement and Education: Peer counseling; promotora services; advocacy; cultural brokers for Latinos, East African, African American and Filipino Seniors. Age; gender and culture/language specific outreach and engagement to home-bound and hard-to-reach elders.
- Outcome: To increase access and retention of elder minorities and reduce disparities in care.
- Assessment: To provide culturally competent, integrated screening and assessment in-home and in the community by cross-cultural gatekeepers via a) outreach to individuals, families, providers, and organizations; b) helping to reduce stressors in older adults and families; and c) linkage to mental health services as appropriate.
- Intervention, Service and Recovery: Age, cultural/linguistic and gender specific and accessible services based on principles of collaboration and service integration. Services to include transportation, screening, assessment, interventions and linkages to specialty mental health services. Multi-disciplinary mobile teams to outreach to older adults living alone and to Senior Centers and ADHC Centers.
- Suicide Prevention: Conduct suicide and depression screening to isolated/homebound seniors by in-home delivery meal services.

The data below supports the selection of the Home Based Prevention Early Intervention Gatekeeper Program:

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San Diego County Demographics:

In San Diego County, in the year 2000, the total population of those aged 60 and over was 453,939 (14.8%) of the total population (2,498,833). Seventy one percent (324,602) were white, 12% (54,217) were Hispanic or Latino, and 3% (15,265) were African American. One thousand nine hundred and fifty (0.4%) were Native American, 9.5% (43,572) were Asian, and 5% (7,636) were multi-racial. Fifty-five percent (55%) were female and 45% were male. Median income was \$49,886. Twenty three (23%) percent received Social Security (\$12,292) and 16% received other than social security, and 9% of those 65 and over participated in government programs. Fifty seven percent (57,212) were Medi-Cal eligible.

San Diego Suicide Statistics:

In San Diego County, older adults have a higher risk of committing suicide than any other age group, with white males being particularly vulnerable. According to data from the Centers for Disease Control, the suicide rate among older adults in San Diego has been generally higher (27.6%) than in the state of California (23.7%) and the United States (18.5%) since 1979 (CHIP Report on Suicide in San Diego 2004). Suicide among older adults in San Diego County is largely a white, male phenomenon. Almost 80% of suicides were male and 94% were White males (HHSA County of San Diego, HHSA, Emergency medical Services, 2004). Widowed men are four times more likely to commit suicide than married men. The number of completed suicides versus suicide attempts is highest among the elderly (one completion to four attempts). Firearms are the leading method of committing suicide among older adult males (72%) and drug poisons among women (35%). The suicide rate was higher in the North Coastal Region (132 or 24.64 per 100,000), which includes Carlsbad, Oceanside, Camp Pendleton, San Dieguito and the North Central/Central San Diego Region. The lowest rate (74) of suicide (18.84 per 100,000) was found in South San Diego County. Depression and suicide in older adults have a strong correlation; therefore identifying and treating depression is an essential strategy for reducing risk of suicide.

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Suicides by San Diego County Health Service Region:

Health Service Region	Number	Rate†
North Coastal	132	24.64
North Central	137	21.63
Central	90	21.87
South	74	18.84
East	108	21.55
North Inland	132	21.80
Unknown		12
Total	685	22.24

†Rate per 100,000

Source: County of San Diego Health and Human Services Agency, Emergency Medical Services, Medical Examiner Database, 1995 – 2004

Nutrition and Mental Health

According to a Virginia State University article, *As We Age: Nutrition for Senior Adults*, aging affects nutritional status. Proper nutrition and wellness practices help aging adults maintain healthy, productive lifestyles. Many low-income, homebound older adults do not receive adequate nutrition. Poor nutrition lowers resistance to illness and recent studies have shown that Vitamin B-12 plays an important role in physical and mental health. Nutrition services can help to maintain the older adults' physical and mental well being.

Evidence-based and Promising Practices

This program will combine the following evidence-based practices to deliver the multicultural, gender sensitive, in-home PEI Services:

Meals on Wheels Mental Health Outreach Program Model developed by Redwood Coast Seniors, Inc.

Developed and successfully implemented by Mendocino County in the past five years, the program has demonstrated positive results for a) capacity to address needs of multicultural diverse older adults of different ages and gender, b)

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effectiveness of identifying clinical depression and on ensuring client follow up and timely treatment, c) improvement on nutritional risk profile, d) increase on social contact and decrease on isolation and e) improved health status.

Targeted Outreach for Vulnerable Older Adults: The Gatekeeper Model

The Gatekeeper Model is a proven and unique case-finding model developed at the Spokane Mental Health Center. The Gatekeeper Model trains employees of community businesses and corporations who work with the public to serve as community gatekeepers by identifying and referring community-dwelling older adults who may be at risk and in need for aging and/or mental health services.

Outcome findings for this program demonstrate that 40% of clients referred to the program were found by community-based gatekeepers. Clients referred by gatekeepers were more frequently socially isolated, economically disadvantaged and less likely to have a physician. Gatekeeper clients were also more likely to be women and to be younger than others referred to the agency. Gatekeeper clients were receiving fewer services at referral and were identified as needing more services at intake. Gatekeepers find a distinct population of community-dwelling older adults who are not found by more traditional referral sources (Journal on Aging Soc Policy, 1998).

Additionally, this PEI program may include, but not be limited to, a depression management, evidence-based practice or promising practice such as the Program Encourage Active, Rewarding Lives for Seniors (PEARLS). The PEARLS program is a community-integrated, home-based treatment for depression that significantly reduced depressive symptoms and improved health status in chronically medically ill older adults with minor depression and dysthymia. This program teaches seniors depression management techniques. The intervention is offered in eight, 50-minute problem solving treatment sessions with social and physical activities over 19 weeks ([JAMA, April 7, 2004, Vol. 291, No. 13](#)).

An evaluation study conducted in 2003 by the University of Washington showed that those who received the PEARLS intervention were three times more likely than non-participants to significantly reduce their depressive symptoms (43% vs. 15%) or completely eliminate their depression (36% vs. 12%). There were improvements in participants' functional and emotional well being and they reduced their utilization of health care services.

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3. PEI Project Description:

This program was selected in response to community requests for services that address needs of at-risk homebound seniors for prevention and early intervention and those less likely to seek traditional mental health services.

This program will address the following key community mental health needs:

- Suicide Risk: This program will increase knowledge of the signs of depression and suicide risk and appropriate actions will be taken to prevent suicide by the Home Based Prevention Early Intervention Gatekeeper Program staff, volunteers, clients and their families.
- Stigma Reduction: The program will provide education and support to reduce stigma and to promote linkage with services and supports.
- Disparities in Access to Mental Health Services: This program will reach older adults who are underserved in the public mental health system, particularly older adults who are racially, ethnically and culturally diverse and who live in the downtown area of the City of San Diego and North San Diego County.

This program will be implemented in partnership with a behavioral health services provider and existing Home Meal Delivery provider (AIS contracted program). The goal of the program is to deliver prevention and short-term early intervention mental health services to older adults age 60 and above who are participants of the Home-Based Prevention Early Intervention Gatekeeper Program.

The existing Home Based Prevention Early Intervention Gatekeeper Program reaches seniors who have multiple risk factors for depression and suicide. It is funded by the Older Americans Act Title III C-2, State General Funds, participant donations and local funds. This program will provide nutritious meals seven days a week, nutrition education and nutrition risk screening. Eligible individuals are 60 years of age or over who are homebound by reason of illness or disability or who are otherwise isolated. The goals of the program are to reduce social isolation and to promote better health through nutrition. Good nutrition is a major factor in keeping seniors independent and healthy for as long as possible. The level of need for home delivered nutrition services and nutrition related supports for each eligible participant is assessed and re-assessed according to OAA eligibility criteria.

As per Older Americans Act regulations, the program has “a sufficient number of qualified staff with the appropriate education and experience to carry out the requirements of the Program.” Staff members include a Program Manager, a

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Registered Dietician, eligibility workers who provide the eligibility assessments and re-assessments of home delivered meals clients and their nutritional risk and home delivered meals drivers who are either volunteer or paid staff with a primary responsibility to deliver meals and conduct a "Daily Status Check" on all program participants.

In addition to nutritious meals provided by the already existent home delivered meals services mentioned above, the PEI added/enhanced services will include outreach, education, depression screening, mental health assessment, suicide risk assessment, brief intervention/counseling, linkage, referral to community resources and follow-up.

The target population for these services is the underserved culturally/ethnically diverse isolated seniors that are homebound due to illness and/or disability and are facing cultural barriers and/or stigma. These individuals are at risk for depression, medication misuse and substance abuse. Those experiencing late-life onset of depression and/or at risk for suicide are also part of the target population for this program.

The Home Based Prevention Early Intervention Gatekeeper Program shall utilize the Gatekeeper model to identify older adults experiencing depression and or at risk for suicide. This program shall provide services to individuals in greatest economic or social need living in the downtown area of San Diego and in North San Diego County. This program seeks to address the needs of homebound older adults by reducing isolation, decreasing risk factors for depression and suicide and improving access to preventive and early intervention services and other services and support.

Levels of Intervention

- **Prevention**: Intervention will be directed to older adults vulnerable for and/or at risk of developing depression due to the confluence of medical, social and functional conditions and that, as a consequence, are at a high risk for suicide (with the greatest risk being for adult white men age 65 or older).
- **Early Intervention**: When indicated, the Home Delivered Meals/PEI Mental Health Program will provide early intervention (evidence based brief intervention or a promising practice such as PEARLS) services for those identified at greatest risk based on specific symptoms or signs, but who do not meet Title 9 mental health diagnosis criteria and that may be at risk for depression and suicide without treatment.

