

**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 Mateo

Date: August 29th, 2008

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

County Mental Health Director	Project Lead
Name: Louise Rogers, Director Behavioral Health and Recovery Services	Name: Stephen Kaplan, Director of Alcohol and Other Drug Services, Behavioral Health and Recovery Services
Telephone Number: (650) 573-2544	Telephone Number: (650) 573-3609
Fax Number: (650) 573-2841	Fax Number: (650) 573-2841
E-mail: lrogers@co.sanmateo.ca.us	E-mail: skaplan@co.sanmateo.ca.us
Mailing Address: 225 37 th Avenue, San Mateo, CA 94403	

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 _____

August 29th, 2008

County Mental Health Director

Date

Executed at San Mateo, California

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form No. 2

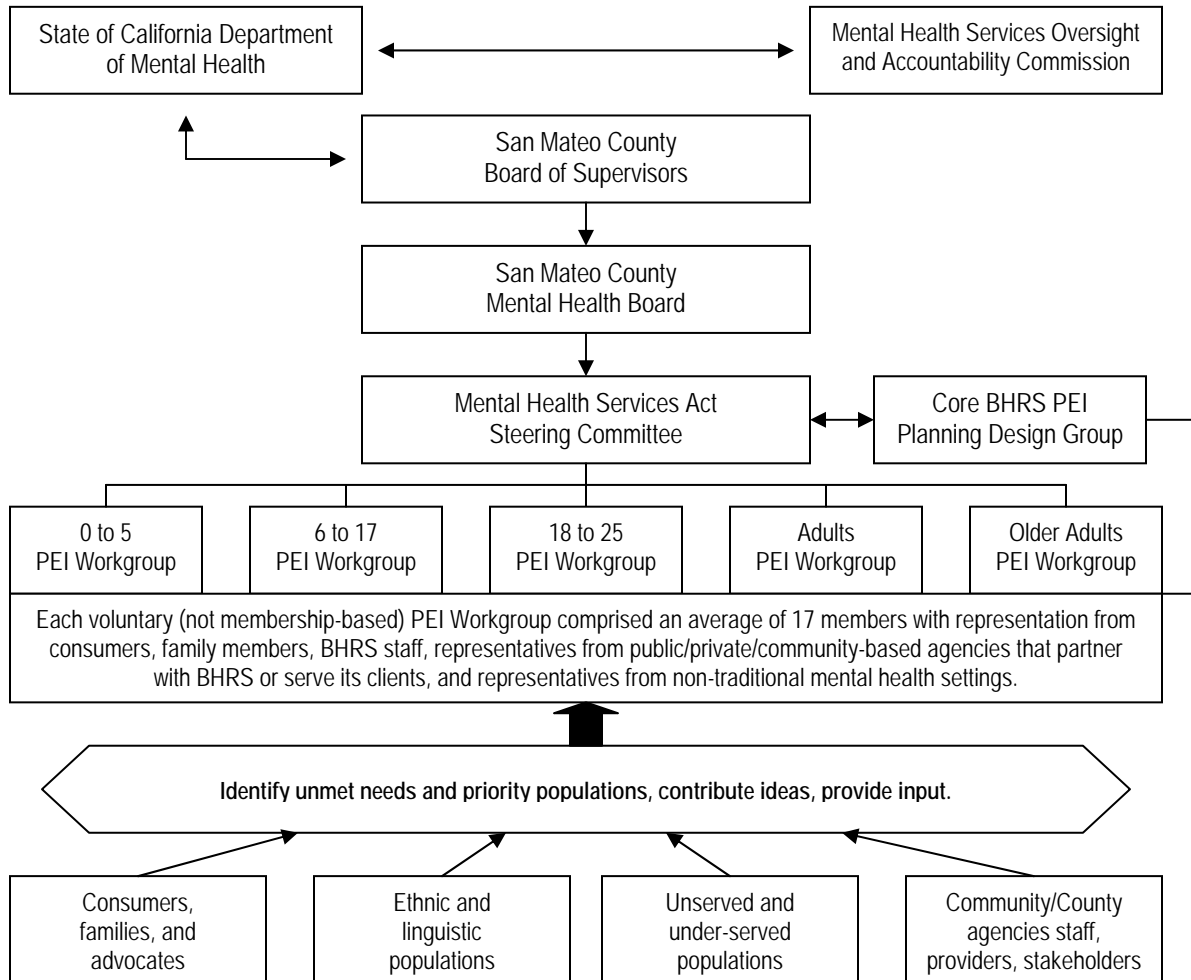
County: San Mateo

Date: August 29th, 2008

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

Guided by high standards for community involvement and participation, San Mateo County's MHA planning processes are specifically designed to facilitate meaningful participation from stakeholders, including un/underserved communities. The overall planning structure we created for our MHA CSS proposal describing the Mental Health Board's and the MHA Steering Committee's roles remains in place (details follow). **Appendix A – Form No. 2** shows the composition of both bodies, and the diagram below depicts the planning structure.



The Director of the Behavioral Health and Recovery Services Division (BHRS) provided overall guidance and direction to the project, while the Director of Alcohol and Other Drug Services and the MHA Coordinator (BHRS) planned and supported the PEI planning process. All three constitute the Core BHRS PEI Planning Design Group.

b. Coordination and management of the Community Program Planning Process

The coordination and management of the planning process rested primarily with the Director of Alcohol and Other Drug Services and the MHSA Coordinator, with assistance in facilitation and research from two leading consulting organizations: the *Prevention Institute*, a national organization focused on prevention, and whose work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups (www.preventioninstitute.org); and Barbara Mauer, from *MCPP Healthcare Consulting* (www.mcpphealthcare.com). Ms. Mauer is a seasoned healthcare professional with extensive experience in behavioral healthcare prevention; she was also very involved in the development of our County's MHSA Community Services and Supports proposal as one of the leading consultants for that effort.

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

In addition to 1.a. and 1.b. above, the leadership of the Children, Youth (including Transition Age Youth), Adults and Older Adults Units of the Behavioral Health and Recovery Services Division was heavily involved throughout the process and collaborated and facilitated our outreach efforts. Furthermore, the MHSA Implementation Group (which meets at least once a month and comprises the BHR Director, the Director of Alcohol and Other Drug Services, all BHR program managers operating and/or overseeing MHSA programs, the MHSA Coordinator, the Health Disparities Manager, representatives from the Office of Consumers and Family Affairs and the chair and past chair of the Mental Health Board), advised the process to ensure broad inclusion of stakeholders as well as adequate outreach strategies.

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.
- 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.

San Mateo County is one of the early implementers of the Mental Health Services Act. Our planning process for the Community Services and Supports (CSS) component¹ --as is the case with all our MHSA planning activities, was designed to facilitate meaningful participation from a broad range of stakeholders including members of historically un-served and under-served communities. A structured planning process involved the Mental Health Board (MHB); the MHSA Steering Committee; and Child and Youth, Transition Age Youth, Adult and Older Adult Work Groups. All MHB, MHSA Steering Committee and Work Group Meetings were open to the public.

¹ The information provided in relation to the San Mateo County's Community Services and Supports planning process has been quoted from the original approved proposal for that component.

The MHSA Steering Committee² worked with Mental Health Services Division³ staff to develop the composition, roles and responsibilities of the Steering Committee and of the Work Groups. The Mental Health Board approved the draft planning process proposal before it was submitted for approval to the California Department of Mental Health (DMH). Together, the Steering Committee co-chairs secured the commitment of a broad cross-section of community and organizational leaders and mental health consumers, family members and advocates to comprise the Steering Committee.

Each of the four CSS Work Groups met in a series of five full and half day facilitated meetings from March to June 2005. The Work Groups gave stakeholders the opportunity to review the results of prior planning efforts, local service utilization data, descriptions of existing community services and supports, summaries and presentations on best practice research and findings from focus groups and community meetings. Work Groups were also the locus for providing input into the planning process and prioritizing target populations, focus issues, and high priority strategies for each age group. Throughout the process, Work Groups forwarded their recommended priorities to the Steering Committee for review and comment.

The MHSA Steering Committee (chaired by the President of the Board of Supervisors and co-chaired by the Chair of the Mental Health Board) met monthly to review Work Group deliberations and priorities and to provide comment and feedback to the Work Groups. This planning culminated in a joint meeting on June 10th, 2005 at which Work Group members and Steering Committee members reviewed the priorities of all four Work Groups and reflected on the feedback from the community outreach process. They worked in small groups and one large plenary to generate an integrated set of priorities and budget reflecting the recommendations of all four Work Groups.

To inform the process the Mental Health Services Division conducted an intensive community outreach process to assure there would be substantial, meaningful input from consumers, family members, and representatives of populations that have been historically un/under-served by the Mental Health Services Division and would be unlikely to participate in formal planning meetings. The Mental Health Services Division partnered with numerous community stakeholders to conduct over 100 focus groups and community meetings targeting un/under-served populations, which were held in all communities in the County between March and June, and input was received from over 1,000 individuals. The two Youth Commissioners serving on the Mental Health Board also conducted a mental health awareness survey of high school students that generated over 1,000 responses.

As described in item 1. a. above, San Mateo's MHSA PEI planning process was guided by the highest standards for broad and inclusive community involvement and participation, including un/underserved communities.

² The MHSA Steering Committee has continued to meet since its formation in 2005, and is the body charged with approving all MHSA proposals prior to submission to the State.

³ Now "Behavioral Health and Recovery Services" since the integration in 2007 of Mental Health and Alcohol and Other Drug Services.

Aggressive outreach strategies were used to secure participation of representatives of un/underserved populations as well as from the community at large.

Examples of outreach strategies include:

- Posters and fliers (bilingual) created and sent to/placed at county facilities, as well as other venues like family resource centers and community-based organizations.
- E-mails disseminating information about the planning process sent to over 1,000 electronic addresses in a database we continuously update as we come across new contacts.
- As with our CSS process, we made it a point in our outreach materials to emphasize the MHSA principles of transformation, with the overarching goal of making the mental health delivery system more responsive to the needs of the un/underserved.
- Refreshments and food were provided, and consumers and family members were offered stipends for their time; taxi vouchers were provided to facilitate transportation for individuals who needed assistance.
- We held special meetings with family partners to seek out their input and ideas (with simultaneous interpretation in Spanish).
- We held a meeting at a senior facility that houses older adults on the more elderly side of the age spectrum; this was the only way in which this particular group could provide input into the process. A similar meeting was held for Spanish-speaking seniors.
- Our outreach successfully engaged the Education community, which participated in the process from beginning to end. Furthermore, the leadership of the Office of Education took on the task of mapping all evidence-based practices currently in place in all 24 school districts throughout the County with the sole purpose of informing the PEI planning process. This provided extremely useful information.
- The MHSA Steering Committee, the MHSA Implementation Group, community partners, and other agencies (public and private) provided input and suggestions on engaging the un/underserved and suggested stakeholder groups to involve in this effort.
- Examples of participating organizations serving unserved and underserved communities that collaborated with outreach and/or were directly involved in the planning process include: One East Palo Alto; El Concilio; Free at Last; For Youth By Youth; Pyramid Alternatives; Asian American Recovery Services, Edgewood Center for Children and Families, Caminar, among many others.

As part of its newly adopted mission, the Behavioral Health and Recovery Services Division sees all outreach activities as critical, and as an opportunity for the continued building of positive relationships with the community. We believe that if we want to maintain a continued, fruitful dialogue with the members of different communities, we must partner with the community-based organizations they trust and seek help from. It is our belief that doing so will ensure meaningful community participation necessary to truly transform our mental health services delivery system.

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form No. 2

The development of the MHSA PEI planning process by the Behavioral Health and Recovery Services Division began even before the guidelines were released in late 2007. We reviewed the prevention-related results of the extensive community outreach process conducted in 2005 for CSS as well as the recommendations of the age-focused Work Groups that developed the State-approved MHSA CSS plan for San Mateo County. In addition, we identified related County strategic initiatives and Board of Supervisors recommendations that needed to be factored into the planning process. Examples are: the Roadmap for Alcohol, Tobacco and Other (ATOD) Prevention; the Health Disparities Summit; the Community Health Assessment; Linguistic Access Study; the Adolescent Report; among others⁴. The development of the planning process took into account and reflected a much larger countywide effort of assessment and identification involving un/under-served populations.

Once the PEI requirements were released at the State level, we brought all of the pieces together. In January 2008, the MHSA Steering Committee approved parameters for our local PEI planning process, which began in February. Like CSS, the PEI planning process was also structured around age-focused workgroups: **0 to 5**; **6 to 17**; **18 to 25**; **Adults**; and **Older Adults**. What follows is a summary of net meeting hours (per Work Group, and total):

Net meeting hours	0 to 5	6 to 17	18 to 25	Adults	Older Adults
Within age-specific work group	10	7	7	10	10
With other work groups	7	10	10	7	7
TOTAL EACH WORK GROUP	17	17	17	17	17
TOTAL PLANNING PROCESS	85				

Below is the detail of Work Group meetings held, with dates and duration:

Work Group	Date	Time	Comments
0 to 5	2/29	1 to 5 pm	First 2.5 hours and last half hour of the meeting: all age groups together. Remainder of the time: age-specific breakout session.
	3/14	9 to 12 am	-
	4/17	9 to 12 am	-
	5/16	9 to 12 am	-
	6/26	1 to 5 pm	First and last hour of the meeting: all age groups together. Remainder of the time: age-specific breakout session with 6 to 17 and 18 to 25 work groups.