Components of the Home Delivered Meals Prevention and Early Intervention Program

Prevention and Early Intervention Services

The following is a description of the PEI services to be provided by the program:

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- **Education:** As a part of the initial eligibility assessment or re-assessment, all clients who participate in the Home Delivery Meals program will be given health and mental health promotion information with a special focus on depression, ways to prevent it and its effective treatments. Education is important in helping clients to **overcome barriers** and the stigma of seeking depression care.
- **Screening:** Valid and reliable tools such as the Patient Health Questionnaire 9 (PHQ-9) Items and Screening Brief Intervention Referral and Information (SBRI) will be utilized by gatekeepers (home delivery meals drivers) to identify individuals who may be depressed and/or may have problems with alcohol and other substance and/or may be misusing their medications. These screening tools will be part of the Home Based Prevention Early Intervention Gatekeeper Program's initial and annual eligibility assessment/reassessment. Results of the screening will be reviewed by the **Prevention Early Intervention Specialist**, a masters-level licensed mental health clinician with a specialization in geriatric mental health. The PEI specialist will interpret the scores for the delivery of Prevention and Early Intervention services.
- **Assessment:** For those individuals screening positively for depression, the PEI Specialist will provide a mental health assessment, review results with clients and family/caregivers and recommend a treatment plan within the scope of this program or link client to appropriate mental health services depending on the need.
- **Brief Intervention:** The interventions to be delivered by the PEI Program Specialist will include In-home Problem Solving Therapy (IH-PST) and Behavioral Activation (PEARLS) to help reduce the severity of depressive symptoms and to increase social activities.
- **Referral:** Based on the assessment results, the PEI specialist will provide referral and linkages and coordination between client/caregiver and the service providers. Referrals may be made to MHSA-funded full service partnership (FSP); field capable clinical services (FCCS); county mental health outpatient and case management services; private mental health providers; primary care physicians/clinics; and community-based aging and long-term care services such as adult day health care, alcohol and drug programs, in-home support services, family caregiver support programs and other community resources.
- **Follow-up:** Because late-life depression is often chronic or characterized by a relapse, follow-up services will be provided to prevent further disability and ensure that client and/or caregiver connect with the recommended resources and are receiving needed services. The PEI Specialist will also serve as the liaison between

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client/caregiver and primary care physician when client, in addition to brief therapy, is also receiving medications. Follow-up will also assist program with referral and treatment outcomes tracking.

The total number of staff will be based on the level of services provided and the size of the service area.

Prevention Early Intervention Specialist: A masters-level, licensed mental health clinician with a specialization in geriatric mental health will be responsible for program implementation, oversight and delivery of Prevention and Early Intervention services: screening and interpretation of all depression screening results; mental health assessment and education of clients who score positively for depression or have a change in their emotional and mental status as identified by the eligibility worker, driver and other staff/volunteers; evidence-based brief interventions/short term interventions for clients exhibiting signs and symptoms of depression; linkage and referral to community resources such as mental health service providers (public or private) or to primary care physicians, particularly if the client requires medication management of the depression; and follow up to ensure client is receiving support needed and monitor outcomes of assessment and treatment interventions.

Senior Peer Counselors will provide supportive counseling services and companionship to reduce isolation and the risk of depression.

The following training specific to PEI will be provided by the mental health clinician to the Home Delivered Meals PEI Program staff and volunteers:

- 1) Mental health promotion, prevention and early intervention;
- 2) Recognizing signs and symptoms of depression, alcohol abuse/medication misuse and elder abuse/neglect, as well as the use of evidence-based interventions for suicide prevention such as ASIST, Safe Talk and QPR;
- 3) Knowing what and when to communicate to the mental health clinician if changes in the clients' and caregivers' mental/emotional health and home environment is noticed;
- 4) Understanding the issues of cultural and ethnic diversity in relation to mental health issues to promote cultural sensitivity and competence in working with diverse clients;
- 5) Training will promote the ability of the staff, particularly the eligibility workers and drivers, to identify clients and caregivers who need an assessment by the mental health clinician.

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Supervision is co-facilitated by Home Delivery Program Manager and the PEI Specialist, and program staff will participate in a weekly team meeting to ensure continuity of service delivery. The program will be co-located with an existent home delivery meal program. The interventions will be delivered to clients in their home. The targeted communities are downtown San Diego and North San Diego County.

Key dates and milestones include:

- Receive California DMH approval for Plan – Month 1
- RFP developed, competitive procurement process completed – Month 6
- Contract awarded – Month 7
- Hire staff – Month 7-8
- MOU developed with Home Delivery Meals Programs – Month 7-8
- Gatekeeper and staff training (including cultural and linguistic needs of population) – Month 7-8 (on-going)
- Begin development of policies and procedures – Month 7
- Draft policies and procedures submitted to County for approval – Month 7
- Develop program materials including materials in multiple languages – Month 7
- Outcome tools identified, surveys created – Month 7

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4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Home Delivery Meals Multicultural Gender Sensitive In-Home PEI Services – Gatekeeper Model	Individuals: 250 Downtown 150 North County (Min. 400) Families:	Individuals: 80 Downtown 50 North County (Min. 200) Families:	N/A
TOTAL PEI PROJECT ESTIMATED <i>UNDULICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 400 Families:	Individuals: 200 (duplicated) Families:	

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

The Home Delivered Meals PEI Specialist will be responsible for recommending and establishing linkages and referrals to County-operated mental health services and to other contracted community mental health providers including primary care services. The PEI Specialist will be also responsible for conducting follow up to ensure client's needs have been provided for and that the desired outcomes have been achieved.

For individuals identified in need for substance abuse treatment, preventive community domestic violence services and other social services, clients will be provided referrals to the following services: County HHSA contracted Alcohol and

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Drug Services, Adult Protective Services/Domestic Violence Social Services, Social Security, general relief, and other relevant service providers.

Individuals in need of resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues. While the County-funded Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will also then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services

6. Collaboration and System Enhancements

Contractor for these services will develop an MOU (Memorandum of Understanding) with meal delivery programs in the downtown area of the City of San Diego and the North Coastal region of San Diego County. The Home Delivery Meals program will provide food/nutrition and delivery staff and the mental health program will provide the mental health PEI Specialist.

Through this partnership, both AIS and Mental Health Services will increase and enhance each other's capacity to provide comprehensive and integrated services to homebound seniors by leveraging resources and making available access to a network of services and supports such as senior centers, congregate meal sites, adult day health care centers, multipurpose senior services programs, linkages programs, senior companion programs, Alzheimer day care resource centers, family caregiver support programs and senior community services employment programs.

This PEI program will leverage resources from the OAA Title III funds administered by AIS to reach ethnically and culturally diverse isolated seniors who are traditionally underserved in the public mental health system.

Contractor(s) for these services, in partnership with AIS and system partners, will work on a plan for ongoing sustainability with a final goal of integrating MHSA PEI funded activities within the existing structure of services provided by contracted organization.

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7. Intended Outcomes

Contractor for these services, in close collaboration with AIS and MHS, will identify tools to measure and track the Intended outcomes.

Individual outcomes include:

- Reduction on feeling of isolation,
- Increase social support,
- Reduction and/or elimination of depressive symptoms,
- Reduce incidence of substance abuse,
- Reduce incidence of medication misuse,
- Increase and maintain individual self-sufficiency,
- Reduce number of suicide attempts or completions, and
- Reduce or eliminate of stigma of mental health issues and services utilization.

System and program outcomes include:

- Increase on timely access to care for culturally diverse individuals to reduce disparities in care,
- Increased number of depression screenings,
- Reduction on rates of depression and other behavioral health conditions, and
- Increased number of referrals to Primary Care and to specialty mental health by the home delivery meals program.

Other methods to measure success will include:

- A measure of increased satisfaction with services by clients/caregivers;
- Program evaluation to determine impact on preventing/reducing depression, substance/medication abuse/misuse and prevention of suicide, as well as addressing timely late onset of depression; and

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- Monthly status report.

8. Coordination with Other MHSA Components

Clients identified in need of specialty mental health services will be referred to new MHSA-funded older adult mental health services, full service partnerships or field capable clinical services.

This plan will also benefit from the Primary and Secondary Prevention Plan (PS01) in the following ways:

- Media Campaign – The campaign will include elements that raise public awareness about the risk factors and warning signs of suicide. The campaign will incorporate cultural perspectives in the resulting printed materials and TV/radio/print ads.
- The contracted service provider of this project shall participate on the Interagency Suicide Meeting (referenced in PS01). In being a member of this group, they will assist to develop the County's suicide action plan and ensure cultural sensitivity and awareness for the distinct needs of the target population that they represent and provide PEI services for.
- Suicide Prevention services offered through PEI will be included in Primary Prevention printed materials (described in PS01). This will assist to raise awareness about the availability of suicide prevention services funded under MHSA in San Diego County.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): **Older Adult Services**
 Program ID/Name: **OA02 Home Based Prevention Early Intervention Gatekeeper Program**
 Provider Name (if known): **Pending Competitive Procurement**
 Provider Category (DMH List): **Other**

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	400
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	400
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
Classification	FTE	Per FTE				
Registered Nurse (PEI specialist)	2.00	\$73,600		\$0	\$147,200	\$147,200
OA Peer Counselor/Support Staff	4.00	\$29,510		\$0	\$118,040	\$118,040
Administrative Support	1.00	\$35,000		\$0	\$35,000	\$35,000
	0.00	\$0		\$0	\$0	\$0
	0.00	\$0		\$0	\$0	\$0
Total FTE	7.00	Sub-Total		\$0	\$300,240	\$300,240
b. Benefits%	@ 27.0%			\$0	\$81,065	\$81,065
c. Total Personnel/Staffing Expenses				\$0	\$381,305	\$381,305
2. Operating Expenditures						
Indirect/Administrative Costs		\$58,500		\$0	\$58,500	\$58,500
Operating Costs (includes Facility Costs)		\$49,000		\$0	\$49,000	\$49,000
Start-Up/One-Time Only Costs*		\$59,000		\$0	\$59,000	\$59,000
c. Total Operating Expenses				\$0	\$166,500	\$166,500
3. Subcontracts/Professional Services (list/itemize)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$0	\$0
4. Total Proposed PEI Program Budget				\$0	\$547,805	\$547,805
B. Revenues (list/itemize by fund source)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$547,805	\$547,805
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**

Program ID/Name: **OA02 Home Based Prevention Early Intervention Gatekeeper Program**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals and improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

Position(s) targeted: OA Peer Counselor/Support Staff, 4.00 FTE.

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

PEI PROJECT SUMMARY

Form No. 3

PEI Project Name: Life Long-Learning

County: San Diego

Date: 11/19/08

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

2. PEI Priority Population(s)	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	☐	☐	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☒
3. Children and Youth in Stressed Families	☐	☐		
4. Children and Youth at Risk for School Failure	☐	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		
6. Underserved Cultural Populations	☐	☐	☐	☐

PEI PROJECT SUMMARY

Form No. 3

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

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Older Adult Populations as one of our 10 priority focus areas. Below is a list of venues and opportunities offered to community stakeholders to participate in the PEI planning process and to provide valuable input for the selection of the proposed program.

Aging and Mental Health Workgroup – June 2006

- Recommendations: Primary care provider (PCP), Aging Network provider, older adults, family/caregivers education and training.
- Strategy: Development, dissemination and evaluation of culturally competent educational DVD and written materials to include individuals with limited language, visual and hearing capacities.
- Topics: Mental illness, stigma, depression and suicide signs and symptoms, identification, treatment models, resources, information and referral.
- Target: Primary care providers (MD, NP, PA, RN, SW), hospital and emergency room staff, client, family/caregiver and other support systems (IHSS, skilled nursing facility and assisted living staff, church and housing staff).
- Partners: UCSD Research Center, Older Adult Coalition, Aging Summit/Mental Health Workgroup.
- Comments: Dissemination methods must include mainstream approaches beyond TV, Internet (community outreach); key stakeholders must be involved in the planning and organizing of this effort; project partners: AOAMHS, AIS Long-Term Integration Program, Elder Death Review Team, and UCSD Geriatric Research Center – UCSD has volunteered to donate equipment and manpower to produce a high-quality product; collaboration with an academic institution to evaluate effectiveness of this strategy on decreasing stigma, depression and suicide.

Older Adult PEI Stakeholder Forum – November 2007

This forum was hosted by the Older Adult Mental Health Council and the Older Adult PEI Committee of the Council, and it was the first of the scheduled PEI Planning venues in San Diego. The forum brought together close to 100 individuals. The key issues related to late onset identified at this event were

- Educate older adults and their caregivers to differentiate between normal aging.

PEI PROJECT SUMMARY

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- Partnership in developing, offering and marketing free classes for seniors to become educated and engaged in areas of mental, physical and social health and well being. San Diego Community College District will provide qualified instructors, facilities, research, supplies and equipment.

Older Adult Focus Group – February 2008

- Early education, every day, about everything related to the aging process, resources, and benefits.
- Educate older adults on how to speak to the doctor about feelings of loss depression, diabetes.
- In conjunction with the broader Team San Diego Community Training, to develop a specific module for the prevention of suicide in older adults with physicians, office staff and other community providers. The module will include prevention, education, intervention techniques and tools for office staff.

Older Adult Needs Assessment – Minority Report, March 2006

The following comments were provided by Asian/Pacific Islander, African American and Latino participants:

- Lack of understanding of the needs of older adults by primary care physicians;
- Inaccurate provider attitudes towards older adults;
- Inability to communicate with older adults and the lack of sufficient time spent with clients' visits; Service providers to speak and communicate in the client's language;
- Clinician to understand the cultural issues affecting older adults;
- More information needed about available services;
- Stigma related to a diagnosis of mental illness an important barrier to using services – educate older and younger generations alike to address this problem;
- Provider lack of cultural understanding of the needs of Asian/Pacific Islander older adults;
- Age discrimination – perceived ageism among many providers – “They need to listen to what you say to them instead of saying ‘because you’re old, you don’t know what you’re talking about’. That’s not so. Who wants to hear that? You know what you know.” (Older Adult Advocate);
- Primary care providers to recognize mental health needs of older adults rather than stereotyping as the somatization of their mental disorders;

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- Educate community about culture and diversity of its population;
- Educate health care providers in the needs of older adults and how to work with older adults;
- Educate older adults on how to communicate needs to doctor during a visit with “Well, I just wanted to say that, ... in healthcare in general and mental health in particular, where you need to go in to the doctor with your list of symptoms, complaints, whatever, so you can jam them down when you’re talking to the doctor because their time is limited and yours too, sometimes, when they’re saying ‘You’ve got this doctor right now, but you need to see another one in two hours.’”

3. PEI Project Description:

In partnership with community stakeholders, contractor for the program will address educational needs of target population, family and the aging network providers responsible for promoting, delivering age and culturally/linguistically appropriate comprehensive and integrated care to older adults in San Diego County.

In partnership with AIS, UCSD Extension and local community colleges, contractor for these services will develop, offer, market and disseminate age-appropriate, culturally and linguistically appropriate, free-of-charge educational activities and materials for mental health and prevention education around the community at senior centers, adult day health centers, senior low income housing, faith-based community organizations and educational campuses providing Lifelong Learning opportunities to seniors, family/caregivers and health and social services professionals in San Diego County.

Program Components and Topics: All educational topics are to be refined and developed. Audio and visual aids, as well as manuals and resources, will be available to accompany each module. CME, CEU and Certificate of Completion will be provided as appropriate to all participants.

Module I: Seniors Module – 4 Sessions

This module will include topics as follows:

- Session I: Normal aging, staying sharp, mental fitness and mental health;
- Session II: Speaking to your doctor, how to navigate the healthcare system, and resources;
- Session III: Prescription use and co-occurring conditions (mental health/substance abuse, common health conditions/ mental health in older adults); and

PEI PROJECT SUMMARY

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- Session IV: Stigma reduction, recognizing mental health problems and symptoms in older adults, risk factors, cognitive decline, impact of mental health problems in older adults, depression, suicide prevention, and other mental health conditions.

Module II: Family /Caregiver Curricula – 4 Sessions

This module will be specially tailored and directed to meet the needs of family caregivers and will include topics such as:

- Session I: Care giving in America, skills for care giving, care giving needs, long distance care giving, chronic illness and impact in care giving, caregiver self-care, strategies and resources;
- Session II: Stigma reduction, recognizing mental health problems and symptoms in older adults, risk factors, cognitive decline, impact of mental health problems in older adults, depression, suicide prevention, other mental health conditions, prescription use, co-occurring conditions (mental health/substance abuse, common health conditions/ mental health in older adults), how to navigate the healthcare system, and resources;
- Session III: Caregiver burden, domestic violence/elder abuse, trauma, communication between generations; and
- Session IV: Life re-training for widows/widowers, healthy life styles, successful strategies and resources to cope with life challenges.

Module III: Primary Care Provider, Office Staff, First Responders and Allied Professionals – 3 Sessions

This module will include topics such as:

- Session I: Mental health promotion, depression screening, assessment, diagnosis, and brief intervention/ treatment with older adults in primary care;
- Session II: Prevention, intervention and treatment of alcohol problems among older adults; how to talk to an older adult person who has a problem with alcohol and/or medications; prescription use guide; and medicines and mental illness for mental co-occurring conditions (mental health/substance abuse, common health conditions/mental health in older adults); and
- Session III: Linking older adults and families to medication, alcohol and mental health resources, use of the network of care and other resources.

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Program Staff:

PEI Education Specialist will be responsible for the implementation of the program and Steering Committee; identifying, training and utilizing personnel, resources and processes needed to support the implementation of this PEI Educational Program. The PEI Education Specialist will monitor evaluation, work side-by-side with those implementing the curricula, provide consultation and recommend changes to address them.

To maintain and sustain gains of the program, contractor will establish a mechanism for continuous feedback regarding educational program implementation, public outcome improvements and monitor program implementation.

The educational program plan will be designed based on the expressed needs of older adult, family and care providers and stakeholder recommendations for addressing such needs. This program aims to increase awareness, knowledge and skills addressing aging, wellness, behavioral issues, mental illness prevention, mental health promotion, stigma, depression and suicide in older adults.

The educational program for older adults, family and caregivers to be provided under this plan will be conducted using state of the art approaches in community-based education and will be delivered at community centers, libraries, senior centers, adult day health centers, work sites and centers for life-long learning at community colleges and universities.

Targeted community demographics include

- Seniors, 60 years of age or older, who are at risk of developing mental illness and/or other conditions that may result in needing mental health services;
- Family, caregivers and other people that provide support to older adults when family is not available;
- Primary care providers, other allied professionals (MD, NP, PA, RN, SW), hospital and emergency room staff; and
- Other support systems (in-home support services, skilled nursing facility and assisted living staff, church and housing staff).

This new Older Adult PEI educational program will provide participants, elders, family caregivers, providers and allied professionals with specific knowledge and evidence-based skills to prevent and address aging-related issues, physical and mental health needs and risk factors in late-life.

Key milestones:

- Receive California DMH approval for plan – Month 1

PEI PROJECT SUMMARY

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- RFP developed, competitive procurement process completed – Month 6
- Contract awarded – Month 7
- Hire staff – Month 7-8
- Staff training and certification (including cultural and linguistic needs of population) begins – Month 7-8
- Develop partnerships – Month 7-8
- Begin development of educational material – Month 7
- Draft policies and procedures submitted to County for approval – Month 7
- Develop program materials including materials in multiple languages – Month 7
- Outcome tools identified, surveys created – Month 7
- Begin conducting training modules – Month 8

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Life Long-Learning : Aging and Wellness Enhancing Community Life Long Learning	Individuals: 150 Families: 150 Professionals/Staff: 80 First Responders & Allied professionals: 120	Individuals: Families:	
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 500 Families:	Individuals: Families:	

PEI PROJECT SUMMARY

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

The educational program modules to be implemented will contain self-screening tools, written materials, resources and information as to how to navigate the healthcare system and when, how and who to contact when in need for specialty mental health services.

Content of the curricula and written materials will address themes related to substance abuse treatment, domestic violence, elder abuse and education on how to access resources available within the community. This curriculum will be provided to help address the needs of older adults, their families and other social supports.

Contractor for this service, in close collaboration with County of San Diego Mental Health Services, Aging and Independence Services, UCSD Extension and other local community colleges and educational institutions, will develop and implement this community health education strategy that will serve to support efforts to improve access to quality of care and social programs for older adults and their families with complex needs.

In future years, the funding for the educational and training activities supported may be explored and considered as part of the stakeholder process for MHSA Workforce Education and Training (WET) dollars and by potential in-kind resources and funding available to program's partners.

Individuals in need of resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues. While the County-funded Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will also provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services

6. Collaboration and System Enhancements

Contractor for these services will develop a partnership for the development and implementation of the Older Adult Prevention Early Intervention Educational Program Curricula. The partnership will include academic institutions, aging network providers, faith-based communities, consumer and family advocacy groups, primary care provider organizations, first responders, and healthcare organizations. As members of the steering committee, the partners will participate in the development of the implementation plan to include future program sustainability.

The PEI educational program will support community mental health and primary care systems by:

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1. Educating seniors, family/caregivers on how to access and how to navigate the systems of care;
2. Providing awareness, knowledge and skills to mental health, Primary Care Providers and their office staff on how to promote and maintain wellness and appropriately addressing the bio-psychosocial health care needs of older adults and their families/caregivers;
3. Other educational and personal development opportunities (writing, literature, art, poetry social events, current events, fitness and topics related to finance, politics, spirituality, etc.) will be also available through the partnership, supporting the development and maintenance of older adult and caregiver wellness, social connectives, mental health and health promotion.

7. Intended Outcomes

To monitor, maintain and sustain gains of the program, in partnership with AIS, UCSD Extension, and local community colleges, the contractor for this program will establish a mechanism for tracking and reporting on program implementation, individual and system outcome improvements. Program instructors will be trained by the PEI Education Specialist in the utilization of evaluation/outcomes tools. Outcomes will be collected immediately after each session and at three months and six months following completion of educational programs. Results will be analyzed routinely by the PEI Education Specialist and utilized to provide feedback to the contractor and report to the County on the effectiveness of the program, as well as to identify areas in need to be strengthened or to identify areas of excellence.