⁴ These reports can be located at <http://www.plsinfo.org/healthysmc/>

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form No. 2

Work Group	Date	Time	Comments
6 to 17	2/29	1 to 5 pm	First 2.5 hours and last half hour of the meeting; all age groups together. Remainder of the time: age-specific breakout session.
	3/14	1:30 to 4:30 pm	-
	4/17	1:30 to 4:30 pm	First hour and last half hour of the meeting; with 18 to 25 work group (two facilitation teams). Remainder of the time: age-specific session.
	5/16	1:30 to 4:30 pm	
	6/26	1 to 5 pm	First and last hour of the meeting; all age groups together. Remainder of the time: age-specific breakout session with 0 to 5 and 18 to 25 work groups.

Work Group	Date	Time	Comments
18 to 25	2/29	1 to 5 pm	First 2.5 hours and last half hour of the meeting; all age groups together. Remainder of the time: age-specific breakout session.
	3/14	1:30 to 4:30 pm	-
	4/17	1:30 to 4:30 pm	First hour and last half hour of the meeting; with 6 to 17 work group (two facilitation teams). Remainder of the time: age-specific session.
	5/16	1:30 to 4:30 pm	
	6/26	1 to 5 pm	First and last hour of the meeting; all age groups together. Remainder of the time: age-specific breakout session with 0 to 5 and 6 to 17 work groups.

Work Group	Date	Time	Comments
Adults	2/29	1 to 5 pm	First 2.5 hours and last half hour of the meeting; all age groups together. Remainder of the time: age-specific breakout session.
	3/13	9 to 12 am	-
	4/16	9 to 12 am	-
	5/14	9 to 12 am	-
	6/26	1 to 5 pm	First and last hour of the meeting; all age groups together. Remainder of the time: age-specific breakout session with 0 to 5 and 6 to 17 work groups.

Work Group	Date	Time	Comments
Older Adults	2/29	1 to 5 pm	First 2.5 hours and last half hour of the meeting; all age groups together. Remainder of the time: age-specific breakout session.
	3/13	1:30 to 4:30 pm	-
	4/16	1:30 to 4:30 pm	-
	5/29	1:30 to 4:30 pm	-
	6/26	1 to 5 pm	First and last hour of the meeting; all age groups together. Remainder of the time: age-specific breakout session with 0 to 5 and 6 to 17 work groups.

The strategies utilized in CSS for the determination of community needs and target populations were also utilized for the selection of key mental health needs and priority populations for PEI. This determination involved data and community and expert input gathered through the many outreach activities already described. For PEI, we actualized and updated the relevant CSS data pieces; we also incorporated new information that supplemented the original data sets, with information that became available after our CSS proposal was approved. In addition, more than 100 persons provided additional input via meetings, focus groups, and surveys conducted for PEI, enhancing and refocusing the outreach done for CSS.

The data-driven component of our analysis of un/under-served populations in San Mateo County used the State DMH data regarding prevalence projections as factored by 200% of poverty. However, as acknowledged in DMH Letter No: 05-02, 200% of poverty is not an adequate predictor of need in counties where there is a higher cost of self-sufficiency. While we were unable to factor the details of the State DMH prevalence predictions to incorporate the higher cost of self-sufficiency and the larger base of potential users of public mental health services in San Mateo County, it is worth noting that the San Mateo County self-sufficiency adjustment factor for one adult with two children is 1.9476—a factor that could double the potential population to be served. 200% of poverty prevalence also does not account for the need or mandate under AB3632 for mental health (MH) services for special education students with an Individual Education Plan (IEP) specifying MH services, including psychiatric emergency services. Under these circumstances, comparisons by percentage of the population projected and population served (rather than the numbers themselves) is a more accurate approach to the calculation of the un/under-served. That was our methodology.

It's also noteworthy that an additional feature of the State DMH prevalence projections is that the age breaks do not support a clean analysis of the Transition Age Youth population -the State data considers ages 16-25; nor of the Older Adult population when defined as those over 60, as has been the practice in San Mateo County. The DMH data also does not crosswalk the prevalence by age with prevalence by ethnicity.

As mentioned, whenever possible, other sources were used to describe all relevant factors in the narrative discussions of each PEI project included in the proposal (data sources are identified).

Additionally, we looked at updated data regarding homeless status, disability status, seasonal and migrant farm workers flow and projected demand; we were not always able to factor age cohorts. This information is also provided in the project description included in our proposal.

The participants in the PEI planning process analyzed in detail all the pieces of information described above, as well as the new information gathered for the PEI planning process that supplemented the information obtained during CSS. All these elements informed the selection of the key mental health needs and priority populations.

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

Building upon our successful experience with CSS, individuals and organizations with a history of organizing consumers and family members were asked to assist in the outreach effort via information dissemination and direct outreach. Heart and Soul, our County's consumer run self-help organization, participated both with the outreach and directly in the planning process, as did clients and family members of clients. Current providers of services assisted in a similar manner, as did mental health advocates. Each of the age specific planning committees had representation from clients and family members.

For many consumers and family members the exclusion of the seriously mentally ill and seriously emotionally disturbed as target populations for the PEI component was not easy to understand, nor was the concept of primary prevention. However, as the planning process unfolded, their compassion

and interest for primary prevention was heartening. From the beginning and throughout our planning process we were touched by the many contributions of individuals already involved in the mental health system and by their commitment and desire to contribute their personal experiences towards this effort.

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

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

- Individuals with serious mental illness and/or serious emotional disturbance and/or their families
- Providers of mental health and/or related services such as physical health care and/or social services
- Educators and/or representatives of education
- Representatives of law enforcement
- Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families

The outreach strategies described in 1.b. were used to ensure the participation of the stakeholders mentioned in 3.a., as well as that of other stakeholder groups. **Appendix B – Form No. 2** depicts the list of groups represented throughout the planning process based on attendance to the age-focused workgroup meetings, and MHSAs Steering Committee and Mental Health Board membership and/or meeting attendance (in connection to the PEI planning process).

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

- The Director of Behavioral Health and Recovery Services, the Deputy Director for Children and Youth (BHRS), two Mental Health Board members, and the MHSAs Coordinator participated in a State Department of Education (DOE) sponsored training held on November 15th, 2007. This *“Building Collaboration for Mental Health Services in California Schools Regional Forum”* was funded by the DOE to enhance collaboration by bringing together local representatives of school systems and mental health departments for the occasion of the MHSAs PEI statewide implementation.
- The Director of Alcohol and Other Drug Services, the MHSAs Coordinator, and consultant Barbara Mauer participated as a group in the DMH/CiMH-sponsored webcasts for PEI on November 2nd, 2007 (theme: PEI Guidelines); and on April 2nd 2008 (theme: Juvenile Justice).
- The MHSAs Coordinator and consultants participated in the DMH-sponsored monthly PEI Technical Assistance conference calls.
- The MHSAs Coordinator participates on a weekly basis in the CMHDA-sponsored conference calls, which address each component of the MHSAs -including PEI. DMH staff and MHSOAC staff participate in the calls.
- Stakeholder education:
 - The PEI planning process 4-hour kick-off meeting was structured as a training for all constituents. The training covered general education on prevention and early intervention

(conducted by the *Prevention Institute*), and training on the PEI State guidelines (conducted by Consultant Barbara Mauer).

- Ongoing refreshers of State guidelines were provided throughout the planning process.
- In advance to each planning meeting a 30-minute time slot was allowed to answer stakeholders' questions in a drop-in basis, and the MHS Coordinator answered individual questions from stakeholders via email and telephone throughout the process.
- The MHS Steering Committee, the Mental Health Board, and the BHRS leadership were trained in the State guidelines as well, as was the MHS Implementation Group.

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.

We have answered items 1. to 3. above always referring to the relation between our PEI planning process and our CSS planning process, and how one is grounded in the other, therefore we believe this question has already been answered.

We would like to add that an important lesson learned from CSS was to remain focused on the task at hand while keeping in the forefront the goal of system transformation to better serve clients, families and communities. Furthermore, there has been -and continues to be- a number of major planning efforts that have required extensive participation from the very groups identified in the PEI planning process. Therefore, we have been mindful of, and strategic about, planning fatigue.

With all this in mind, we conceived our PEI planning process to produce two outcomes:

- a) **A proposal for MHS Prevention and Early Intervention;** and
- b) **An overarching Prevention and Early Intervention Framework for Behavioral Health** that will align existing mental health and alcohol and other drug services initiatives within a broad and long-term prevention agenda, including the development of sustainable future efforts. Please see **Appendix E**, where we explain the reasons for developing such broader prevention framework for behavioral health.

Another key question/issue that we grappled with during CSS, and that the PEI planning process has answered from a prevention and early intervention perspective is what evidence-based and promising practices will most effectively address San Mateo County's needs for each population, and how we should prioritize among them given our unique community assets and gaps, and the resources available.

We also made sure that funding decisions were driven by the needs and priorities of participants in our planning process. Here is an example: We arrived at the last meeting of the planning process held on June of 2008 with a list of projects per age group. A main goal of that meeting was to reach final consensus regarding what projects to ultimately include in the final proposal.

Participants of work groups for ages 0 to 5, 6 to 17, and 18 to 25, worked together to finalize the list of projects corresponding to the 0 to 25 age range of our proposal. During the discussion of these projects, representatives from the Education community felt very strongly that while proposed projects for both ends of the 0 to 25 spectrum were adequate, children ages 6-12 were not receiving, in their view, adequate consideration for funding. This prompted a spirited discussion with fellow Work Group

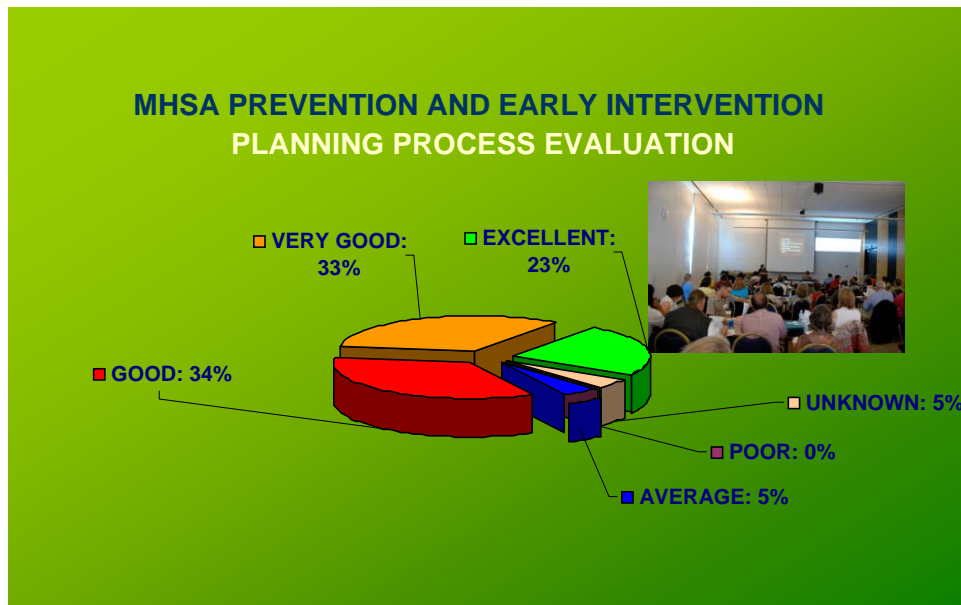
members which resulted in the modification of our “Community Interventions for School Age and Transition Age Youth” to include one intervention targeted at that age range (6 to 12).

The initial projects considered were Seeking Safety and Project Success. As a result of the process situation just described, a third project was added: Teaching Pro Social Skills; in addition, the lower end of the age spectrum for Project Success was lowered from 12 to 9 to capture younger children.

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.

We believe that the information provided throughout **Form No. 2** (including **Appendices A, B, and C**), coupled with the programmatic proposals yet to be introduced, support the assertion that our outreach efforts have produced an inclusive and effective planning process that kept all stakeholders (including but not limited to Transition Age Youth) engaged throughout 5 months of long, labor-intensive meetings.

We believe that an additional measure of success is given by the degree of satisfaction that the participants expressed in the results of a final evaluation form they were asked to fill out at the last meeting of the planning process. Among the questions asked of participants, we inquired if they felt that the key priority populations were included/represented, and the key community needs heard/addressed. The following chart illustrates their answers.



Highlights are:

- 56% of respondents rated the planning process as very good/excellent
- 34% rated it as good
- Overall positive feedback: 90%

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

a. The date of the public hearing:

Hosted by the Mental Health Board, a public hearing was held on July 31st, 2008, at 5:30 p.m., in room 100 of the Health Department Campus located at 225 37th Avenue, San Mateo, CA 94403.

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 plan was posted on the MHSA page of BHRS' website, also linking to the County's Network of Care site. Hard copies were made available to anyone who requested it. Notice of the hearing was widely circulated among all participants, community-based organizations, other community partners and government agencies, and a notice was published twice in the local newspaper of largest circulation.

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

Please refer to **Appendix D – Form No. 2**.

d. The estimated number of participants: 320+ individuals. (PEI only; does not include CSS.)

A total of 224 persons participated directly in the various workgroup meetings. In addition, more than 100 persons provided input via group meetings, focus groups, and surveys.