Contractor will use the following outcome measures to evaluate and track participants' gains and educational program successes:

Utilizing a survey instrument and following exposure to educational session materials, participants will:

- Express satisfaction with program curricula/materials; and
- Report increased knowledge about stigma, mental health, substance abuse, depression and suicide.

Three and six months following completion of educational program:

- Targeted older adults will express satisfaction about Caregiver, PCP and quality of care;
- Family/caregiver will report increased self-care, feeling less stressed and less burden due to care; and

PEI PROJECT SUMMARY

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- Primary care providers, first responders and allied professionals will report increased confidence on delivering services to older adults and increased job satisfaction.

System Outcomes:

- For targeted PCP's – Reduced number or no suicides among participants of the program
- For targeted family/caregiver – Reduced number or no institutional placements

Contractor will conduct a survey on pattern of utilization of health/mental health care system by participants in the program.

Participants in this program will have new knowledge about the aging process and about ways to maintain health. Participants will be able to differentiate normal from abnormal life conditions and identify early symptoms of health conditions needing attention. Primary care providers will experience an improved standard of healthcare practice, a decrease in rates of suicides among individuals visiting primary care doctors prior to committing suicide and increased satisfaction of older adults, family members and care providers in the program.

8. Coordination with Other MHSA Components

Existent Older Adult MHSA CSS–funded programs will be highlighted in the educational curricula and in the resources manual. Participants in the educational program will have the opportunity to personally meet and greet Older Adult MHSA-CSS staff and ask questions about program services, criteria for participation and program outcomes. Representatives of the Older Adult MHSA CSS–funded programs will also serve as members of the program steering committee and as instructors on the different curricula topics as needed.

This Plan will also benefit from the Primary and Secondary Prevention Plan (PS01) in the following ways:

- Media Campaign – The campaign will include elements that address raising public awareness about the risk factors and warning signs of suicide. The campaign will incorporate cultural perspectives in the resulting printed materials and TV/radio/print ads.
- The contracted service provider of this project shall participate on the Interagency Suicide Meeting (referenced in PS01). In being a member of this group, they will assist to develop the County's suicide action plan and ensure cultural sensitivity and awareness for the distinct needs of the target population that they represent and provide PEI services for.

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- Suicide Prevention services offered through PEI will be included in Primary Prevention printed materials (described in PS01). This will assist to raise awareness about the availability of suicide prevention services funded under MHSA in San Diego County.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3
Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
Workgroup - Focus Area (Cnty PEI List): **Older Adult Services**
Program ID/Name: **OA03 Life Long Learning: Aging and Wellness**
Provider Name (if known): **Pending Competitive Procurement**
Provider Category (DMH List): **Other**

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	500
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	500
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
Classification	FTE	Per FTE				
PEI Education Specialist	1.00	\$60,000		\$0	\$60,000	\$60,000
Administrative Support Staff	0.50	\$35,000		\$0	\$17,500	\$17,500
	0.00	\$0		\$0	\$0	\$0
	0.00	\$0		\$0	\$0	\$0
	0.00	\$0		\$0	\$0	\$0
Total FTE	1.50	Sub-Total		\$0	\$77,500	\$77,500
b. Benefits%	@ 27.0%			\$0	\$20,925	\$20,925
c. Total Personnel/Staffing Expenses				\$0	\$98,425	\$98,425
2. Operating Expenditures						
Indirect/Administrative Costs		\$21,000		\$0	\$21,000	\$21,000
Operating Costs (includes Facility Costs)		\$17,500		\$0	\$17,500	\$17,500
Start-Up/One-Time Only Costs*		\$71,000		\$0	\$71,000	\$71,000
c. Total Operating Expenses				\$0	\$109,500	\$109,500
3. Subcontracts/Professional Services (list/itemize)						
11 sessions x 2/yr x 6 regions		\$18,000		\$0	\$18,000	\$18,000
Program Evaluation		\$20,000		\$0	\$20,000	\$20,000
		\$0		\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$38,000	\$38,000
4. Total Proposed PEI Program Budget				\$0	\$245,925	\$245,925
B. Revenues (list/itemize by fund source)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$245,925	\$245,925
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**

Program ID/Name: **OA03 Life Long Learning: Aging and Wellness**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals and improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to;

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

A2 Subcontracts/Professional Services

Training & Education Sessions - Estimated ongoing costs of conducting Community Education Modules including training development, trainers, training facilities, and materials.

Program Evaluation - Estimated ongoing costs of data collection and analysis.

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

PEI PROJECT SUMMARY

Form No. 3

PEI Project Name: REACHing Out

County: San Diego

Date: 11/19/08

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

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	☐	☐	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☒	☒
3. Children and Youth in Stressed Families	☐	☐		
4. Children and Youth at Risk for School Failure	☐	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		
6. Underserved Cultural Populations	☐	☐	☒	☒

PEI PROJECT SUMMARY

Form No. 3

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

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Older Adult Populations as one of our 10 priority focus areas. Below is a list of venues and opportunities offered to community stakeholders to participate in the PEI planning process and to provide valuable input for the selection of the proposed program.

Needs of Alzheimer's Patients and their Caregivers:

Alzheimer's patients and their caregivers have unmet mental health needs. This issue has been brought up in several of the stakeholder forums and focus groups. MHSA PEI provides a great opportunity to provide preventive and timely care to caregivers, as well as support to continue efforts to provide quality of care to consumers and loved ones. The following input and recommendations were provided related to the family/caregivers:

- Need to find isolated caregivers,
- Need to address caregiver burden,
- Need for peer support to address caregiver loneliness and isolation,
- Need education to prevent elder abuse,
- Need for increased resources and services (including respite) available for caregivers,
- Isolated caregivers bear a large burden in caring for individuals and peer counseling may be effective,
- Mobile services and transportation may ease the isolation for these individuals.

Recommendations:

- Mobile services and transportation may ease the isolation for these individuals.
- Develop adequate and culturally competent caregiver support in collaboration with caregiver resource centers in all areas of California.
- Develop caregiver support groups for family and professional and unpaid caregivers providing services to older adults to prevent and address depression in caregiver due to burden of care.
- Increase length of involvement of family in client's life and decrease institutional placement.

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Other Data Analysis to Support the Selection of this Program:

According to the National Institute on Aging, Alzheimer's disease (AD) and related dementias among Hispanics are projected to increase more than 600% in the USA during the first decade of the 21st century. By 2050, 1.3 million Hispanics will have AD, compared to the 200,000 currently living with the disease. Unprepared and unsuspecting Hispanic communities are currently vulnerable to an epidemic of Alzheimer's.

According to the National Institute on Aging (1999), AD affects from 1.5 million to 4 million Americans and is the most common cause of dementia among people age 65 and older. It has been estimated that between 2.4 and 3.1 million spouses or partners, relatives and friends take care of people with AD. This estimate is expected to increase significantly as the U.S. older adult population grows rapidly (National Institute on Aging, 1999). The potential consequences of caring for someone with a dementia illness have been documented extensively. Caregivers exhibit increased rates of depression, physical illness, psychotropic medication use, social isolation, health care utilization, decreased quality of life, sleep problems and decreased immune functioning (Clipp & George, 1990; Drinka, Smith, & Drinka, 1987; Gallagher, Rose, Rivera, Lovett, & Thompson, 1989; Kiecolt-Glaser et al., 1987; Pagel, Becker, & Coppel, 1985; Schulz & Williamson, 1991; U.S. Congress, Office of Technology Assessment, 1990).

Although the current literature on racial and ethnic minority care giving is limited and in need of future research, recent reviews indicate that the trend toward higher distress outcomes may be evident for some groups (for example, U.S. Hispanics) and less so for others (for example, African Americans) (Adams, Kemp, & Aranda, in press; Aranda & Knight, 1997; Galderon & Tennstedt, 1998; Connell & Gibson, 1997; Cox & Monk, 1990; Fredman, Daly, & Lazur, 1995; Haley et al., 1987; Lawton, Rajagopal, Bordy, & Kleban, 1992; Miller, Campbell, Farran, Kaufman, & Davis, 1995; Morycz, Malloy, Bozich, & Martz, 1987).

Among Hispanic families, there is a high acceptance of cognitive impairment and dementia as a normal part of aging to be managed within the family. As a result, Hispanic families, particularly daughters and other female relatives, provide a disproportionate share of Alzheimer care and do so for longer periods of time and at higher levels of impairment than is the case in non-Hispanic families. Research has documented a number of reasons why Hispanics are reluctant to use formal services until they are completely overwhelmed. These include distrust of outsiders, acceptance of stress as a normal and expected part of the familial role and resistance to sharing familial problems with outsiders or admitting that care is too demanding. Families need information, help and support to sustain their role as care givers and to assure that the person with dementia is receiving necessary treatment to help lessen the burden of the disease. Those services must

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be provided in a way that reinforces family values and overcomes cultural barriers to service (Maria P. Aranda, Valentine M. Villa, Laura Trejo, Rosa Ramirez, Martha Ranney; Social Work, Vol.48, 2003).

Systematic review of major outcomes in family/caregiver intervention, as published in 43 studies since 1996, indicates that the major impact for caregivers includes decreased incidence and severity of depression, moderate decrease in reported anger, moderate improvement in stress management, positive changes in clinical health indicators such as blood pressure and stress and small improvement in caregiver burden. Hispanic caregivers are not receiving the healthcare that they need to reduce the risk of mental health problems and continue to care for a loved one. They are less likely than non-Hispanics to see a physician and much less likely to use services provided by other health professionals. Counseling and support has been associated with greater satisfaction with assistance received from others, as well as reduction in caregiver depression. Problem Solving Therapy (PST) has been successfully utilized to enhance the ability of caregivers to cope with stress and to decrease the incidence and severity of depression over a six month period (Frederick Blow, Stephen Bartels, Laurie Brockman, Aricca Van Clitters; SAMHSA TAC, 2007).

Prevalence of Alzheimer's disease in San Diego County varies from study to study. In a report by Garrett, Valle and Velasquez (Hispanic ADAD Prevalence Study, February 2008), it was estimated that 1,889 Hispanics with Alzheimer's lived in San Diego in 2000. Furthermore, Garrett, et al. (2008), reported that the estimated number of Hispanics with Alzheimer's has grown to 2,614 in 2008 and will reach approximately 23,289 by 2050 (an increase of 1,133%). In another report by Fox, Nazareno, Brennan and Ross (Alzheimer's Disease Facts and Figures in California: Current Status and Future Projections, September 2008), it is estimated that there are currently 5,661 Hispanics with Alzheimer's in San Diego and the number is expected to increase to 7,839 and 16,413 by 2015 and 2030 respectively. The Alzheimer's Association San Diego/Imperial Chapter calculates (Evans et al., 2003) that there could be as many as 9,000 Hispanics currently with Alzheimer's disease in the County of San Diego. Equally as important, for every case of Alzheimer's there are approximately 3.34 members of the household providing care (US Census, 2006) and all studies (including National data) project that the number of Hispanics with Alzheimer's will increase at a much faster rate than non-Hispanic White and other ethnic minority populations.