APPENDIX A – Form No. 2

County of San Mateo Mental Health Services Act (MHSA)

STEERING COMMITTEE Current Composition

Debby Armstrong Interim Executive Director First 5 San Mateo County	Beverly Beasley Johnson Director, Human Services Agency County of San Mateo	Dan Becker Hospital Council Representative Mills Peninsula Hospitals	Kathleen Bernard Member Mental Health Board	Clarise Blanchard , Director Substance Abuse and Co-occurring Disorders Youth & Family Enrichment Services
David Boesch Assistant County Manager County of San Mateo	Loren Buddress Chief Probation Officer County of San Mateo	Linda Carlson Executive Director Women's Recovery Association	John Castro Member Mental Health Board	Rodina Catalano Deputy Court Executive Officer of Operation County of San Mateo
Sang-Ick Chang, MD CEO San Mateo Medical Center	Jillian Collins Member, Mental Health Board (Youth Commissioner)	Maryanne Deresinski California Nurses Association South County Mental Health Center	Dr. Susan Ehrlich Medical Director San Mateo Medical Center	Richard Gordon, Co-Chair Board of Supervisors County of San Mateo
John Herbert UAPD Representative South County Mental Health	Dr. Jean Holbrook Superintendent of Schools County Office of Education	Richard Holober President, San Mateo County Community College District	Stephen Kaplan Director of Alcohol and Other Drug, BHRS	Katherine Kerns Member Mental Health Board
Eunice Kushman Family Member	Frank Lalle Director of Grantmaking, Silicon Valley Community Foundation	Carmen Lee, Director, Stamp Out Stigma, Consumer Driven Advocacy and Educational Outreach Program	David Levin Representative for AFSCME	Greg Love Member, Mental Health Board (Sheriff's Office Representative)
Amy Mah Member Mental Health Board	John L. Maltbie County Manager County of San Mateo	Carol Marble, Consumer, Associate Director of Heart & Soul Consumer run self-help Center	Don Mattei, Police Chief and Sheriff's Office Association, Belmont PD	Sharon McAleavy Representative AFSCME
Mary McMillan Deputy County Manager County of San Mateo	Alison Mills Consumer County of San Mateo	Raja Mitry Member, Mental Health Board County of San Mateo	Scott Morrow Health Officer County of San Mateo	Richard Napier Executive Director City/County Association of Government of SMC
John Courtney, Lieutenant Sheriff's Patrol Bureau County's Sheriff's Office	Karen Philip Deputy Superintendent of Schools County Office of Education	Melissa Platte Executive Director Mental Health Association	Steve Robison NAMI County of San Mateo	Fely Rodriguez Member Mental Health Board
Louise Rogers, Director BHRS	Dennis Romano Executive Director CAMINAR	Sharon Roth Member Mental Health Board	Mark Sabin, Executive Director – Project 90 AOD Tx Provider Coalition	Judith Schutzman, Co-Chair Member and Chair of the Mental Health Board
Patrisha Scott Member Mental Health Board	Charlene Silva Director, Health Department County of San Mateo	Janeen Smith Executive Director Pyramid Alternatives, Inc.	Josephine Thompson Member Mental Health Board	Deborah Torres, Director of Prevention and Early Intervention Services Human Services Agency, County of San Mateo
Patricia Way NAMI County of San Mateo	Greg Wild Consumer, Executive Director Heart & Soul	Maya Altman Executive Director Health Plan of San Mateo		

NOTA BENE: All members of the Mental Health Board are members of the MHSA Steering Committee.

APPENDIX B – Form No. 2

GROUPS AND ORGANIZATIONS REPRESENTED THROUGHOUT PEI PLANNING PROCESS

Organizations/Stakeholder Groups	Internet Home Page (when available)
34 Clients, Consumers and Family Members participated in the planning process	
4C's of San Mateo County (Child Care Coordinating Council)	http://www.thecouncil.net/
Achieve Kids, Palo Alto (serves children and youth with behavioral problems)	http://www.achievekids.org/
African American Community Health Advisory Committee (addresses health issues in community)	http://www.aachac.org/about_us/mission_goals.html
Aging and Adult Services	http://intranet/health/aas/
Alcohol and Other Drug Services (BHRS)	http://www.co.sanmateo.ca.us/smc/department/home/0,2151,1954_1300986004.00.html
Asian American Recovery Services (serving the Asian Community)	http://www.aars-inc.org/about/about.html
Bay Area Partnership for Children and Youth (helps schools access public funding)	http://www.bayareapartnership.org/wwwa/wwwa-aboutus.htm
Bayshore Childcare (gives affordable childcare to families)	http://web.mac.com/bayshorechildcare/BCCS/Welcome.html
Behavioral Health and Recovery Services (leadership and line staff)	http://www.co.sanmateo.ca.us/smc/department/home/0,2151,1954_1115375523.00.html
Belmont Police Department (law enforcement)	http://www.belmontpd.org/
CAMINAR (support services in communities for people with disabilities)	http://www.caminarinc.org/
Commission on Aging	http://www.co.sanmateo.ca.us/smc/department/home/0,,95903231_95903282_96589548.00.html
Commission on Disabilities	http://www.smhealth.org/smc/department/cod/home/0,,65129_65175.00.html
Community Gatepath (helps children and adults achieve goals and dreams)	http://www.communitygatepath.com/
Community Learning Center	
ComPeer (develop and manage national sponsorships and alliance programs)	http://www.compeer.org/
Crisis Center (promotes awareness about suicide and suicide prevention programs)	http://www.crisiscenter.cc/
Doelger Senior Center (commits to improving the lives of senior citizens)	http://www.doelgercenter.com/
Edgewood Center for Children and Families (serving Youth and Families of various ethnicities)	http://www.edgewoodcenter.org/
El Concilio of San Mateo (serving the Latino Community)	http://www.el-concilio.com/
Family Services Agency	http://intranet.co.sanmateo.ca.us/health/fhs/index.html
First 5	http://www.co.sanmateo.ca.us/smc/department/home/0,,4313274_4522401.00.html
For Youth by Youth (youth driven youth services)	
Fred Finch Youth Center (serving Youth and Families of various ethnicities)	http://fredfinch.wordpress.com/
Free at Last (offers street outreach and intervention for bilingual people)	http://www.freeatlast.org/
Health Plan of San Mateo	http://www.hpsm.org/
Health Department Policy and Planning	http://www.co.sanmateo.ca.us/smc/department/home/0,2151,1954_539700217.00.html
Heart and Soul (consumer run self-help center)	http://heartandsoulinc.org/301.html
Human Services Agency	http://hsa.co.sanmateo.ca.us/Web/index.htm

APPENDIX B – Form No. 2

GROUPS AND ORGANIZATIONS REPRESENTED THROUGHOUT PEI PLANNING PROCESS

Organizations/Stakeholder Groups	Internet Home Page (when available)
Jewish Family and Children's Services (provides community support for all ages)	http://www.jfcs.org/default.asp
Mateo Lodge Inc. (serving young adults with SMI –housing, crisis management, community support)	http://www.sanmateo.networkofcare.org/
Menlo Park Senior Center (offers health, recreational and education programs for seniors)	http://www.menlopark.org/departments/com/seniors.html
NAMI - National Alliance on Mental Illness (improve quality of life for people with mental health problems)	http://www.namisanmateo.org/home.asp
OASIS – Older Adult System of Integrated Services	
Office of Consumer and Family Affairs (within BHRS)	
One East Palo Alto (community based group trying to improve East Palo Alto)	http://www.epa.net/oepa/
Our Second Home (dedicated to changing and supporting the lives of children and adults with disabilities)	http://www.oursecondhome.org/
Outlet Program (supports lesbian, gay, bisexual, transgender, queer and questioning youth)	http://www.projectoutlet.org/index.html
Pacific Tonga Ma'a Tonga	
Peninsula Conflict Resolution Center (provide conflict prevention, management and resolution services)	http://www.pcrcweb.org/
Pre to Three Partners Program (support center for expecting mothers or those with young children)	http://www.co.sanmateo.ca.us/smc/department/home/0,3230,1954_194745,00.html
Probation Department (reduces crime, delinquency, and recidivism in a cost-effective manner)	http://www.co.sanmateo.ca.us/portal/site/Probation
Professional Association for Childhood Education Alternative Program (improve lives of families and children)	http://www.paceapp.org/
Public Health	http://intranet.co.sanmateo.ca.us/health/ph/index.html
Pyramid Alternatives (counsel and support families affected by alcohol, drug or abuse problems)	http://pyramidalternatives.org/wordpress/
Ravenswood Family Health Center (provides primary medical care and prevention services for all ages)	http://www.ravenswoodfhc.org/about.htm
Redwood City School District (education)	http://www.redwoodcity.org/residents/schools.html
Redwood City Veterans Memorial Senior Center	http://www.redwoodcity.org/parks/cc/veterans_info.html
Ron Robinson Senior Care Center (senior services)	http://www.co.sanmateo.ca.us/smc/department/home/0,,11881357_12641310_645292622,00.html
San Mateo and Foster City School District (education)	http://www.smfc.k12.ca.us/
San Mateo County Office of Education (education)	http://www.smcoe.k12.ca.us/homex.asp?Q=Homepage
Youth Services Center (provide safety, security and growth to youth at risk, their families and our community)	http://www.co.sanmateo.ca.us/smc/department/home/0,2151,1909_755557869,00.html
Sheriff's Office (law enforcement)	http://www.co.sanmateo.ca.us/smc/department/home/0,,14095463_14132006,00.html
South San Francisco Parks and Recreation	http://www.ssf.net/depts/rcs/default.asp
Spring Street Homeless Shelter	
Stamp Out Stigma (designed to make positive changes in the public perception of mental illness)	http://www.stampoutstigma.org/aboutus.html
The Center for Youth (enhance the health of young people and help them address challenges in their lives)	http://www.theyouth.org/healthcenter.php
Vocational Rehabilitation Services (counseling, case management, assessment, and vocational training)	http://www.co.sanmateo.ca.us/smc/department/hsa/home/0,2151,15587225_18152561,00.html
Youth and Family Enrichment Services (empowers youth, families and individuals to overcome challenges)	http://www.thevolunteercenter2.net/org/4106717.html
Youth Leadership Institute (teaches young people to be advocates and policymakers)	http://www.yli.org/policy/

APPENDIX C – Form No. 2

PREVENTION AND EARLY INTERVENTION-RELATED INPUT GATHERED DURING CSS

GENERAL FINDINGS – ALL AGE-FOCUSED WORKGROUPS	FOCUS GROUPS HELD: <ul style="list-style-type: none">▪ Children and youth: 38 focus groups were held that included youth consumers, family members, community members, and/or providers of services targeting children consumers. 456 participants. In addition, the Youth Commissioners led an effort to conduct a survey of 1,000 high school students.▪ Transition Age Youth: 41 focus groups were held that either included TAY consumers, TAY youth, family members of TAY or providers of services targeting TAY. 13 were TAY-focused and included 97 participants. 586 participants.▪ Adults: 50 focus groups were held that included adult consumers, family members, community members, and/or providers of services targeting adult consumers. 703 participants.▪ Older Adults: 22 focus groups were held that either included Older Adult community members, consumers, family members of Older Adults, or providers of services targeting Older Adults. A total of 276 participants were involved in these 22 focus groups and community meetings.
	GENERAL FINDINGS: <ul style="list-style-type: none">▪ Many people felt that lack of knowledge of mental illness and mental health services, coupled with an impenetrable system resulted in people accessing care only in crisis. Early intervention was non-existent, according to most participants. Participants suggested the following to improve prevention and early intervention:<ul style="list-style-type: none">▪ Public education to increase public awareness. Community fora could be a good vehicle for early intervention and prevention strategies with neighborhood leaders and residents becoming better informed of strategies, services and natural supports that promote wellness and recovery.▪ Families felt that early intervention and prevention efforts should occur in natural community settings, such as schools, libraries, community centers, and youth serving agencies. Some advocated for early childhood and school-based screenings and assessments.▪ Peer-led information sessions for families were also recommended. The “promotora” model was mentioned repeatedly, especially among Latino families. We heard often that Latinos get information by word of mouth and are more likely to listen to someone they know and trust.▪ The creation of a more user-friendly system of access, including broader eligibility requirements would facilitate early intervention.▪ Some participants expressed the need for community support for families experiencing social and economic stresses, which would reduce mental health issues.▪ TAY mentioned gang and violence prevention as important factors.▪ Families and providers discussed the need for 24/7 respite services.▪ There is a greater need for recognition and support of some key transitions in youth life (i.e., middle school to high school).▪ TAY use the internet to find information. Information about mental health services and resources available should be easily accessible online.

NOTA BENE: Prevention and Early Intervention themes were addressed in the groups within the discussions on Access. We asked questions about ways to improve access and increase knowledge about mental health services in un/underserved communities.

APPENDIX D – Form No. 2

SAN MATEO COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION
MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMENTS PROVIDED DURING THE PUBLIC COMMENT PERIOD
JULY 2ND, 2008 – AUGUST 4TH, 2008
(INCLUDES COMMENTS DURING PUBLIC HEARING HELD ON JULY 31ST)

Date: 07/02/2008

Medium: Comments from the public at the Mental Health Board meeting where the MHSA PEI Draft Proposal was released for public comment.

- **Teresa Walker**, Family Member, former Mental Health Board member.

Ms. Walker offered comments regarding the 18 to 25 age segment. She expressed enthusiasm for the PEIR program, which is designed to address first onset of mental illness. She also expressed disappointment that this program was not selected when a final decision was made at the last PEI planning meeting. While she understands that the funds are insufficient to include this program, she also felt that people who do not have first-hand experience with mental illness cannot fully grasp what happens over the years when mental illness is not addressed at the onset.

She emphasized that mental health services should cater to people who experience early onset of mental illness, and that this is what the MHSA is supposed to do.

- **Karen Philip**, San Mateo County Office of Education

Ms. Philip expressed satisfaction with the process and appreciated inclusion of the K-5 population as part of the School Age proposal. She characterized the planning process as thoughtful and inclusive.

Ms. Philip also emphasized her belief that mental health services for school age children and youth should be delivered in the school setting, because that is where children and youth are.