3. PEI Project Description:

The Resources for Enhancing Alzheimer's Caregiver Health (REACH) model, a well-documented promising practice, is a multifaceted, personalized intervention that can significantly improve the quality of caregiver health and enhances family care giving. Based on the REACH study, the REACH program appears to be a promising practice as well as cost-

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effective intervention when compared with alternatives. "REACH has two goals: to test the effectiveness of multiple different interventions and to evaluate the pooled effect of REACH interventions overall. REACH developed from a National Institutes of Health initiative that acknowledged the well documented burdens associated with family care giving as well as the existence of promising family caregiver interventions reported in the literature," (Schultz, R., Burzio, L., Burns, R., Eisdorfer, C., Gallagher-Thompson, D., Gitlin, L., Mahoney, D., 2003, Resources for Enhancing Alzheimer's Caregiver Health (REACH): Overview, Site-Specific Outcomes, and Future Directions, *The Gerontologist*, 43(4), 514-520).

REACH is the first randomized, controlled trial to look systematically at the effectiveness of a multi-component caregiver intervention provided to ethnically diverse populations. This research has shown that the rate of clinical depression was significantly lower among caregivers in the intervention group than those in the control group (12.6 percent and 22.7 percent respectively). The rate of institutionalization for care recipients was lower in the intervention group when compared with the control group (4.3 percent vs. 7.2 percent), but this difference was not statistically significant. Large and clinically important quality of life improvements were found for 45% of Hispanic caregivers, 40% of White caregivers and 28% of African American caregivers in the intervention group, compared with 7%, 13% and 11%, respectively, in the control group. For Hispanics, the intervention was found to be the most effective in reducing depressive symptoms and problem behaviors of the care recipient.

This program seeks to replicate the Resources for Enhancing Alzheimer's Caregiver Health (REACH), a novel program that enhances dementia caregivers' quality of life. Following the REACH model of providing a carefully constructed and controlled intervention, a trained project staff person will visit with caregivers at home nine times, talk with them during three 30-minute telephone calls and offer five structured telephone support sessions.

This PEI program is likely to achieve the desired PEI outcomes, particularly among underserved populations. Evaluation of the program will seek to replicate and adapt the REACH study results with Hispanic caregivers. This intervention has demonstrated strong evidence of efficacy in providing education, care and support for Alzheimer's patients' caregivers and with community retention of Alzheimer's patients. This PEI program will directly impact prevention and early intervention with caregivers and indirectly impact CSS outcomes for delaying institutionalization of older adults.

This Caregiver REACHing Out program will provide a well-designed, tailored strategy to prevent or decrease symptoms of depression due to isolation and burden of care in Hispanic caregivers of Alzheimer's patients. The program will be initially implemented in the South Bay Region of San Diego and expanded to other Hispanic populated regions of San Diego County as new resources become available.

This program will utilize a combination of prevention and early intervention strategies:

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- Prevention through information sharing, education, screening and peer support activities facilitated by bi-lingual/bi-cultural Peer Counselors; and
- Early intervention activities such as assessment, role playing, problem solving, skills training, and stress-management techniques facilitated by the bi-lingual/bi-cultural Masters-level Care Manager.

Staff:

- Care Manager: A bi-lingual and bi-cultural Masters-level clinician will screen and assess all participants before services begin and six months later. Areas of screening and assessment will include depression, substance abuse and overall quality of life in these five specific areas: 1) depressive symptoms, 2) the burden of care giving (such as the level of stress), 3) engagement in self-care activities (such as getting rest or seeing a doctor when needed), 4) level of social support, and 5) problem behaviors exhibited by the person. Those identified in need of early intervention services will be provided with one or more of the following short-term structured supports: Problem Solving Therapy (PST), Coping Skills Training (CST), and/or short-term telephone support.
- Peer Counselor: Trained peer counselors will offer all participants outreach services, education and support in English and Spanish for Spanish-speaking caregivers through face-to-face contacts and the Caregiver Help-line.

Training:

Contractor for these services will provide Clinical Care Manager and Peer Support staff training on the Resources for Enhancing Alzheimer's Caregiver Health (REACH) national model and on other caregiver resources, mental health services and advocacy services available to Hispanic caregivers in San Diego County.

Caregivers of Alzheimer's patients, due to high demand for their time and energy, have difficulties caring for themselves. This can often result in caregivers developing mental health problems. The final goal of the program is to make positive, meaningful differences in caregivers' and care recipients' quality of life.

Key dates and milestones include:

- Receive California DMH approval for Plan – Month 1
- RFP developed, competitive procurement process completed – Month 6
- Contract awarded – Month 7
- Hire staff – Month 7-8

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- Staff training and certification (including cultural and linguistic needs of population) begins – Month 7-8
- Begin development of policies and procedures – Month 7
- Draft policies and procedures submitted to County for approval – Month 7
- Develop program materials including materials in multiple languages – Month 7
- Outcome tools identified, surveys created – Month 7
- Begin delivery of services – Month 8

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
REACHing Out Prevention and Early Intervention with Hispanic Alzheimer's' Caregivers	Individuals: 400 Families:	Individuals: 200 Families:	
TOTAL PEI PROJECT ESTIMATED <i>UNDULICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 400 Families:	Individuals: 200 Families:	

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

Caregivers identified as needing specialty mental health services and other services not provided by this program will be referred to existent mental health core programs such as regional outpatient mental health clinics, adult and older adult

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MHSA-funded programs, fee-for-service providers, Integrated Mental Health and Primary Care Program for adult and older adults and emergency services.

Individuals in need of additional services and supports not available in the REACHing Out program will be referred to community-based organizations and social services agencies such as the Alzheimer's Association, Adult Protective Services (APS), Southern Caregivers, and In Home Support Services (IHSS). The contracted entity for these services will develop a Memorandum of Understanding (MOU) with key providers of these services to ensure all caregiver needs are addressed in a timely and seamless fashion.

This program will be developed in partnership and close collaboration with Aging and Independence (local AAA) and existing providers of Alzheimer's and caregiver support services.

Individuals in need of resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues. While the County-funded Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will also then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services

6. Collaboration and System Enhancements

In close collaboration with AIS Caregiver Coalition staff, Contractor for this program will develop partnerships with local Hispanic/Latino organizations such as the Chicano Federation, Casa Familiar, San Ysidro Health Center, etc., to extend outreach to Hispanic/Latino families, raise awareness on mental health needs of caregivers, encourage prevention and mobilize advocacy for policy change. Alzheimer's is a large issue that families and voluntary organizations must conquer with a concerted public commitment to research, education and culturally competent preventive health care and supportive services.

With a final goal of integrating MHSA PEI funded activities within the existing structure of the program and to ensure program sustainability, contractor will seek and secure funding opportunities beyond the term of the PEI allocation.

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7. Intended Outcomes

Caregiver:

- Improvement in caregivers' overall quality of life
- Decrease in depressive symptoms
- Increased involvement in self-care
- Decreased feelings of anger
- Decreased levels of stress
- Increased care giving abilities
- Increased level of connectiveness and social support

Alzheimer's and Dementia Care recipients:

- Decreased problem behaviors
- Decrease rate of institutional placement
- Improved quality of life

System and Process Outcomes:

- Prevent and reduce incidence of depression
- Prevent elder abuse/neglect
- Delay institutional placement

A program evaluation study will measure prevalence of clinical depression among the caregivers by tracking the number of individuals with a diagnosis of clinical depression after participation in the program, as well as collecting data on care recipients' placement in institutions during caregiver participation in the program.

Through this program, family/caregivers will enjoy a higher quality of life, experience a reduction in depressive symptoms and be better skilled to care for loved ones. This program will reduce older adults' placement in institutional care and decrease the potential for elder abuse.

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8. Coordination with Other MHSA Components

Caregivers found to be in need of long-term specialty mental health services will be referred to MHSA CSS-funded services such as a full service partnership or field capable clinical services. The contractor for this program will coordinate services and referrals via a centralized toll-free referral and information line.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): **Older Adult Services**
 Program ID/Name: **OA04 REACHing-Out (REACH, Resource for Enhancing Alzheimer's Caregiver Health)**
 Provider Name (if known): **Pending Competitive Procurement**
 Provider Category (DMH List): **Other**

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	600
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	600
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
	Classification	FTE	Per FTE			
	Care Manager (clinician)	2.00	\$73,600	\$0	\$147,200	\$147,200
	Peer Counselor/Support Staff	4.00	\$29,510	\$0	\$118,040	\$118,040
	Administrative Staff	0.50	\$35,000	\$0	\$17,500	\$17,500
		0.00	\$0	\$0	\$0	\$0
		0.00	\$0	\$0	\$0	\$0
	Total FTE	6.50	Sub-Total	\$0	\$282,740	\$282,740
	b. Benefits%	@ 27.0%		\$0	\$76,340	\$76,340
c. Total Personnel/Staffing Expenses				\$0	\$359,080	\$359,080
2. Operating Expenditures						
	Indirect/Administrative Costs		\$55,300	\$0	\$55,300	\$55,300
	Operating Costs (includes Facility Costs)		\$46,000	\$0	\$46,000	\$46,000
	Start-Up/One-Time Only Costs*		\$56,000	\$0	\$56,000	\$56,000
c. Total Operating Expenses				\$0	\$157,300	\$157,300
3. Subcontracts/Professional Services (list/itemize)						
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$0	\$0
4. Total Proposed PEI Program Budget				\$0	\$516,380	\$516,380
B. Revenues (list/itemize by fund source)						
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
			\$0	\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$516,380	\$516,380
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**

Program ID/Name: **OA04 REACHing-Out (REACH, Resource for Enhancing Alzheimer's Caregiver Health)**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals and improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

Position(s) targeted: Peer Counselor/Support Staff, 4.00 FTE.

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

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PEI Project Name: Salud

County: San Diego

Date: 11/19/08

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

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	☐	☐	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☒
3. Children and Youth in Stressed Families	☐	☐		
4. Children and Youth at Risk for School Failure	☐	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		
6. Underserved Cultural Populations	☐	☐	☐	☒

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

Consistent with MHSA guidelines, the County of San Diego has conducted an inclusive community planning process in selecting MHSA PEI Older Adult Populations as one of our 10 priority focus areas. Below is a list of venues and opportunities offered to community stakeholders to participate in the PEI planning process and to provide valuable input for the selection of the proposed program.