APPENDIX D – Form No. 2

SAN MATEO COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION
 MENTAL HEALTH SERVICES ACT
 PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMENTS PROVIDED DURING THE PUBLIC COMMENT PERIOD
 JULY 2ND, 2008 – AUGUST 4TH, 2008
 (INCLUDES COMMENTS DURING PUBLIC HEARING HELD ON JULY 31ST)

Date: 07/08/2008	Medium: Letter	Sender: Teresa Walker, Family Member, former Mental Health Board member.
<p>Text of the Letter (transcription):</p> <p>As a member of the Prevention and Early Intervention (PEI) committee for School Age and Transition Age Youth, I would like to make the following comments regarding the selection of the PROJECT SUCCESS proposal for MHSA funding.</p> <p>I do not believe that PROJECT SUCCESS, while a worthwhile program, meets the purpose and intent of MHSA for funding. I quote from the Act: SECTION 2.</p> <ul style="list-style-type: none"> (a) Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age.... (b) Failure to provide timely treatment can destroy individuals and families.... (c) Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government.... Children left untreated often become unable to learn or participate in a normal school environment.... (d) In cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with severe mental illness. Thousands ended up on the streets homeless and incapable of caring for themselves... We can and should offer these people the care they need to lead more productive lives. 		<p>Response from BHRS:</p> <p>Thank you so much for your input and participation throughout the MHSA PEI planning process.</p> <p>Based on the overall order of priorities coming from the planning process, we are including PIER in our proposal, although funds are not available at this time. Including PIER will allow us to fund the project if in the future sufficient expansion funds become available, without having to go through a new planning process.</p> <p>Under the project description of the "Community Interventions for School Age and Transition Age Youth" project in the draft proposal, is stated that: "Project SUCCESS is considered a <u>SAMHSA</u> model program that prevents and reduces substance use and abuse and associated behavioral issues among high risk, multi-problem adolescents. It works by placing highly trained professionals (Project SUCCESS counselors) in the schools to provide a full range of prevention and early intervention services." It is our opinion that the nature and intent of the program fall well within the parameters of the MHSA in general, and of the PEI requirements in particular. We are happy to provide more information on the project to further clarify its pertinence should you deem it necessary.</p> <p>As we also stated in the project description, "Project SUCCESS is a research-based program that builds on the findings of other successful prevention programs by using interventions that are effective in reducing risk factors and enhancing protective factors." Enclosure 3 of the State PEI guidelines states the "Prevention in mental health involves reducing risk factors or stressors, building protective factors and skills and increasing support."</p>

APPENDIX D – Form No. 2

SAN MATEO COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION
 MENTAL HEALTH SERVICES ACT
 PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMENTS PROVIDED DURING THE PUBLIC COMMENT PERIOD
JULY 2ND, 2008 – AUGUST 4TH, 2008
(INCLUDES COMMENTS DURING PUBLIC HEARING HELD ON JULY 31ST)

Date: 07/08/2008	Medium: Letter	Sender: Teresa Walker, Family Member, former Mental Health Board member.
<p>(e) With effective treatment and support, recovery from mental illness is feasible for most people....</p> <p>SECTION 3. Purpose and intent. (a) To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services....</p> <p>SECTION 4. Part 3.6 PREVENTION & EARLY INTERVENTION PROGRAMS 5840 (a) The Department of Mental Health shall establish a program designed to prevent mental illnesses from becoming severe and disabling....</p> <p>Project SUCCESS, as drafted, specifically leaves out as a PEI Priority Population "Individuals Experiencing Onset of Psychiatric Illness." Therefore, it does not address the Purpose and Intent of MHSA which is to provide timely and effective treatment for persons suffering with mental illnesses.</p>		<p>We respectfully disagree with your assertion that Project SUCCESS does not meet the purpose and intent of the MHSA.</p> <p>While this program does not specifically target "Individuals Experiencing Onset of Psychiatric Illnesses", it does target other priority populations identified by consensus by the PEI work group members, specifically "Trauma Exposed Individuals"; "Children and Youth in Stressed Families"; "Children and Youth at Risk for School Failure"; and "Children and Youth at Risk of or Experiencing Juvenile Justice Involvement". Different practices target different populations.</p> <p>Project SUCCESS uses several intervention strategies such as: information dissemination, normative and prevention education, problem identification and referral, community based process and environmental approaches. In addition, resistance and social competency skills, such as communication, decision making, stress and anger management, problem solving, and resisting peer pressure are taught. The counselors primarily work with adolescents individually and in small groups; conduct large group prevention/education discussions and</p>

APPENDIX D – Form No. 2

SAN MATEO COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION
 MENTAL HEALTH SERVICES ACT
 PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMENTS PROVIDED DURING THE PUBLIC COMMENT PERIOD
JULY 2ND, 2008 – AUGUST 4TH, 2008
 (INCLUDES COMMENTS DURING PUBLIC HEARING HELD ON JULY 31ST)

Date: 07/08/2008	Medium: Letter	Sender: Teresa Walker, Family Member, former Mental Health Board member.
<p>As a member of the PEI Transition Age Youth Committee, I read many proposals. In my opinion, the only one that satisfies the criteria of the MHSA is the <u>Portland Identification and Early Referral Program (PIER)</u>. It is a research program with the mission of reducing the incidence of psychotic illnesses (such as schizophrenia and bipolar disorder) in the Greater Portland, Maine area. The PIER Program is based on earlier studies conducted in the United Kingdom, Australia, United States and Scandinavia that focused on interrupting the very early progression of schizophrenia and other severe psychotic disorders. The goals of these studies were to improve outcomes and prevent the onset of the psychotic phase of these illnesses.</p>		<p>programs, train and consult on prevention issues with alternative school staff; coordinate the substance abuse services and policies of the school and refer and follow-up with students and families needing substance abuse treatment or mental health services in the community.</p>
<p>When the vote was taken between the Project SUCCESS proposals and the PIER Program at the final meeting of the Prevention and Early Intervention Planning Meeting, the PIER program was rejected because:</p>		<p>PIER satisfies the criteria of the MHSA PEI in that it is an evidence-based practice that targets specifically the population defined as “Individuals Experiencing Onset of Psychiatric Illnesses”, although this does not render other practices, such as Project SUCCESS, inadequate to target other populations, or contrary to other MHSA PEI criteria.</p> <p>PIER and SUCCESS target very different populations, therefore they are not “comparable”.</p>
<p>1. It was too expensive.</p>		<p>At the last planning meeting –where a final recommendation was made by all age-focused work groups on the projects to include in the final proposal, workgroup members evaluated the individual budgets for each projects. They found that if PIER were funded there would not have been funds available for anything else for the 0 to 25 age group.</p> <p>1. The estimated cost of PIER was \$1,031,719. While participants agreed that this program would address a very important need, they were also faced with the dilemma of funding only PIER, or funding: the Early Childhood Community Team for 0 to 5 (\$370,531); and the Community Interventions for School Age and Transition Age Youth, for a total of</p>

APPENDIX D – Form No. 2

SAN MATEO COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION
 MENTAL HEALTH SERVICES ACT
 PREVENTION AND EARLY INTERVENTION PLAN

**SUMMARY OF COMMENTS PROVIDED DURING THE PUBLIC COMMENT PERIOD
 JULY 2ND, 2008 – AUGUST 4TH, 2008
 (INCLUDES COMMENTS DURING PUBLIC HEARING HELD ON JULY 31ST)**

Date: 07/08/2008	Medium: Letter	Sender: Teresa Walker, Family Member, former Mental Health Board member.
<p>2. In my opinion, it also lost because the committee was heavily lopsided with most members being employees of the children’s mental health division. It is understandable that they would like to have more funding for youth in stressed families or exposed to trauma or at risk for school failure or involved with the juvenile justice system. I noticed that when the vote was taken all the family members involved (a total of four) voted for the PIER program.</p>		<p>\$536,198. The latter includes 3 interventions targeting different age groups within the 6 to 25 group (Project Success, Teaching Prosocial Skills, and Seeking Safety). The group members struggled with the decision. The recommendations were made by a substantial majority attending this final meeting.</p>
<p>When the state hospitals were closed 30 years ago, the state provided some funds to counties to take care of people with mental illnesses in the community. Unfortunately, the funds were diverted to people who were having problems in living and not to people with mental illnesses –with disastrous results. We cannot allow this to happen again. We cannot permit the MHSA funding to be diverted from its purpose, which is to provide timely treatment for mental illness.</p> <p>Sincerely,</p> <p>Teresa (Terry) Walker</p> <p>cc. NAMI San Mateo County</p>		<p>2. Those in attendance were comprised of a diverse group of 27 stakeholders only 4 of whom were county children’s mental health staff. Recognizing the importance of PIERS there was strong disappointment that there was insufficient funds available to fund this program.</p> <p>We wholeheartedly agree with the sentiment that MHSA funds must not be diverted from its purpose and intent. We believe the PEI proposal reflects the values and principles of the MHSA, the direction of our local steering committee, the specific requirements of PEI, and the identified needs in the community.</p> <p>Thank you for you feedback and for your advocacy.</p>

APPENDIX D – Form No. 2

SAN MATEO COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION
 MENTAL HEALTH SERVICES ACT
 PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMENTS PROVIDED DURING THE PUBLIC COMMENT PERIOD
JULY 2ND, 2008 – AUGUST 4TH, 2008
 (INCLUDES COMMENTS DURING PUBLIC HEARING HELD ON JULY 31ST)

Date: 07/10/2008	Medium: E-mail	Sender: Raja Mitry, Mental Health Advocate, Mental Health Board member
<p>I have been excited about the positive possibilities arising out of Prevention/Early Intervention from the very first time I heard about this planning phase of the MHSA and have anticipated with much pride the opportunities to reach those in desperate need of being touched by not only hope but real services.</p> <p>I am compelled to submit the following comments during this public comment period for the Prevention/Early Intervention Plan:</p> <p>Clearly, the importance of the prevention of psychological distress promotes interpersonal well-being and the development of resilience. The cultivation of relationships with caregivers and, through mindful awareness, with oneself to minimize the suffering of daily stressors and trauma is achievable, albeit not an easy journey.</p> <p>Prevention work offers exciting opportunities. The Family Law system is an arena where family members, and especially children, going through the breakup of the family structure and the ensuing court process are exposed to much distress, helplessness, and confusion that, without compassionate and insightful intervention -- inevitably produce any number of mental and emotional disturbances, as well as substance abuse and involvement in the justice system. Engaging the judges, mediators, and facilitators of Family Law Court may be only second to engaging youth and young adults in mental health activism. To your credit and the exemplary BHRS leadership, I'm aware of the department's receptiveness and efforts to invite Family Law representatives to the dialogue table and engage in the P/EI workgroups -- so that they might have keener sensitivity to and understanding of the needs of individuals experiencing the</p>		<p>Response from BHRS:</p> <p>Thank you so much for your leadership, input and participation throughout the MHSA PEI planning process.</p> <p>We couldn't agree more with your thoughtful, insightful comments. We will take this input into account for the writing of the different RFP's (request for proposal) to implement the programs proposed. Furthermore, we conceive the RFP process as a participatory one, and we will be honored to count on your advocacy and input.</p> <p>The key to the success of each of the efforts we are proposing is the extent of collaboration that is established between key individuals and organizational stakeholders. Youth and representatives from the Family Law System whose participation you're advocating for, are certainly among those key stakeholders. We will continue to make every effort to maximize the involvement of youth and of the Family Law System in the MHSA process.</p> <p>Thank you for your feedback and for everything you do as a mental health advocate in San Mateo County.</p>

APPENDIX D – Form No. 2

SAN MATEO COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION
MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMENTS PROVIDED DURING THE PUBLIC COMMENT PERIOD
JULY 2ND, 2008 – AUGUST 4TH, 2008
(INCLUDES COMMENTS DURING PUBLIC HEARING HELD ON JULY 31ST)

Date: 07/10/2008	Medium: E-mail	Sender: Raja Mitry, Mental Health Advocate, Mental Health Board member
<p>trauma of family breakups and be able to make appropriate referrals for prevention and early intervention services.</p> <p>We cannot minimize the fact that family disruption has led to suicidal and homicidal behaviors, children's academic failure and other high-risk situations, severe depression and numerous mental health difficulties. The recommendations of the Family Law mediators and decisions of judges have lifelong impact that affect not only parents and children but also extended family members.</p> <p>Not only on a personal level, but also as an advocate, I have strongly believed in the opportunities that the MHSA presents for doing the prevention work and to continue promoting Wellness and Recovery. That, to me, means honoring the dignity of the individual and the family and be active in taking steps to uphold their human value and restore their broken spirits. The collaborative process has proven productive in this County. My hope is that as Prevention and Early Intervention work continues through the years that the key Family Law players consistently be at the table (and in the near future!) to promote "restorative justice" and importantly, attempt to avert - to any possible extent - brokenness of the human spirit, and be effective agents in the preventive and early intervention process. It is crucial that they hear the stories and move to actions that benefit!</p>		

APPENDIX D – Form No. 2

SAN MATEO COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION
 MENTAL HEALTH SERVICES ACT
 PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMENTS PROVIDED DURING THE PUBLIC COMMENT PERIOD
JULY 2ND, 2008 – AUGUST 4TH, 2008
 (INCLUDES COMMENTS DURING PUBLIC HEARING HELD ON JULY 31ST)

Date: 07/19/2008	Medium: Comment at East Palo Alto Mental Health Advisory Group meeting	Sender: Faye McNair-Knox, PhD., Executive Director of One East Palo Alto, community advocate, provider.
Dr. McNair-Knox recommended that the Pacific Islander community be included as one of the communities for which the stigma proposal is intended.		Response from BHRS: There is much need in the Pacific Islander community that would benefit from focus through this initiative. In addition, future expansions of CSS outreach could be targeted to this community. Thank you so much for your input, as well as for your participation in the PEI planning process.