Qualitative Assessment of Need for Mental Health Services Among Older Adults in San Diego County – February 2006

San Diego Mental Health Services, in partnership with the University of California San Diego (UCSD) Geriatric Research Center completed the *“Qualitative Assessment of Need for Mental Health Services Among Older Adults in San Diego County”*. This OA Needs Assessment was done in partnership with UCSD research Center, funded by a grant from the National Institute of Mental Health (NIMH). The Older Adult System of Care Council and AOAMHS provided the impetus for this assessment with the purpose of identifying older adult needs in San Diego County. Results were and continue to be used to develop programs and services to address needs of older adults and assisted to inform the development of the PEI Older Adult Plans. The following individuals assisted with the assessment: Lawrence A. Palinkas, Ph.D.; Viviana Criado, M.P.A.; Dahlia Fuentes, M.S.W., M.P.H.; Sally Shepherd, R.N.; Hans Milian, M.P.H.; David Folsom, M.D.; and Dilip V. Jeste, M.D. The results and recommendations from this study follow.

This report confirmed the needs of older adults documented in the literature to include that many of the physical complaints of clients with chronic conditions are related to depression. Paraphrasing the words of an older adult advocate: “It’s no secret that in our older population, several things stand out – the increase of chronic illness as we get older, that we are enjoying a longer life, and that we also have to manage illnesses into our older years and indeed; it is false to separate the physical from the mental, because many of our chronic illnesses carry with it a great deal of depression.”

Stakeholder recommendations from the needs assessment included:

- Incorporating health promotion and disease prevention programs for older adults that include adequate nutrition and exercise,
- Adequate attention to older adults in primary care,
- Need for preventive mental health services,
- Service enhancements,
- Specific geriatric expertise,

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- Culturally competent services and interventions,
- Need to improve access, and
- Peer support.

Older Adult PEI Stakeholder Forum – November 2007

This forum was hosted by the Older Adult Mental Health Council and the Older Adult PEI Committee of the Council, and it was the first of the scheduled PEI Planning venues in San Diego. The forum brought together close to 100 individuals. The key issues related to late onset identified at this event were:

- Provide prevention and early intervention in co-occurring/co-morbid disorders,
- Integrated screening for older adults as they have problems self identifying,
- Prescription Rx misuse,
- Chronic disease management for diabetes and integrated services for co-occurring issues, and
- Continued training of professionals and gatekeepers.

Older Adult Mental Health Council (OAMHSOC) Prevention Early Intervention Committee – February 2008

Established in September 2007 with the responsibility to review all older adult PEI related input received by the administration, the PEI Committee of the Council diligently prepared recommendations for the Older Adult Mental Health Council's review and approval. The following recommendations have been endorsed by the OAMHSOC Council supporting the development of the Salud program.

Co-occurring Disorders/Integrated Treatment of Diabetes and Depression (SALUD):

- Chronic disease self-management to prevent and address co-morbid depression in diabetic, Hispanic elders;
- Age, cultural/linguistic, gender specific and accessible services based on principles of collaboration and service integration;
- Services to include transportation, screening, assessment, interventions and linkages to specialty mental health;

Co-morbid depression and diabetes among older persons is common and costly and it is believed to adversely affect the self-management of diabetes due to negative affects on energy, motivation, concentration, self-efficacy and interpersonal interaction. The prevalence of depression is higher among people with diabetes (24%) than in the non-diabetic population

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(17%) (Diabetes Care, 2005). In San Diego, the hospitalization rate due to diabetes is much higher for Hispanics than for other non-Hispanic Whites (212 per 100,000) (CHIP, 2004). Diabetes is known to be under-diagnosed in the Hispanic population, especially among the elderly.

In 2004, a needs assessment conducted by the Community Health Improvement Partners (CHIP), a San Diego-based organization, found that diabetes and mental health issues are both among the top five issues of major concern for older adults over 65. According to the local Alzheimer's Association, the County's Hispanic, 60+ years population is estimated to grow 66% by 2010 and 652% by 2050, particularly in the San Ysidro Health Center (SYHC) catchments area.

According to SYHC's 2007 annual federal report (UDS Report), the health center's elderly Hispanic population consists of 5,975 patients between 50 to 64 years, 2,092 patients between 65 to 74 years, 527 patients between 75 to 84 years and 208 patients 85 years and over. The target area served by SYHC is comprised of two major statistical areas, namely the central and south suburban areas of San Diego County. Census data from 2000 indicates that 857,414 people live in this geographic area (SYHC Annual 2007 UDS Report).

In 2004, the number of unduplicated medical encounters due to diabetes among Hispanic older adults 65+ in San Diego County was 1224 and 651 (53%) of these encounters took place in North and South San Diego County regions.

3. PEI Project Description:

This program will incorporate culturally and linguistically tailored evidence based practices (EBP) or promising practices that may include, but is not limited to, the Chronic Care Model developed by Stanford University and IMPACT Problem Solving Therapy. Interventions will target multiple risk factors, particularly medication adherence, dietary behaviors, physical activity and appointment adherence.

This PEI Salud program was selected based on a logic model with input from community stakeholders. The program seeks to replicate the results of the IMPACT + DULCE pilot project, which evaluated the integrated treatment of co-morbid depression and diabetes in primary care setting over the course of 16 months (MHSA CSS OA-3). Both of these EBPs have very solid evidence of efficacy with older adults and Hispanic populations. The results of the IMPACT + DULCE pilot project demonstrated a positive impact on self-care activities and diabetes control, significant reductions in depressive symptoms as measured by PHQ9 scores, improvement in quality of life and improved adherence to food and excursive plans. This program offers the opportunity to pilot a project and provide integrated care for mental health and medical conditions.

This program is consistent with the goals of PEI to prevent the development of long disabling conditions and to reduce disparities in healthcare.

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Services/ Staff:

- Integrated Clinical Care Manager: A bilingual/bicultural, Masters-level RN with a background in the treatment of chronic conditions and mental health will provide integrated screening, assessment and management of diabetes and depression, education and brief solution-oriented counseling utilizing Problem Solving Therapy – In Primary Care (PST-PC).
- Promotora/Health Educator Outreach: Promotoras will provide culturally competent health care outreach, engagement, individual and group peer support, chronic disease self-management education and follow up. These prevention services will be provided by trained senior promotoras/health educators in seniors' home and in places in the community where Hispanic seniors and their families gather in the two selected regions. This will include places where ethnic individuals congregate in their communities such as churches, low income housing, ethnic markets, social service agencies and community health clinics.
- Project Lead: A licensed clinical professional with a minimum of three years experience developing, implementing and managing older adult programs will provide supervision to all program staff. The Lead will be responsible for tracking and reporting County Monthly Outcomes.

Target Population: For this program, the target population will be unserved or underserved Hispanic older adults, 60 years of age and over with a diagnosis of diabetes and with symptoms of depression and/or at risk of developing depressive symptoms who are willing to have a program staff and/or Community Health Worker meet with them in their home or chosen location. Older adults identified as in-need for substance abuse, domestic violence and/or elder abuse services will be referred to appropriate services via the existent Call Center operated by the local AAA.

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

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Early Intervention will include integrated diabetes/depression care management by the Master's-level RN who will provide both diabetes care and depression care. Intervention will be delivered in primary care settings in North County Health Services in North County and at San Ysidro Health Center in the South Bay area of San Diego County. The program will serve approximately 400 unduplicated Hispanic older adults. Staff will use two recruitment strategies: 1) approach potential participants while they are in the clinic for routine care and 2) outreach to senior housing, senior centers, churches, faith based communities and natural places where Hispanic community gathers.

The program design supports the development of a integrated care for diabetic clients experiencing depression by assigning responsibility for mental health and medical care to one single care provider.

Key milestones include:

- Receive California DMH approval for Plan – Month 1
- RFP developed, competitive procurement process completed – Month 6
- Contract awarded – Month 7
- Staff training and certification (including cultural and linguistic needs of population) begins – Month 7-8
- Begin development of policies and procedures – Month 7
- Draft policies and procedures submitted to County for approval – Month 7
- Develop program materials including materials in multiple languages – Month 7
- Outcome tools identified, surveys created – Month 7
- Begin delivery of services – Month 8

PEI PROJECT SUMMARY

Form No. 3

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Salud Pilot Implementation: Prevention and Early Intervention of Co-Occurring Diabetes and Depression with Hispanic Elders	Individuals: 400 Families:	Individuals: 130 Families:	
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 400 Families:	Individuals: 130 (duplicated) Families:	

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

Clients identified as needing extended specialty mental health services will be referred by an Integrated Care Manager (ICM) to County and/or contracted specialty mental health.

In planning for PEI and understanding the multiple needs of older adults as at-risk populations, the County of San Diego Health and Human Services Agency (HHSA) Behavioral Health Services (BHS) has brought County departments and divisions to the table to ensure the needed support for the successful development of partnerships and collaborations with the following sectors: AIS (local AAA) and the Aging Network, Alcohol and Drug Services (ADS), Adult Protective Services (APS), Public Health, Domestic Violence, social services and housing services. Older adults in need of substance abuse, domestic violence or elder abuse services will be referred to appropriate services via the existent Call Center operated by the local AAA.

In partnership with AIS (local AAA), community health clinics, community organizations and national and county technical assistance, contractor will develop and implement a program to provide culturally competent outreach, education, and integrated short term care on co-morbid diabetes and depression in community health centers. Program activities will include prevention and early intervention activities.

PEI PROJECT SUMMARY

Form No. 3

Individuals in need of resources will be referred to the Access and Crisis Line to be linked to County-funded programs and/or services to address their specific needs and issues. While the County-funded Access and Crisis Line has extensive information regarding substance abuse treatment programs and all County-funded mental health services, individuals will also be referred to 2-1-1 San Diego and the San Diego County Domestic Violence Hotline as appropriate. This will also then provide access to basic needs services, including homeless and shelter programs, as well as assist callers with obtaining linkage to non-traditional mental health related services

6. Collaboration and System Enhancements

Contractor for these services will work in close collaboration with County of San Diego Mental Health Services, Aging and Independence Services (local AAA), San Ysidro Mental Health Services and North County Health Services in the implementation of this program.

In partnership with community-based organizations providing services to Hispanic older adults, the Salud program will expand the capacity to provide culturally competent depression screening and integrated short term treatment for depression and diabetes in the North Coastal, North Inland and South regions of San Diego and will demonstrate reduction of unnecessary hospital and emergency room admissions and, most importantly, will help to reduce diabetes death rates.

7. Intended Outcomes

Individual Outcomes include:

- Increased access to care,
- Increased self-care,
- Prevention and reduction of depression and its symptoms,
- Improved disease management,
- Reduction on inappropriate hospital visits and
- Client satisfaction.