APPENDIX D – Form No. 2

SAN MATEO COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION
 MENTAL HEALTH SERVICES ACT
 PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMENTS PROVIDED DURING THE PUBLIC COMMENT PERIOD
JULY 2ND, 2008 – AUGUST 4TH, 2008
(INCLUDES COMMENTS DURING PUBLIC HEARING HELD ON JULY 31ST)

Date: 07/30/2008	Medium: E-mail	Sender: Gregory Wild, Consumer, Executive Director of Heart and Soul
<p>At our May 12 Adult Workgroup meeting, our handouts regarding the anti-stigma initiative specifically stated-in bold-that the county should work with Stamp Out Stigma to develop an anti stigma program for this county. Yet, in the June meetings, including the final report which is currently open for public comments, there is no mention of Stamp Out Stigma.</p> <p>Why is that? Stamp Out Stigma has been in business for eighteen years, reaching thousands of people not only in the greater Bay Area, but throughout California, other parts of the United States, and other countries.</p> <p>Please let me know where the organizations stands in the county's plans to fight stigma, and please add Stamp Out Stigma to the county's anti stigma initiative.</p> <p>Thank you.</p>		<p>Response from BHRS:</p> <p>Thank you so much for your input, as well as for your participation in the PEI planning process.</p> <p>The State guidelines for MHSA Prevention and Early Intervention require the use of evidence based practices. Included in the guidelines were identified based practices that counties could select from for their proposal. Counties could identify practices outside of the list as long as they were evidenced based. The San Mateo County proposal to the State identifies specific evidenced based practices and promising approaches selected by stakeholders, which will be implemented as part of our age-focused PEI projects if approved by the State. We have consistently stated throughout the process that the funding of specific organizations to implement these practices will be decided through the request for proposals (RFP) process subsequent to receiving approval of the plan. It would be inappropriate to identify any specific organization for funding as part of the actual proposal. However, we have also emphasized throughout the process our intent to leverage existing resources and, where possible, build on those efforts. As the anti-stigma effort gets organized we will be looking for such opportunities.</p> <p>Lastly, if you check the unabridged proposal in our website (www.smhealth.org/BHRS) you will see that item 4) of the stigma proposal reads: "San Mateo County supports anti-stigma programs that provide trainings and presentations featuring consumers as presenters. The presenters are paid a small stipend for their work. One time funding would be used to recruit additional presenters, especially from the ethnic and language communities that are underserved. Funding would also support stipends for additional presentations, some of which might be as part of the training described in 3) above. Examples of such programs are Stamp Out Stigma and NAMI's In Our Own Voice."</p> <p>We hope this addresses your concerns. Thank you for your feedback.</p>

APPENDIX D – Form No. 2

SAN MATEO COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION
MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN

SUMMARY OF COMMENTS PROVIDED DURING THE PUBLIC COMMENT PERIOD
JULY 2ND, 2008 – AUGUST 4TH, 2008
(INCLUDES COMMENTS DURING PUBLIC HEARING HELD ON JULY 31ST)

Date: 07/30/2008	Medium: E-mail	Sender: Gregory Wild, Consumer, Executive Director of Heart and Soul
-------------------------	-----------------------	---

Date: 07/31/2008	Medium: Comments from the public at the Public Hearing to hear to the MHSa PEI draft proposal.
-------------------------	---

– **Karen Philip**, San Mateo County Office of Education

Ms. Philip reiterated the comments offered at the 07/02 Mental Health Board –when the MHSa PEI Draft Proposal was released for public comment.

Ms. Philip wishes programs like Teaching Prosocial Skills could be implemented at all schools in San Mateo, as children would benefit greatly. She sees the partnership with Schools as essential in relation to the behavioral health of children and youth, and looks forward to future opportunities.

Lastly, Ms. Philip reiterated that she was very pleased with the MHSa PEI planning process. She felt that the process heard all voices and was flexible and open to the needs and concerns expressed by stakeholders.

APPENDIX E – Form No. 2

MAKING THE CASE FOR THE DEVELOPMENT OF A PREVENTION FRAMEWORK FOR BEHAVIORAL HEALTH

BACKGROUND

In August 2007, the senior leadership of the Health Department (of which BHRS is one of its Divisions) initiated a cross-department workgroup aimed at identifying and providing recommendations to address policy opportunities in the area of prevention.

The rationale behind this idea was simple: As we anticipated new resources that would be made available to strengthen Prevention and Early Intervention (PEI) from the perspective of mental health through the Mental Health Services Act (MHSA), we wanted to ensure that we would work from "what we know" as a Department, and that we facilitated communication and information-sharing regarding key learnings from prior and current prevention efforts.

Based on nominations from Division Directors, a workgroup was formed that included management-level representatives from all the relevant Divisions of the Health Department: Behavioral Health and Recovery Services (BHRS); Public Health; Aging and Adult Services; Family Health Services; Emergency Medical Services; and Health Policy and Promotion. The representatives from BHRS were the Director of the Division, the Director of Alcohol and Other Drug Services, and the MHSA Coordinator, all of whom constitute the Core BHRS PEI Planning Design Group.

The workgroup focused initially on sharing and synthesizing information regarding prevention related activities within the Health Department. The focus was on primary and secondary intervention; tertiary prevention was not part of the scope of analysis.

For the purposes of that work, these prevention categories were defined as follows:

CATEGORY	AIM
Primary Prevention (Prevention)	Reduce incidence (occurrence of new cases)
Secondary Prevention (Intervention)	Reduce prevalence (total number of all cases at a given time)
Tertiary Prevention (Treatment)	Reduce the sequelae and complications arising from the problem/disorder once it is manifested.

The workgroup developed two products:

- 1) A summary of existing prevention efforts, by Division, categorizing current Departmental resources and programs targeting prevention by level (i.e., primary, secondary); targeted population (i.e., universal, selected, indicated); and approach (as defined by the Spectrum of Prevention⁵); and
- 2) A set of recommendations for strengthening Departmental focus on prevention for consideration of the senior leadership of the Health Department.

⁵ Extends beyond education models by identifying 6 levels: Complementary levels; produce "synergy" when used together.

⁶ Findings informed the MHSA PEI planning process.

APPENDIX E – Form No. 2

MAKING THE CASE FOR THE DEVELOPMENT OF A PREVENTION FRAMEWORK FOR BEHAVIORAL HEALTH

The review of existing efforts indicated that:

- There are many target populations that are shared between Divisions and for which we direct staff and contractor partner resources.
- Our targeted outcomes differ by program and Division, and reflect the distinct expertise and specialization that resides across the Department. These are reflected, too, in the types of interventions offered.
- Our efforts span across the levels of prevention and are predominantly targeting “selected” populations.
- Our prevention approach, as characterized by the Spectrum of Prevention, includes a shared focus on strengthening individual knowledge, promoting community education and educating providers. We direct less consistent focus to changing organizational practices or influencing policy (within the frame of the Spectrum of Prevention).
- There are opportunities to think more collaboratively to both advocate and secure resources for primary prevention, including health education, youth development and community capacity building/community strengthening.
- There is recognition that certain prevention activities (e.g., effective messaging to some populations, diversion/targeting of resources to high-priority populations/areas where others may not be included) requires accepting a certain amount of risk; as a Department we recognize that we are unevenly prepared to take on that risk.
- There is a perceived conflict between furthering the message that the “Health Department is for everyone” and the necessary targeting of certain (and in some cases small) populations required of prevention activities.

WHY A PREVENTION FRAMEWORK FOR BEHAVIORAL HEALTH?

As our Division participated in the work described above, and taking into account the integration of Mental Health and Alcohol and Other Drug (AOD) under the BHRS umbrella, as well as the attention being given to persons with co-occurring disorders, it quickly became apparent that this is the right time for BHRS to develop a Division-specific prevention framework. This framework will ensure that the principles of transformation of the Mental Health Services Act jointly with the recent AOD community-based prevention strategies form the foundation for a solidly integrated prevention effort.

From the perspective of prevention, the journey towards transformation demands that we:

- move “upstream” to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes;
- integrate efforts to support sustainability;
- involve non-traditional parties.

In its final form, the framework will delineate efforts that ensure our prevention work occurs in all spheres of the prevention spectrum, with an emphasis on mitigating current health disparities in San Mateo County. Its key goal or goals will promote primary prevention strategies for each designated constituent area. In

APPENDIX E – Form No. 2

MAKING THE CASE FOR THE DEVELOPMENT OF A PREVENTION FRAMEWORK FOR BEHAVIORAL HEALTH

addition, the framework will provide a description of what is already in place in San Mateo County to achieve those goals, and will specify activities along the Spectrum of Prevention that could support achieving and sustaining those goals⁷.

The process design not only has ensured meaningful community involvement, but also alignment with the prevention goals of the Mental Health Services Act, with its principles of transformation putting wellness and recovery at the center; and in alignment with our County's overall efforts to move upstream, for the benefit of the citizens of San Mateo.

⁷ *The MHSAs PEI planning process provided an excellent opportunity to launch our divisional prevention framework development. Participants were oriented to the purpose of the framework, and along with participants from an earlier AOD prevention planning effort, enlisted to work on the development of the framework. The group counts on the participation of clients, family members, representatives from non-traditional mental health settings, and an average of three representatives from all MHSAs PEI planning process work groups. The Director of Alcohol and Other Drug Services leads the effort, and the MHSAs Coordinator is also a member of this group.*

PEI PROJECT SUMMARY

Form No. 3

County: San Mateo

PEI Project Name: Early Childhood Community Team

Date: August 29th, 2008

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

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

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

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 PEI workgroup that focused on ages 0 to 5 identified families at risk due to demographics, children in families with known risk, and ultimately all families among their priority populations. The chair of the PEI planning process, who participated in all age-focused workgroup meetings, is also the co-chair of the Co-Occurring Steering Committee. Many co-occurring change agents participated in the age-focused workgroups, resulting in attention to prevention and early intervention initiatives that would address both mental health and substance abuse conditions.

The workgroup reviewed a BHRS PEI data report that updated analyses prepared during the 2005 CSS planning process. Among the findings in the data were:

All Ages

- More people of all ages were actually served by BHRS than projected by state prevalence methods when restricted to 200% of poverty.
- More males and fewer females of all ages were served than projected.
- More TAY and adults were served than projected.
- Significantly more Whites and African Americans of all ages were served than projected.
- Fewer Pacific Islanders, significantly fewer Asians and slightly more Native Americans of all ages were served than projected.
- Fewer Latinos of all ages were served than projected, however in the last two years the number of Latinos served has increased from around 3,000 to almost 4,000.
- Significantly fewer people of all ages were served in their primary language than may need it.
- Few people think of San Mateo County as having seasonal and migrant farm workers, but the western portion of the county has an active agricultural component and is geographically isolated by coastal foothills and distributed along the coastline. At any given point in time in 2004 (Data Source: San Mateo County 2000 Census Data) there were 3,183 farm workers and/or their families. Using the Surgeon General's prevalence numbers, we might expect to have served 172 of these individuals. However, in FY 06/07, our Coastside clinic served a total of 252 individuals, and only 31 were identified as Latino. The farm workers and their families are significantly unserved.

Children and Families

- Slightly fewer children/youth were served by BHRS than projected. Among the children served were 102 in the BHRS Pre to Three program, along with their families. Of their parents, 228 were TAY. Three quarters of these families were on MediCal, the rest were mostly uninsured. About half of those served were Latino and Spanish speaking.

PEI PROJECT SUMMARY

Form No. 3

- About 10,000 children are born to San Mateo County residents each year. In 2007, 41% of all children and youth in the county were Caucasian/white, followed by Latinos/Hispanics (31%), Asians (19%), multiracial children (5%), African Americans (2%), Pacific Islanders (2%), and Native Americans (0.4%).
- Research shows that young children with depressed mothers are more likely to have socio-emotional and behavioral problems, difficulties in school, poor peer relationships, aggression, lower IQ scores, impulsivity and developmental delays. Nationally, about 8% to 15% of childbearing women and up to 48% of low-income mothers experience postpartum depression within the first year after childbirth. Among San Mateo County mothers of children ages 0-5 in 2006, 6.4% reported symptoms of depression, with marked differences in rates by race/ethnicity and income level. Caucasian/white mothers were least likely to show signs of depression, and very low-income mothers (< \$15,000 per year) were about 12 times more likely to report symptoms of depression than mothers with annual household incomes of more than \$80,000.
- There are significant health disparities among racial, ethnic and income groups in San Mateo County, on issues ranging from physical health to school success to safety. African American mothers, for example, continue to have the highest percentage of babies born at low birth-weight (14 percent compared to 6.6 percent for all county infants in 2004). Though the overall teen birth rate has fallen in the last decade, rates for Latinas and African Americans were eight to 10 times higher than for Caucasian/white and Asian teens in 2004.
- A 2005 national study estimated that more than 5,000 children are expelled from state-funded pre-kindergarten programs alone; for-profit and faith-affiliated centers were nearly twice as likely to expel children. Many others aren't expelled but disrupt classrooms. The University of Washington's Center on Infant Mental Health and Development estimates that as many as 20,000 Washington children [5%] under the age of 5 may have "significant emotional behavioral problems". While data is not available specifically for San Mateo County, the 5% estimate would mean that, of the approximately 44,800 children birth through four in San Mateo County, 2,240 are at significant risk.

Workgroup members were also briefed on results from the extensive focus groups conducted for CSS in 2005. Key points from CSS planning related to families and children included:

- **The system is hard to understand.**
- There are geographic barriers: Providers and parents in Coastside, Pacifica, Pescadero and North County both indicated a virtual absence of services for youth in these communities with significant unmet need.
- Over two thirds identified need for an expanded outreach and community education effort.
- Existing points of access difficult to penetrate.
- Need more transportation supports.
- Cultural competence: Need for a culturally competent system beyond having translated materials.
- Need for bilingual, bicultural and culturally competent staff with knowledge of cultures served.