PEI PROJECT SUMMARY

Form No. 3

System and Program Outcomes include:

- Reduced ethnic disparities,
- Improved outcomes for diabetes care,
- Reduction of inappropriate admissions to emergency room and in-patient care and
- Reduction in the diabetes death rate.

To demonstrate that the program intended outcomes are met, the contractor will develop and implement a data reporting system and will submit monthly program status reports to the County of San Diego.

Clients with chronic diabetes will have a better quality of life and prevent/reduce the development of depression. For those with co-occurring depression and diabetes, the program will offer the opportunity to learn how to manage depression and prevent re-occurrence. Successful results of the implementation will support efforts to move towards system-wide implementation.

8. Coordination with Other MHSA Components

This program will be initially implemented in three of the six HHSA San Diego County regions (North Inland, North Coastal and South Regions) at local community clinics providing services to Hispanic communities currently providing integrated mental health and primary care CSS-funded services. Clients identified in CSS-funded programs having diabetes will be referred to this program for diabetes/depression integrated care and treatment. Clients in need of long-term comprehensive services will be referred to the specialty mental health CSS-funded programs to include field capable clinic services, full service partnerships or to other core mental health services or other MHSA CSS services. Staff and peer promotoras at the selected sites will also have access to the Geriatric Mental Health Specialty training offered through a CSS-funded program and to other CSS-funded training opportunities offered by County Mental Health Services.

PEI Revenue and Expenditure Budget Worksheet

Enclosure 3

Form No. 4

Date: 10/31/08

County: **SAN DIEGO**
 Workgroup - Focus Area (Cnty PEI List): **Older Adult Services**
 Program ID/Name: **OA05 Salud**
 Provider Name (if known): **Pending Competitive Procurement**
 Provider Category (DMH List): **Mental Health Treatment/Service Provider**

	FY 07-08	FY 08-09
Proposed Total Number of Individuals/Families to be served:	0	400
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families served through PEI Expansion:	0	400
Estimated Months of Operation:	0	12

				Total Program/PEI Project Budget		
Proposed Expenses and Revenues		Est Annual \$		FY 07-08	FY 08-09	Total
A. Expenditure						
1. Personnel/Staffing						
a. Salaries, Wages						
Classification	FTE	Per FTE				
RN (integrated care manager)	2.00	\$73,600		\$0	\$147,200	\$147,200
Peer Counselor/Support Staff (promotora)	4.00	\$29,510		\$0	\$118,040	\$118,040
Project Lead	0.50	\$78,410		\$0	\$39,205	\$39,205
Administrative Staff	1.00	\$35,000		\$0	\$35,000	\$35,000
	0.00	\$0		\$0	\$0	\$0
Total FTE	7.50	Sub-Total		\$0	\$339,445	\$339,445
b. Benefits%	@ 27.0%			\$0	\$91,650	\$91,650
c. Total Personnel/Staffing Expenses				\$0	\$431,095	\$431,095
2. Operating Expenditures						
Indirect/Administrative Costs		\$66,500		\$0	\$66,500	\$66,500
Operating Costs (includes Facility Costs)		\$55,000		\$0	\$55,000	\$55,000
Start-Up/One-Time Only Costs*		\$67,000		\$0	\$67,000	\$67,000
c. Total Operating Expenses				\$0	\$188,500	\$188,500
3. Subcontracts/Professional Services (list/itemize)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
a. Total Subcontract/Professional Svcs Expenses				\$0	\$0	\$0
4. Total Proposed PEI Program Budget				\$0	\$619,595	\$619,595
B. Revenues (list/itemize by fund source)						
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
		\$0		\$0	\$0	\$0
1. Total Revenue				\$0	\$0	\$0
C. Total Funding Requested for Proposed PEI Program				\$0	\$619,595	\$619,595
D. Total In-Kind Contributions				\$0	\$0	\$0

PEI Revenue and Expenditure Budget Narrative

Enclosure 3

Form No. 4

Date: 11/25/08

County: **SAN DIEGO**
Program ID/Name: **OA05 Salud**

Program Budget - Proposed Program services will be provided by a County contracted service provider. The Program service provider will be selected through a competitive procurement with negotiation process. The competitive procurement process is expected to generate innovative proposals and improve on County projected Program staffing, performance, and cost effectiveness.

Estimated Months of Operation - The Fiscal Year 2008-2009 Program Budget amounts anticipate full year costs and revenues. However, the Program will start mid-year or later depending on the selected procurement process and any delays in the process.

Personnel/Staffing:

A1a Classifications, FTEs, and Salaries - Classifications, FTEs, and salaries are Program staffing projections based on County staff experience and expertise, current County Behavioral Health Services contracts, research to identify the same or similar proposed services, and Federal Bureau of Labor Statistics information for the San Diego area.

Clients and Family Members - Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose how they will recruit, hire, and retain qualified mental health clients and family members for all Program positions.

Position(s) targeted: Peer Counselor/Support Staff (promotora), 4.00 FTE.

A1b Benefits - The Benefit rate (27%) is based on the average rate in current County Behavioral Health Services contracts.

A2 Operating Expenditures:

Indirect/Administrative Costs and Operating Costs - Indirect/Administrative Costs and Operating Costs (which include facility costs) are based on current County contracted Behavioral Health services contracts. An average base rate per FTE (Indirect/Administrative, \$13,000 & Operating Costs, \$21,000) was determined and applied to the proposed Program. Projected costs were adjusted to recognize some differences in service needs and economies of scale.

Start-Up Costs - The Program Budget includes Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Basic Start-Up costs are 12% of projected full year Program costs. Projected Start-Up costs were expanded to anticipate one-time Vehicle, Specialized Training, and Consultant or Event costs. Start-Up costs will be identified by potential service providers proposals submitted in response to competitive procurement. Proposed Start-Up costs may include, though are not limited to:

- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation
- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist Program implementation

B Revenues:

Program specifications to be issued as part of the competitive procurement and service provider selection criteria will require that potential service providers propose any other revenues that may be leveraged to enhance or expand services.

PEI Administration Budget Worksheet

Form No. 5

County:	SAN DIEGO
Date:	11/25/2008

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2007-08	Budgeted Expenditure FY 2008-09	Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator		1		\$67,557	\$67,557
b. PEI Support Staff					\$0
c. Other Personnel (list all classifications)					\$0
					\$0
					\$0
					\$0
					\$0
d. Employee Benefits				\$38,845	\$38,845
e. Total Personnel Expenditures			\$0	\$106,402	\$106,402
2. Operating Expenditures					
a. Facility Costs				\$350,000	\$0
b. Other Operating Expenditures				\$2,581,709	\$0
c. Total Operating Expenditures			\$0	\$2,931,709	\$0
3. County Allocated Administration					
a. Total County Administration Cost			\$0	\$740,861	\$740,861
4. Total PEI Funding Request for County Administration Budget			\$0	\$3,778,972	\$3,778,972
B. Revenue					
1 Total Revenue			\$0	\$0	\$0
C. Total Funding Requirements			\$0	\$3,778,972	\$3,778,972
D. Total In-Kind Contributions			\$0	\$0	\$0

Mental Health Services Act PEI Administration Budget Narrative
County of San Diego

A. EXPENDITURES

1. Personnel Expenditures
 - a. MHSA PEI Coordinator – Overall responsibility for development, implementation, evaluation and monitoring of MHSA PEI. Budget is based on San Diego County Salary schedule for the position in FY 08-09 at step 5 with 3.5% cola and performance based incentive at 4% for FY 08-09.
 - b. MHSA Support Staff – None identified
 - c. Other Personnel – None identified
 - d. Employee Benefits – This includes FICA, medical and dental insurance, disability insurance, workers compensation insurance, retirement plan contributions, and other employee benefits. This is based on 57.5% benefit rate for County of San Diego in FY 07/08.
2. Operating Expenditures
 - a. Facility Costs - Facility Improvements, workstations and equipment.
 - b. Other Operating Expenditures - Professional services to include consultant contracts to support the development, implementation, monitoring and reporting of MHSA PEI, temporary office staff to perform clerical duties and temporary expert professional staff to support the development, implementation and monitoring of MHSA PEI. Rent, utilities and equipment based on average annual cost of \$5,5792 per FTE, and general office expenditures based on average annual cost of \$1,056 per FTE.
3. County Allocated Administration
 - a. Countywide Administration (A-87) - county-wide administrative support functions is a flat rate of approximately 1.3% of total program expenditures of \$21,414,173. Other allocated administration expenditures include Health and Human Services Agency overhead (centralized personnel, training, financial services, etc.) and Mental Health Administration overhead (management information systems, revenue billing and claiming, planning, program oversight and various reporting requirements) at a rate of approximately 2.16% of program expenditures of \$21,414,173.

PREVENTION AND EARLY INTERVENTION BUDGET SUMMARY

Form No. 6

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

County:	SAN DIEGO
Date:	11/25/2008

#	PEI Program/Project	Total	Funds Requested by Age Group			
			*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
PS01	Outreach and Education; Media Campaigns & Targeted Populations	\$1,933,600	\$193,360	\$193,360	\$966,800	\$580,080
PS02	Youth Peer Support Line	\$214,560	\$53,640	\$160,920	\$0	\$0
PS03	Family Peer Support Line	\$214,560	\$107,280	\$107,280	\$0	\$0
VF01	Veterans and Families Outreach and Education	\$1,120,000	\$179,200	\$470,400	\$380,800	\$89,600
DV01	South Region Point of Engagement	\$620,008	\$93,001	\$279,003	\$248,004	\$0
DV02	South Region and Polinsky Children's Center Trauma Exposed Services	\$923,907	\$739,126	\$184,781	\$0	\$0
DV03	Central Region Community Violence Services	\$593,085	\$355,851	\$0	\$237,234	\$0
RC01	Rural Integrated Behavioral Health and Primary Care Services	\$1,568,000	\$548,800	\$266,560	\$533,120	\$219,520
NA01A	Services Program with Elder Navigator	\$357,012	\$142,805	\$107,104	\$71,402	\$35,701
NA01B	Collaborative Native American Initiative - Urban Youth Center	\$483,310	\$483,310	\$0	\$0	\$0
NA01C	Prevention Education to San Diego American	\$549,497	\$219,799	\$164,849	\$109,899	\$54,950
NA01D	Prevention Program	\$407,181	\$162,872	\$122,154	\$81,437	\$40,718
EC01	Positive Parenting Program (Triple P)	\$1,512,000	\$1,512,000	\$0	\$0	\$0
SA01A	School-Based Program	\$1,916,150	\$1,916,150	\$0	\$0	\$0
SA01B	School-Based Program - Family Outreach	\$1,219,850	\$1,219,850	\$0	\$0	\$0
SA02	School-Based Suicide Prevention	\$916,596	\$229,149	\$687,447	\$0	\$0
FB01	Cool Program	\$1,456,000	\$371,280	\$1,011,920	\$72,800	\$0
CO01	Bridge to Recovery	\$1,815,000	\$0	\$235,950	\$1,343,100	\$235,950
CO02	Screening, Community Based Alcohol and Drug Services (ADS) Programs	\$1,150,000	\$253,000	\$126,500	\$644,000	\$126,500
OA01	Elder Multicultural Access and Support Services (EMASS)	\$514,153	\$0	\$0	\$0	\$514,153
OA02	Home Based Prevention Early Intervention Gatekeeper Program	\$547,805	\$0	\$0	\$0	\$547,805
OA03	Life Long Learning: Aging and Wellness	\$245,925	\$0	\$0	\$0	\$245,925
OA04	REACHing-Out (REACH, Resource for Enhancing Alzheimer's Caregiver Health)	\$516,380	\$0	\$0	\$387,285	\$129,095
OA05	Salud	\$619,595	\$0	\$0	\$0	\$619,595
	Administration	\$3,778,972	\$1,549,495	\$726,746	\$895,744	\$606,987
Total PEI Funds Requested:		\$25,193,145	\$10,329,968	\$4,844,975	\$5,971,625	\$4,046,579