PEI PROJECT SUMMARY

Form No. 3

- Culture-related barriers: Fear... of deportation, of child welfare involvement, of rejection from own community due to cultural beliefs about mental illness.
- Need for shift towards a consumer-friendly system.
- Need for consumer, peer, and family-led supports and services.
- Need for services provided in natural community settings and co-located and integrated with other services and supports.
- Train teachers to better work with behavioral health issues.
- Lack of integration of children and youth-serving systems.
- Need more therapists in schools.
- More parent support.
- Quality of life issues for children tended to revolve around the families' needs for stability and the child's need to have as many opportunities as possible to experience the normal joys of childhood.
- Building closer collaborative relationships with the schools, mental health, other child serving agencies, community agencies, and with parents.

3. PEI Project Description:

"All children are born eager to explore their world and master their development. From conception to a child's first day of kindergarten, development proceeds at a pace exceeding that of any stage of life. Infants, toddlers and preschoolers rapidly develop capabilities in emotional regulation, relationships, cognition, motor development and language. These capabilities form the foundation from which all future development builds. Whether that foundation is sturdy or fragile depends to a great degree on the quality of the young child's early environments and relationships. Human relationships are the building blocks for healthy development. **Positive early relationships greatly influence a child's ability to achieve later success in school and in life.**" (Social-Emotional Development in Young Children, Michigan Department of Community Health.)

The proposed **Early Childhood Community Team project** incorporates several major components that build on current models in our community, in order to **support healthy social emotional development of young children**. A **Community Team** would comprise a **community outreach worker, an early childhood mental health consultant, and a licensed clinician**. BHRS PEI funding will support at least one team; if additional partnership funding for community outreach worker(s) can be developed, there might be two teams, and if the model is demonstrated as successful, other funding sources might support replication with additional teams serving additional communities. Each team would be targeted to serve a specific geographic community within San Mateo County, in order to build close networking relationships with local community partners also available to support young families. Per the recommendation of our planning workgroup, the initial BHRS PEI team site will be targeted to serve a community with a high proportion of Latino and/or isolated farm worker families, or a community experiencing a significant degree of interpersonal violence, which has significant impact on families and young children.

PEI PROJECT SUMMARY

Form No. 3

The **community outreach worker** would be a key team member, networking within the community and community based services to identify young families with children between birth and three and connect them with necessary supports. Another role would be to offer groups for families with young children, using the **Touchpoints Program**. This approach, developed by T. Berry Brazelton, is based on the concept of building relationships between children, parents and providers around the framework of "Touchpoints," or key points in early development. Participants learn how to use relationship-building and communication strategies when they deliver care and interact with children and families. Such groups are currently provided at various sites in San Mateo County. The new groups would be provided in the community served by the team(s), focused on families identified and engaged by the outreach worker. The Touchpoints groups would include fathers as well as mothers and other caregivers, and the team(s) would be connected to the countywide Fatherhood Collaborative expanding resources in support of fathers and other types of parenting curricula used with diverse populations.

The **second team member (Early Childhood Mental Health Consultant)** would focus on supporting social emotional development in child care settings by providing early childhood mental health consultation. This service typically consists of the following activities:

- Observing the interaction of the caregiver(s) with young children
- Observing a child's interaction with caregiver(s) and other young children
- Consulting with the caregiver(s) regarding overall support of positive social emotional development
- Consulting with the caregiver(s) on developmental or behavioral concerns regarding a specific child
- Facilitating family and caregiver meetings
- Facilitating referrals for additional services for children and families

Currently this type of consultation is available within 10 sites in San Mateo County (including Head Start preschool programs, Early Head Start family childcare programs, and other programs in Redwood City, Daly City, South San Francisco, central San Mateo and East Palo Alto) and reaches about 1700-1800 children. In communities that have high proportions of families at risk, there are limited early childhood consultation services.

Child care is provided by licensed family day care providers, license exempt providers, and family/friends/neighbors. The child care resource and referral agency in San Mateo works with all of these types of child care settings and manages a data base with all types of providers, searchable by specific community. It provides support for the county's child care providers and preschool programs, investing in professional development and helping improve program quality through a variety of workshops, programs and support services—however, most services are offered in central San Mateo and may not be attended by providers from other parts of the County.

PEI PROJECT SUMMARY

Form No. 3

By making early childhood mental health consultation available to more child care providers, the team will reach families at risk and in distress at an early point in the developmental process. The team(s)' community outreach workers will also be able to identify and connect with family/friend/neighbor providers that may not have been previously known to the resource and referral agency and facilitate their connection to ongoing supports. The services would be publicized as a part of educational efforts with child care providers, and used in providing technical assistance to child care providers in the selected community.

The third team member will be a **licensed clinician** who provides brief, focused services to families that are identified with a need by the community outreach worker, the early childhood mental health consultant or partners in the network of community services such as primary care providers (note that brief services are defined as less than one year). The clinician will screen for postpartum depression and facilitate appropriate service plans with primary care and/or mental health services. Preferably, the clinician will be trained in Child-Parent Psychotherapy (CPP) for children exposed to trauma and violence, a service developed by Lieberman (see Question 5). While there are some clinicians in the San Mateo area that have been trained in this model (for example, the BHRS Pre to Three clinicians) this PEI project could train additional clinicians in the model, which is particularly useful for young families at risk due to trauma.

The goal of CPP treatment is to support and strengthen the parent-child relationship as a vehicle to long-term healthy child development. With trauma-exposed individuals, these treatments incorporate a focus on trauma experienced by the parent, the child, or both. Sessions include the parent(s) and the child and can be conducted in the home. Individual parent or child sessions may be added as needed.

Related to the initiation of these community teams, there is an opportunity to improve the coordination among countywide agencies and local community based services in the selected community(ies). Countywide, there is an interagency group, the **Early Childhood Mental Health Collaborative**—what is envisioned is the initiation of local collaboratives focused on specific communities.

Implementation of this program by San Mateo BHRS will require several phases, assuming that PEI funding becomes available in November 2008:

Pre-Project Development (Dec 08-Mar 09)

- Joint planning with funding partners and countywide agencies to finalize capacity projections and local early childhood MH collaborative(s)
- RFP for community-based agency(ies) to provide the community team members (agencies may or may not be agencies currently participating in the county mental health program)--a significant requirement will be the ability to outreach into the ethnic and cultural populations that are currently un/underserved in the system, such as Latino and Asian/Pacific Islander populations.
- Selection and contract development.
- Staff recruitment for the team members

PEI PROJECT SUMMARY

Form No. 3

- Staff training in the educational, consultation and treatment approaches proven to be successful.

Phase I: Detailed planning with child care providers (Mar 09-May 09)

- The selected agency(ies) would develop detailed implementation plans with local early childhood MH collaborative(s)s for rolling out the outreach, parent groups, consultation and clinical services from the team

Phase II: Education and consultation services (Jun 09-ongoing)

- Initiate services according to detailed implementation plans

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	
Early Childhood Community Team Project	Individuals: 15 Families: 5		One.
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 15 Families: 5		One.

5. Alternate Programs

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

Touchpoints

The quality of the infant-caregiver relationship is a risk or protective factor for infants' later development. Infants who develop a "secure" attachment relationship with the primary caregiver during the first year of life are more likely to have positive relationships with peers, to be liked by their teachers, to perform better in school, and to be more resilient in the face of stress or adversity as preschoolers and later. Infants who develop an

insecure attachment relationship are at risk for a more troublesome trajectory; factors associated with insecure relationships include maternal mental health problems, including depression, substance abuse, family violence, and unresolved grief. Because of the strength of influence of the infant-caregiver relationship, any factors that impact the infant-caregiver relationship play a determining role in the emotional functioning of the young child (Zeanah et al.,2000). As a specific program, one study finds that the Touchpoints model increases the parenting self-confidence of adolescent parents (Percy et al, 2001).

How does early-life trauma impact development?

Attachment, the emotional bond formed between an infant and its primary caretaker, profoundly influences both the structure and function of the developing infant's brain. Failed attachment, whether caused by abuse, neglect or emotional unavailability on the part of the caretaker, can negatively impact brain structure and function, causing developmental or relational trauma. Early-life trauma affects future self-esteem, social awareness, ability to learn and physical health. When the attachment bond goes well, neurological integration develops normally, and relationship brings the expectation of safety, appreciation, joy and pleasure. If the attachment bond was unsuccessful and traumatizing, neural dysregulation and memories of a failed relationship become the basis for adult expectations of intimacy...

Attachment isn't the only factor that creates early-life trauma. Neurological dysregulation, brought about by neurologically disabling experiences in the womb and at birth, is also traumatizing and interferes with the attachment bond. If the dysregulation isn't severe, a good attachment can help bring about neurological regulation in a dysregulated baby...There is a correlation between early trauma and resiliency or vulnerability to highly stressful experiences later in life. People who have been traumatized as infants and young children are more at risk for traumatic experiences later in life. In helping people who have become traumatized, we don't need to be neuroscientists but we do need to use interventions that change the brain.

How does traumatic response differ from a normal stress reaction?

Stress is an essentially normal response to feeling overwhelmed or threatened. Fight, flight and freeze are survival responses that developed to protect us from danger. In moments of stress, hormones release and, as our heart beat speeds up and blood pressure increases, we breath quicker, move faster, hit harder, see better, hear more accurately, and jump higher than we could only seconds earlier. If we're nervously driving at high speed on the freeway at night, we can respond more effectively to unexpected hazards because we are exceptionally alert. These neurological and physiological changes enable us to better protect ourselves in the moment. But once the danger has passed, our nervous systems calm down and we return to a state of equilibrium or neurological balance. Positive stress can produce feelings of exhilaration and opportunity. Not all people experience stress in the same way. One person's exhilarating challenge may be another's terrifying experience.

Much has been written about the disadvantages of stressful life styles that keep us running on overwhelm and create constant physiological stimulation so that our bodies are kept from returning to a quieter calmer state of balance. But social and life style changes can usually restore

physiological and psychological balance. This is not the case when someone becomes traumatized. Traumatization is stress frozen in place –locked into a pattern of neurological distress that doesn't go away by returning to a state of equilibrium. Traumatization promotes ongoing disability that can take many mental, social, emotional and physical forms. Like normal stress, trauma is also experienced differently by different individuals.

What are the common links between both high and low impact experiences that trigger traumatic responses?

Trauma and loss are parts of life. It is not what happens to us but how we react to it that determines whether or not a life-threatening experience or a series of less intense experiences will, in fact, be traumatizing. The more vulnerable the organism, the more it is at risk for the neural dysregulation that can follow traumatic experiences. Whether dysregulation follows an intense event described with symptoms of PTSD or a seemingly benign event or series of events with symptoms like depression, anxiety or relationship disorders, emotionally traumatizing events contain three common elements:

- It was unexpected;
- The person was unprepared; and
- There was nothing the person could do to prevent it from happening.

What kinds of experience can be traumatic?

The ability to recognize emotional trauma has changed radically over the course of history. Until recently psychological trauma was noted only in men after catastrophic wars. The women's movement in the sixties broadened the definition of emotional trauma to include physical and sexual abuse of women and children. Now, the impact of psychological trauma has extended to experiences that include

- Natural disasters, such as earthquakes, fires, floods, hurricanes, etc.
- Physical assault, including rape, incest, molestation, domestic abuse and serious bodily harm
- Serious accidents, such as automobile or other high-impact scenarios
- Experiencing or witnessing horrific injury, carnage or fatalities

Other often overlooked potential sources of psychological trauma include

- Falls or sports injuries
- Surgery, particularly emergency, and especially in first 3 years of life
- Serious illness, especially when accompanied by very high fever
- Birth trauma
- Hearing about violence to or sudden death of someone close

Source: http://www.healingresources.info/trauma_attachment_stress_disorders.htm

PEI PROJECT SUMMARY

Form No. 3

Three randomized trials support the efficacy of relationship-based therapies with trauma-exposed children. In addition, two randomized trials demonstrate the efficacy of relationship-based interventions with other at-risk groups. **Child-Parent Psychotherapy (CPP) for children exposed to domestic violence:** Lieberman, Van Horn, & Ghosh Ippen (2005) conducted a randomized controlled trial of CPP for children who had witnessed domestic violence. Mother-child dyads were randomized to either CPP ($n = 42$) or Case Management plus community referrals for psychotherapy ($n = 33$). The study involved 36 boys and 39 girls aged 3-5 ($M = 4.06$; $SD = 0.82$), exposed to domestic violence in addition to other traumas: physical abuse (49%); community violence (46.7%), and sexual abuse (14.4%). Children were from a variety of ethnic backgrounds: 37% mixed ethnicity (predominantly Latino/Caucasian), 28% Latino, 14.5% African American, 10.5% White, 7% Asian, and 2% of other ethnicity. On average mothers had experienced 12.36 stressful life events. Mean monthly income was \$1,817 ($SD = \$1,460$); 23% received public assistance and 41% had incomes below the federal poverty level. CPP was conducted during 50 weeks by master's and Ph.D. degree-level clinicians. Fidelity was monitored through intensive weekly supervision and case conferences. Comparison group mothers received monthly case management and were connected to community clinics; 73% of mothers and 55% of children received individual psychotherapy. The attrition rate was 14.3% in the CPP group and 12% in the comparison group, with no significant group differences. CPP participants attended on average 32.09 sessions ($SD = 15.20$). Among those who received individual psychotherapy in the comparison group, 50% of mothers and 65% of children attended more than 20 sessions. Children and mothers were assessed at intake, mid-treatment, post-treatment, and 6-months post-treatment. Children were assessed using the Child Behavior Checklist (CBCL: Achenbach and Edelbrock, 1983, Achenbach, 1991) and the Structured Interview for Diagnostic Classification DC: 0-3 for Clinicians (DC: 0-3; Scheeringa et al., 1995). Parents were assessed using the Symptoms Checklist-90 Revised (SCL-90-R; Derogatis, 1994) and the Clinician Administered PTSD Scale (CAPS; Blake et al., 1990). At posttreatment, CPP children showed significantly greater reductions in total behavior problems ($d = .24$) and traumatic stress symptoms ($d = .64$). CPP mothers showed significantly greater reductions in avoidant symptomatology ($d = .50$). Results from the 6-month follow up showed that improvements in children's behavior problems ($d = .41$) and in maternal symptoms ($d = .38$) continued after treatment ended (Lieberman, Ghosh Ippen, Van Horn, 2006).

Alicia F. Lieberman, PhD is the Irving B. Harris Endowed Chair in Infant Mental Health and Vice Chair for Academic Affairs at the UCSF Department of Psychiatry, and Director of the Child Trauma Research Project at San Francisco General Hospital. She is a clinical consultant with the San Francisco Human Services Agency. She is active in major national organizations involved with mental health in infancy and early childhood. She is president of the board of directors of Zero to Three. Dr. Lieberman is currently the director of the Early Trauma Treatment Network (ETTN), a collaborative of four university sites that include the UCSF/SFGH Child Trauma Research Project, Boston Medical Center, Louisiana State University Medical Center, and Tulane University. ETTN is funded by SAMHSA as part of the National Child Traumatic Stress Network, a 40-site national initiative that has the mission of increasing the access and quality of services for children exposed to trauma in the United States.

PEI PROJECT SUMMARY

Form No. 3

6. Linkages to County Mental Health and Providers of Other Needed Service

If young families are identified that need more intensive services than those offered by the Community Team, a referral will be made either into one of the BHRS clinics or the Birth to Three service (which is a collaborative program with public health nurses and mental health staff, based on the evidence based Nurse Family Partnership model), in order to match the child and family with an appropriate level of services. In addition, community based resources will be utilized to support the broader need of the families that are served.

One of the major needs of young families is child care, and child care settings offer a focused opportunity to support healthy social emotional development. The child care resource and referral agency offers current and potential child care providers and other community members in San Mateo County an array of information, consultation, and training services in the areas of child care and development and early childhood education, operating a free Technical Assistance phone service for current and potential child care providers, Monday through Friday, from 9AM to 12PM. Counselors are available to answer questions and provide information, referrals, and guidance on various issues related to becoming a child care provider and working with children and families.

7. Collaboration and System Enhancements

The project description above documents the intended collaboration with funding partners and countywide agencies (for example, First 5). San Mateo's PEI efforts for the early childhood population will be woven into the work and the models that are already in use, expanding capacity and targeting it to at-risk populations. The state funded preschools will be implementing a standard social/emotional development curriculum, which dovetails nicely with the teams' projected activities.

In San Mateo County, there are a number of linkages to individuals with extensive background in early childhood mental health, available to provide consultation and support to the community teams, including Linda Perez, PhD, who is affiliated with San Mateo County's Pre to Three Program.

This project will also intersect well with a potential project now awaiting a funding decision. The Bay Area Region Maternal Care Improvement Project has the following goals:

- Decrease maternal morbidity and mortality by improving maternal mental well-being through increased detection and access to treatment of mental health problems or co-occurring substance abuse problems for women during the prenatal period and up to 1 year following their pregnancy.
- Pilot a regional approach/standard of screening, assessment, and referral for women with or at risk of MISA.
- Promote an integrated clinical and public health approach to promoting maternal mental well-being and decreasing maternal morbidity and mortality.

PEI PROJECT SUMMARY

Form No. 3

If funded the project will develop the following components:

- **Tool Kit.** A Bay Area Regional Interdisciplinary Collaborative will review existing instruments and recommended practices and produce a Perinatal Mental Health/Substance Abuse Screening and Referral Tool Kit for use by Bay Area health care providers (obstetricians, pediatricians, nurses, lactation specialists, social workers and other health care professionals involved in the perinatal care of a woman and her baby). This Tool Kit will include materials to be used by MCAH and other public health programs that interface with providers, e.g., PowerPoint presentation, handouts, etc.
- **Regional Promotion to Providers.** The Regional Collaborative, local jurisdiction collaboratives and Maternal Child Health Programs will participate in a campaign to promote and disseminate throughout the Bay Area the use of the tool kit, and standard/best practice of screening and referral. Venues will include Grand Rounds, Professional Meetings, RPPC, CMQCC, local First Five Commissions, SB 696 Community Benefits Collaboratives, etc.
- **Resource Inventory.** Each health jurisdiction will develop an inventory of local mental health and substance abuse support and treatment resources which will be available on a regional web site for use by health care providers
- **Targeted Information for Women.** Pregnant and postpartum women will be given materials and provided information about MISA and available resources during pregnancy and postpartum
- **Provider Pilots.** Two or three hospital obstetric/pediatric departments or physician group practices will be pilot sites. They will institute a policy and a supportive system of education, training, and tracking of documented mental health and co-occurring mental health and substance abuse screening and referrals to identified resources and distribution of educational materials to women and families. Data will be used to evaluate project impact: completed screening and referral, impact on system and practice and barriers encountered.

This project could provide valuable materials that relate to stigma and serve as a source of referrals for the PEI funded community team(s) serving young families.

8. Intended Outcomes

- Increased knowledge, skills and competence among early childhood caregivers regarding how to support healthy social emotional development
- Increased knowledge and confidence among families with very young children regarding how to support healthy social emotional development
- Early identification of families that require more assistance and support, with documented connections to additional services

PEI PROJECT SUMMARY

Form No. 3

9. Coordination with Other MHSA Components

As noted above, a small percentage of those served may be referred into formal mental health services provided by BHRS. However, we expect that most individuals will use community based health and human service supports.

All training aspects involved in the implementation of the project will be carried out in coordination with the MHSA Education and Training activities, benefiting from lessons learned and leveraging resources whenever possible. The same is true for other components whenever applicable.

As part of our continuous quality improvement practices we see coordination (of MHSA and non-MHSA programs) as a critical aspect of our service delivery philosophy, which strives to ensure a seamless service experience for all who interact with our system.

PEI PROJECT SUMMARY

Form No. 3

County: San Mateo PEI Project Name: Community Interventions for School Age and Transition Age Youth Date: August 29th, 2008

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

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

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

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 PEI workgroup that focused on ages 6-25 worked in subgroups focused on 6-17 and 18-25. They identified students at risk, youth who are unserved or underserved, and those experiencing early onset of psychotic illnesses among their priority populations. The chair of the PEI planning process, who participated in all age-focused workgroup meetings, is also the co-chair of the Co-Occurring Steering Committee. Many co-occurring change agents participated in the age-focused workgroups, resulting in attention to prevention and early intervention initiatives that would address both mental health and substance abuse conditions.

The workgroup reviewed a BHRS PEI data report that updated analyses prepared during the 2005 CSS planning process. Among the findings in the data were:

All Ages

- More people of all ages were actually served by BHRS than projected by state prevalence methods when restricted to 200% of poverty.
- More males and fewer females of all ages were served than projected.
- Slightly fewer children/youth were served than projected.
- More TAY and adults were served than projected.
- Significantly more Whites and African Americans of all ages were served than projected.
- Fewer Pacific Islanders, significantly fewer Asians and slightly more Native Americans of all ages were served than projected.
- Fewer Latinos of all ages were served than projected, however in the last two years the number of Latinos served has increased from around 3,000 to almost 4,000.
- Significantly fewer people of all ages were served in their primary language than may need it.

Children/Youth/Young Adults

- There were 356 drop-outs in grades 9-12 for the 2005-06 school year. The populations with the highest rate of drop-out are Latinos at 2.3% and African Americans at 2.5%. (Source: California Department of Education Educational Demographics Unit).
- In 2005, there were 890 juvenile felony arrests, 93% of juveniles arrested for felony offenses were ages 13-17. The number of juvenile felony arrests per 1,000 youth ages 10-17, by race/ethnicity were 94.7 percent African American and 16.1 Latino. (Data Source: State of California Department of Justice, California Criminal Justice Profiles.)

PEI PROJECT SUMMARY

Form No. 3

- The National Co-morbidity Survey Replication, reported in the June 2004 issue of Archives of General Psychiatry, focused on studying the prevalence of mental health need in those 18 and above, and found that mental disorders “gain the strongest foothold” by attacking youth—50% of all cases start by age 14 and 75% by age 24.

Workgroup members were also briefed on results from the extensive focus groups conducted for CSS in 2005. Key points from CSS planning related to transition age youth included

- More counselors are needed at schools.
- Transportation support is needed to access services.
- Age-appropriate housing options.
- System perceived as unwelcoming.
- Need for culturally competent services beyond translation of materials.
- Need for an integrated service experience (all systems working together).

Providers, family members and TAY youth stated that what they need is:

- Easy access
- Continuity of care
- Trusting, enduring relationships
- Respect for the individual, family and culture
- Empowerment for families and youth to define their goals and have input into their services

3. PEI Project Description:

This project will focus on school age and transition age youth, reaching out to them in non-traditional settings such as schools and community based agencies, such as substance abuse programs, drop-in centers, youth focused and other organizations operating in communities with a high proportion of underserved populations. The project will use community based agencies to provide population and group based interventions to at-risk children and youth 6-25.

PEI PROJECT SUMMARY

Form No. 3

The first intervention, **Teaching Prosocial Skills (TPS)**, addresses the social skill needs of students who display aggression, immaturity, withdrawal, or other problem behaviors. Students are at risk due to issues such as growing up poor; peer rejection; low quality child care and preschool experiences; after-school care with poor supervision; school failure, among others. **Teaching Prosocial Skills** is based on **Aggression Replacement Training (ART)**.

ART was developed by Arnold P. Goldstein, Barry Glick and John C. Gibbs, and takes concepts from a number of other theories for working with youth, and incorporates them into a comprehensive system. Peer learning and repetition are elements of the model. ART is an evidence based program broadly utilized. Social skills training, anger control, and moral reasoning are the main components of both ART and TPS.

The Teaching Prosocial Skills model includes three key components:

- *Skillstreaming* (the behavioral component)--teaches what to do;
- *Anger Control Training* (the emotional component)--teaches what not to do;
- *Moral Reasoning Training* (the values component)--teaches why to use the skills. This intervention will target 6 to 9 yrs. old. Of the three components mentioned above, *Skillstreaming* is the key one for this particular age group.

The second intervention, **Project SUCCESS** (Schools Using Coordinated Community Efforts to Strengthen Students), is considered a SAMHSA model program that prevents and reduces substance use and abuse and associated behavioral issues among high risk, multi-problem adolescents. It works by placing highly trained professionals (Project SUCCESS counselors) in the schools to provide a full range of prevention and early intervention services. BHRS PEI funds would be used to fund up to three separate school sites.

Project SUCCESS is a research-based program that builds on the findings of other successful prevention programs by using interventions that are effective in **reducing risk factors and enhancing protective factors**. Project SUCCESS counselors use the following intervention strategies: information dissemination, normative and prevention education, problem identification and referral, community based process and environmental approaches. In addition, resistance and social competency skills, such as communication, decision making, stress and anger management, problem solving, and resisting peer pressure are taught. The counselors primarily work with adolescents individually and in small groups; conduct large group prevention/education discussions and programs, train and consult on prevention issues with alternative school staff; coordinate the substance abuse services and policies of the school and refer and follow-up with students and families needing substance abuse treatment or mental health services in the community.

PEI PROJECT SUMMARY

Form No. 3

The following four program components are utilized in Project SUCCESS:

- Prevention Education Series – An eight- session Alcohol, Tobacco, and Other Drug prevention program conducted by the Project SUCCESS Counselor with small groups of students.
- Individual and Group Counseling – Project SUCCESS counselors conduct time limited individual sessions and/or group counseling at school to students following participation in the Prevention Education Series and an individual assessment. There are seven different counseling groups for students to participate in.
- Parent Programs – Project SUCCESS includes parents as collaborative partners in prevention through parent education programs.
- Referral - Students and parents who require treatment, more intensive counseling, or other services are referred to appropriate agencies or practitioners in the community by their Project SUCCESS counselors.

The third intervention, **Seeking Safety**, is an approach to help people attain safety from trauma/PTSD and substance abuse. It will be targeted toward Transition Age Youth through their contacts with community based organizations. Seeking Safety is a manualized intervention (also available in Spanish), providing both client handouts and guidance for clinicians. It is conducted in **group and individual** format; with **diverse populations**; for **women, men, and mixed-gender** groups; using **all topics or fewer topics**; in a **variety of settings**; and for both **substance abuse and dependence**. It has also been used with **people who have a trauma history**, but do not meet criteria for PTSD. The key principles of Seeking Safety are:

- 1) Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions).
- 2) Integrated treatment (working on both PTSD and substance abuse at the same time)
- 3) A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse
- 4) Four content areas: cognitive, behavioral, interpersonal, case management
- 5) Attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues)

Seeking Safety consists of 25 topics that can be conducted in any order: Introduction/Case Management, Safety, PTSD: Taking Back Your Power, When Substances Control You, Honesty, Asking for Help, Setting Boundaries in Relationships, Getting Others to Support Your Recovery, Healthy Relationships, Community Resources, Compassion, , Creating Meaning, Discovery, Integrating the Split Self, Recovery Thinking, Taking Good Care of Yourself, Commitment, Respecting Your Time, Coping with Triggers, Self-Nurturing, Red and Green Flags, Detaching from Emotional Pain (Grounding). Life Choices, and Termination.

This intervention would be offered throughout San Mateo County, in a wide variety of settings, through community based agencies such as substance abuse and mental health programs, drop-in centers, youth focused and other organizations operating in communities with a high

PEI PROJECT SUMMARY

Form No. 3

proportion of underserved populations. By purchasing these group services on an hourly basis, BHRS can maintain maximum flexibility in distributing this intervention across settings and underserved populations. The intent would be to offer 15 groups annually, assuming that each group series is about 50 hours.