County:	SAN DIEGO
Date:	10/31/2008

BUDGET NOTES:**Program Service Providers**

Proposed Program services will be provided by County contracted service providers. Program service providers will, except for one School Based and the Native American Programs, be selected through a competitive procurement with negotiation process. The competitive procurement process and negotiation with all Program service providers is expected to provide an opportunity for potential service providers to propose innovative Programs that will improve on projected Program performance and cost effectiveness.

Fiscal Year 08-09

The Fiscal Year 2008-2009 Program Budget amounts in the Budget Summary and the individual Budgets anticipate full year costs, though the Programs are anticipated to start mid-year or later. The amounts include estimated initial year Program Start-Up expenditures.

Start-Up Costs

The attached individual Program Budgets include Start-Up costs for the implementation of proposed Program services in the initial year of Program operation. Start-Up costs are generally 12% of projected full year Program costs. For some Programs, anticipated Start-Up costs were expanded to include Vehicles, Specialized Training, and required Consultant or Event costs. Start-Up costs may include, though are not limited to;

- Vehicles for outreach and transportation
- Specialized Training (including Training for Trainers)
- Consultants or Events to assist in the implement the Program
- Facility Improvements to assist in developing staff workspace and meeting rooms
- Brochures & Reference/Referral Material development (including translation into multiple languages) and initial printing
- Computers, Printers, Communication Equipment and related Software for Program staff and Program participant access
- Furniture, Fixtures, Equipment, and Supplies for staff and Program participant/public areas
- Training and related Equipment, Materials, and Supplies for staff and as needed for Program implementation

County: San Diego County

Date: 11/19/08

- ☐ 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.

San Diego County Prevention and Early Intervention First Break 'Cool' Program (FB01). It should be noted that the name of this program may change when implemented.

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

San Diego County Mental Health Program Managers and PEI project leads discussed the various proposed PEI programs and determined that FB01 First Break Cool Program would be locally evaluated due to the high level of input stakeholders and community members voiced for services to this unique and underserved population.

Community feedback determined that programs for at-risk transitional age youth (TAY) and their families should increase access to and opportunities for care and promote early detection of mental health issues through screening by frontline gatekeepers. Community input also stressed the need for support and outreach to at-risk youth, improvement in transportation to and from services, linkage with existing community services, utilization of community based settings for service delivery, and support for individuals and families at high risk of or experiencing a first break.

In an effort to address community needs, this First Break PEI Program (FB01) utilizes a gatekeeper model with gatekeepers at schools, colleges, primary care facilities, family resource centers, churches, substance abuse programs, Emergency Screening Unit, Emergency Psychiatric Unit, and within Child Welfare Services and Justice Systems. The program also focuses on family education and incorporates mobile outreach for assessment and supportive interventions. The First Break Program also includes a treatment component, whereby an individual may be provided comprehensive and integrated services for up to 18 months. This program provides TAY and families with linkages to primary care physicians, substance abuse services and other appropriate social and recreational services in the community. Linkages to existing MHSA/CSS programs will also be utilized as resources for TAY and the family. These

services include integrated primary care settings and mental health programs; family, youth and peer support services; family and youth information and education programs; school based mental health services; mobile adolescent services; enhanced mental health services for TAY; and full service partnership programs and clubhouses.

In the Cool clinical component of the program, staff will treat and follow participants for up to 18 months, tracking and trending client and program outcomes. We currently collect demographic data, axis diagnoses, and substance abuse, residential, educational and employment status for all clients. In addition, we will be able to track hospitalizations, incarcerations, and referrals to other resources *via review of clinical record*.

In addition to the value stakeholders placed on services for this population, the Cool program lends itself to this evaluation project because of the evaluation and research component currently integrated in the program's design. Outcomes will be measured by tracking and trending baseline, 6, 12, and 18, month intervals on various measures including the Structured Interview for Prodromal Symptoms (SIPS). The program participants will also complete pre- and post-surveys assessing their level of knowledge acquired.

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

It is expected that by assisting TAY individuals and their families in detecting and identifying early at-risk behaviors for a first break, we will be able to minimize the debilitating effects of untreated mental health issues and link TAY and their families to appropriate needed services. In addition, this intervention will increase the chances of maintaining TAY in the family system and home with supports, as well as providing interventions that will assist TAY and their family in developing the resilience that is necessary to address mental health issues.

Individual and family outcomes include 1) increase in education and awareness of at-risk behaviors and features; 2) early detection and identification of at-risk behaviors and features; 3) improved well being and hopefulness; 4) management of behaviors, symptoms, and features; 5) family education and involvement; 6) reduction of prolonged suffering; 7) increase in timely access to services; 8) diversion from incarceration; and 9) avoidance of school failure.

System level outcomes include reduced hospitalization for TAY experiencing first psychotic break, collaboration, partnership development, and ongoing education with primary care providers and other gatekeepers.

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/ DISCRIMINATI ON
<u>ETHNICITY/ CULTURE</u>							
African American	6	15	7	5	4	1	2
Asian Pacific Islander	4	10	3	4	1	0	3
Latino	10	35	17	15	10	2	20
Native American	1	1	1	1	0	1	1
Caucasian	6	24	12	7	5	1	6
Other (Indicate if possible)	10	15 (Middle Eastern, African Refugee, LGBTQ)	3	4	3	2	7
<u>AGE GROUPS</u>							
Children & Youth (0-17)	10	20	12	11	8	3	24
Transition Age Youth (16-25)	16	80	30	25	15	5	24
Adult (18-59)	-	-	-	-	-	-	-
Older Adult (>60)	-	-	-	-	-	-	-
TOTAL	26	100	52	36	23	8	48
Total PEI project estimated <i>unduplicated</i> count of individuals to be served: 100							

**Estimated population is based on San Diego County Gap Analysis and target population of the region. Numbers may vary based upon bidder's proposal.

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

All program participants will be given pre- and post-surveys assessing level of knowledge acquired. The program will also be tracking and trending outcomes at 6, 12, and 18 month intervals for TAY participants. We will evaluate data collected from research tools including the Structured Interview for Prodromal Symptoms (SIPS). The SIPS is a structured diagnostic interview used to diagnose three prodromal syndromes and is similar to the Structured Clinical Interview for DSM-IV (SCID). The SIPS includes the Schizotypal Personality Disorder Checklist (SOPS). SIPS also include an operational definition of the three prodromal syndromes [Criteria of Prodromal Syndromes (COPS)] and psychosis onset [Presence of Psychotic Syndrome (POPS)].

The Cool Program will also utilize the Mental Health Recovery Treatment Scale (MRTS) and the Substance Abuse Treatment Scale Revised (SATS-R) tools to assess mental health and substance abuse recovery of clients over the age of 18 years old, as well as the County's in-house developed tool for measurement of residential and employment status. These measures are currently used to gauge client outcomes in TAY and adult County mental health programs. We will collect this data on a monthly reporting tool and create a yearly progress report of program outcomes.

System level outcomes will be measured through pre- and post-surveys to all gatekeepers in order to assess their level of knowledge gained through the educational component of the program. In addition, increased partnerships and collaborations between providers will be evaluated through collaborative agreements or MOUs.

5. How will data be collected and analyzed?

All client data will be collected by the provider and evaluated by the County of San Diego Quality Improvement Department and/or an independent consultant.

We are currently in our second year of development of a new management information system (MIS) and we anticipate this MIS to be fully functional within two years. In the meantime, we have started to use the Anasazi management information system and monthly contract monitoring tools. The program will also complete other required reporting measures at the discretion of the County. The information from these monthly reports is collected and analyzed by the program monitor and our Quality Improvement department. Other data collection forms may be developed upon consultation with the evaluation and research consultants of the program. Data analysis will involve comparisons between

program outcomes and stated requirements in the contract Statement of Work and other standards developed during the contracting process.

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

Outreach and engagement activities will be conducted with culturally diverse community gatekeepers in primary care centers, churches, and schools. At a minimum, informational materials for monolingual Spanish-speaking families and TAY will be provided.

All programs are required to complete and submit monthly and yearly reports on culturally competent staff patterns, language ability, use of interpreters, and trainings attendance. Clinical records are reviewed by the quality improvement unit on specific cultural competence domains. The County of San Diego requires mental health contractors to complete four hours of Cultural Competence training annually. In addition, we have integrated cultural competence assessment questions into the mental health assessment tool, thus informing a culturally competent treatment and service approach.

We will also require that contractors conduct an evaluation of the community they serve to identify the unique cultural groups, needs, and desired outcomes for this program from the community. From this evaluation, contractors will develop a plan to meet the needs of this community. This plan will be reviewed by the County and approved or provided with suggestions for strategies to address the needs of the community.

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

The research component at this time is under negotiations with Dr. William McFarlane, MD, psychiatrist and researcher at Maine Medical Center, and will be finalized within the next three to six months. Dr. McFarlane will provide the technical assistance, consultation, and training to Cool staff on the model of service, clinical tools, and program implementation to ensure fidelity to the model of service.

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

This report will be posted on the San Diego Network of Care website, which is the mechanism used for public review of all MHSA documents. This information will be disseminated to the Mental Health Board and the Children's, Adult, and

Older Adult System of Care Councils. The evaluation report will also be provided to the County's TAY Committee. These Boards and Councils represent various stakeholder groups in our County and are open to the public.