Implementation of this program will require several phases, assuming that PEI funding becomes available in November 2008:

Pre-Project Development (Dec 08-Mar 09)

- The County Office of Education collaborated with BHRS' data gathering effort by mapping all early intervention programs and prevention curricula that are in place in the schools, in all 23 San Mateo County School Districts. The San Mateo County Health Department, Human Services Agency and Probation Department have recently completed a project to jointly map all of their programs, including services provided in schools. However, there are many other services being delivered by community based agencies that are grant or foundation funded that are also active in schools. The mapping that the County Office of Education has completed will enable BHRS to understand where the gaps are within the schools and target PEI projects to address those gaps.
- RFP for community-based agency(ies) to operate the programs (which may or may not be agencies currently participating in the county mental health program)--a significant requirement will be the ability to outreach into the ethnic and cultural populations that are currently underserved in the system, such as Latino and Asian/Pacific Islander populations.
- Provider selection and contract development.
- Staff recruitment for the programs.
- Staff training in the evidence based treatment approaches.

Phase I: Detailed planning with school partners (Mar 09-Jun 09)

- Collaborate with community based settings to plan for implementation of the program

Phase II: Education/outreach, assessment and treatment services (Jul 09-ongoing)

- Initiate services according to detailed implementation plans

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	
Community Interventions for School Age and Transition Age Youth	Individuals: 0	Individuals: 0	One.
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 0	Individuals: 0	One.

5. Alternate Programs

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

Teaching Prosocial Skills (TPS) is a multi-component cognitive-behavioral treatment to promote pro-social behavior by addressing factors that contribute to aggression in children and adolescents including limited interpersonal social and coping skills, impulsiveness, over-reliance on aggression to meet daily needs, and egocentric and concrete values. A cost benefit analysis by the **Washington State Institute for Public Policy** finds this program results in reduced criminal behavior and significant cost savings. TPS utilizes Aggression Replacement Training curriculum.

TPS consists of three components each of which is conducted with a group of 6-8 youth including Skillstreaming, Anger Control Training, and Moral Reasoning Training. Skillstreaming teaches youth pro-social skills. The approach, developed by Arnold Goldstein, consists of a series of social learning instructional procedures that are used to teach a set of 50 skills. The instructional procedures include: modeling prosocial skills, role-playing (guided practice of the skills), performance feedback (praise and reinstruction), and transfer training (homework involving applying the new skill in real life situations). Anger Control Training teaches youth how to manage angry feelings. In a complimentary way, the approach, developed by Eva Feindler and her colleagues, consists of a series of social learning procedures taught across 10 weekly sessions, including recognizing triggers and

PEI PROJECT SUMMARY

Form No. 3

cues, learning and using reducers, use of reminders and appropriate Skillstreaming alternatives to anger or aggression. Moral Reasoning Training, through social perspective taking opportunities, teaches youth higher levels of moral reasoning, characterized by mutuality (treating others as you would hope they would treat you), and interdependence and cooperation for the sake of society. The approach consists of facilitated discussion in regards to understanding and responding to a series of moral dilemma vignettes.

Project Success is in the SAMHSA National Registry.

Seeking Safety meets criteria in the field as an effective treatment for PTSD/substance abuse (also known as an evidence-based practice). See for example, Chambless & Hollon (1998), *Defining empirically supported therapies*. J Consulting and Clinical Psychology, 66, 7-18 as well as the following specific studies:

- Adolescent girls (randomized trial) (Najavits et al., 2006)
- Women with co-occurring disorder (controlled trial) (Morrissey et al., 2005)
- Women in substance abuse treatment (Young et al., 2004)
- Young African-American men (Hamilton, 2006)

How does traumatic response differ from a normal stress reaction?

Stress is an essentially normal response to feeling overwhelmed or threatened. Fight, flight and freeze are survival responses that developed to protect us from danger. In moments of stress, hormones release and, as our heart beat speeds up and blood pressure increases, we breath quicker, move faster, hit harder, see better, hear more accurately, and jump higher than we could only seconds earlier. If we're nervously driving at high speed on the freeway at night, we can respond more effectively to unexpected hazards because we are exceptionally alert. These neurological and physiological changes enable us to better protect ourselves in the moment. But once the danger has passed, our nervous systems calm down and we return to a state of equilibrium or neurological balance. Positive stress can produce feelings of exhilaration and opportunity. Not all people experience stress in the same way. One person's exhilarating challenge may be another's terrifying experience. Much has been written about the disadvantages of stressful life styles that keep us running on overwhelm and create constant physiological stimulation so that our bodies are kept from returning to a quieter calmer state of balance. But social and life style changes can usually restore physiological and psychological balance. This is not the case when someone becomes traumatized. Traumatization is stress frozen in place –locked into a pattern of neurological distress that doesn't go away by returning to a state of equilibrium. Traumatization promotes ongoing disability that can take many mental, social, emotional and physical forms. Like normal stress, trauma is also experienced differently by different individuals.

What are the common links between both high and low impact experiences that trigger traumatic responses?

Trauma and loss are parts of life. It is not what happens to us but how we react to it that determines whether or not a life-threatening experience or a series of less intense experiences will, in fact, be traumatizing. The more vulnerable the organism, the more it is at risk for the neural dysregulation that can follow traumatic experiences. Whether dysregulation follows an intense event described with symptoms of PTSD or a seemingly benign event or series of events with symptoms like depression, anxiety or relationship disorders, emotionally traumatizing events contain three common elements:

- It was unexpected;
- The person was unprepared; and
- There was nothing the person could do to prevent it from happening.

What kinds of experience can be traumatic?

The ability to recognize emotional trauma has changed radically over the course of history. Until recently psychological trauma was noted only in men after catastrophic wars. The women's movement in the sixties broadened the definition of emotional trauma to include physical and sexual abuse of women and children. Now, the impact of psychological trauma has extended to experiences that include

- Natural disasters, such as earthquakes, fires, floods, hurricanes, etc.
- Physical assault, including rape, incest, molestation, domestic abuse and serious bodily harm
- Serious accidents, such as automobile or other high-impact scenarios
- Experiencing or witnessing horrific injury, carnage or fatalities

Other often overlooked potential sources of psychological trauma include:

- Falls or sports injuries
- Surgery, particularly emergency, and especially in first 3 years of life
- Serious illness, especially when accompanied by very high fever
- Birth trauma
- Hearing about violence to or sudden death of someone close

http://www.healingresources.info/trauma_attachment_stress_disorders.htm

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

If youth are identified who need more intensive services than those offered at the school or community based site, a referral will be made into one of the BHRS clinics, in order to match the youth and family with an appropriate level of services. In addition, community based resources will be utilized to support the broader need of those served.

7. Collaboration and System Enhancements

This project will require the broad collaboration of the mental health system, all of the middle and high schools within the 23 San Mateo County school districts, and school based family resource centers. A central aspect of implementing this project is the completion of community wide mapping of the services provided within the schools by governmental and community based agencies, and identification of gaps to be addressed.

This project will also require collaboration with organizations that support and serve school aged youth and transition aged youth, including community based agencies, such as substance abuse and mental health programs, drop-in centers, youth focused and other organizations operating in communities with a high proportion of underserved populations.

8. Intended Outcomes

Teaching Prosocial Skills

- The program is expected to improve the youth's ability to deal with anger provoking and similar uncomfortable situations. It is expected that the youth's risk to recidivate will be reduced and that the youth's skills and attitudes will be impacted positively. Reduced criminal behavior, decreased conduct problem behaviors, increased prosocial behaviors and improved anger control are expected outcomes from a successful TPS implementation.

Project Success

In a recent study with regular secondary school students, 9 months and 21 months following the intervention, comparisons of pretest users in the intervention group with pretest users in the control group indicated:

- An increase in the degree to which Project SUCCESS students reported they cared about their families

PEI PROJECT SUMMARY

Form No. 3

- An increase in the amount of help Project SUCCESS students said they expected to receive from the police, when needed
- A decrease in Project SUCCESS students' reported number of friends who smoked cigarettes
- Greater confidence among Project SUCCESS students that their parents would try to stop them if they were to start smoking

These are the types of outcomes that can be expected from Project SUCCESS.

Seeking Safety

- Improvement in PTSD and/or or trauma-related symptoms
- Improvements in other areas, including social adjustment, general psychiatric symptoms, suicidal plans and thoughts, problem-solving, sense of meaning, depression, and quality of life

9. Coordination with Other MHSA Components

As noted above, a small percentage of those served may be referred into formal mental health services provided by BHRS. However, most individuals will use community based health and human service supports, and it is not anticipated that there would be significant utilization of the FSP for TAY.

All training aspects involved in the implementation of the project will be carried out in coordination with the MHSA Education and Training component activities. The same is true for other components whenever applicable. For example, through CSS we currently fund a school-based project in the middle-school setting using Project SUCCESS, which is one of the evidence-based practices selected by our stakeholders for this PEI project. We will make sure that we take into account the lessons learned from the ongoing implementation of Project SUCCESS, and coordinate efforts whenever possible. The same is true for Teaching Pro Social Skills and for Seeking Safety, as these two practices are also currently active in our system.

As part of our continuous quality improvement practices we see coordination (of MHSA and non-MHSA programs) as a critical aspect of our service delivery philosophy, which strives to ensure a seamless service experience for all who interact with our system.

PEI PROJECT SUMMARY

Form No. 3

County: San Mateo

PEI Project Name: Primary Care/Behavioral Health Integration: IMPACT Model

Date: August 29th, 2008

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

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

2. PEI Priority Population(s) Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
C. 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	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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 PEI Workgroup that focused on older adults identified individuals who are isolated, who are unserved or underserved, and those experiencing deteriorating health and cognition (which puts them at risk of serious psychiatric illness) among their priority populations. The PEI Workgroup that focused on adults identified individuals who are in other service systems, those who are at-risk/stressed/traumatized, those who are disconnected, and those who are unidentified but need intervention among their priority populations. The chair of the PEI planning process, who participated in all age focused workgroup meetings, is also the co-chair of the Co-occurring Steering Committee. Many co-occurring change agents participated in the age focused workgroups, resulting in attention to prevention and early intervention initiatives that would address both mental health and substance abuse conditions.

The Workgroup reviewed a BHRS PEI data report that updated analyses prepared during the CSS planning process. Among the findings in the data were:

All Ages

- More people of all ages were actually served by BHRS than projected by state prevalence methods when restricted to 200% of poverty.
- More males and fewer females of all ages were served than projected.
- More TAY and adults were served than projected and about the same number of older adults as projected.
- Significantly more Whites and African Americans of all ages were served than projected.
- Fewer Pacific Islanders, significantly fewer Asians and slightly more Native Americans of all ages were served than projected.
- Fewer Latinos of all ages were served than projected, however in the last two years the number of Latinos served has increased from around 3,000 to almost 4,000.
- Significantly fewer people of all ages were served in their primary language than may need it.
- According to the National Comorbidity Survey Replication, over a 12 month period, 60% of those with a mental disorder received no psychiatric treatment at all. Groups such as the elderly, racial/ethnic minorities and those with low income or without insurance had the greatest unmet need for treatment. Those who did get treatment were more likely to be seen by a primary care physician (22.8%) than by a psychiatrist (12%) or a non-psychiatrist mental health specialist (16%).
- The National Comorbidity Survey Replication also reports that in any given year, 9.5% of the population age 18 and older will experience a mood disorder (e.g., depression, bipolar), and that 45% of those with mood disorders are severely affected. The median age of onset is 30 years of age, but the delay in initial treatment contact ranges from six to eight years. The cost of depression in healthcare and the workforce has been

PEI PROJECT SUMMARY

Form No. 3

well documented—among the five conditions (mood disorders, diabetes, heart disease, hypertension, and asthma) that account for 49% of total healthcare costs and 42% of illness-related lost wages, mood disorders rank third in healthcare costs, first in work loss costs and second in total costs. Yet it is under-recognized and under-treated in primary care settings (30-40% not identified and about 10% only on benzodiazepines). (Data Source: Integrating Behavioral Health and Primary Care Services, NASMHPD, 2005).

- Depression, isolation and loneliness are prevalent in San Mateo County. Mental health services to deal with depression are inadequate, as are the variety of community structures needed to deal with loneliness and isolation. In San Mateo County, a total of 25.2% of surveyed adults reported having had a period lasting two years or longer during which he or she was sad or depressed on most days. This proportion is significantly *higher* than found in 1998 and 2004, but is similar to the 2001 finding. A total of 6.1% of survey respondents report experiencing high stress on a daily basis, with these perceptions higher among Blacks. In addition, roughly 25% of adults experience some degree of difficulty with feelings of isolation or loneliness. Similarly, one out of four experiences some degree of difficulty with fear, anxiety or panic.

Older Adults

- The San Mateo County 2000 Census Data shows that there are over 100,000 individuals in San Mateo County with a sensory, physical, mental or self-care disability. The breakdown by age group is listed below and prevalence assumptions from the U.S. Surgeon General's Report (9-13% of children have a serious emotional disturbance (SED) and 5.4% of adults and older adults have a SMI) are applied to calculate the number that would need mental health services.

Age	Individuals with a sensory, physical, mental or self-care disability	Prevalence Assumption	In need of mental health services
5-20	3,969	@ 13%=	516
21-64	73,274	@ 5.4%=	3,957
65+	30,397	@ 5.4%=	1,641

It is the older adult population that stands out as unserved. In FY 06/07 a total of 1,198 were served; only 156 of these were served by the Elder Outreach program, designed to reach isolated, disabled and home-bound elderly.

- Currently, more than one out of three area seniors lives alone, and nearly one out of five lives below the 200% poverty threshold. Further, seniors in San Mateo County report much higher prevalence of debilitating chronic conditions, such as arthritis, diabetes, heart disease, high cholesterol, high blood pressure, and chronic lung disease. Rates of diabetes, asthma and chronic lung disease are increasing among the senior population. (Source: 2008 Community Assessment: Health & Quality of Life in San Mateo County (March 2008))
- A meta-analysis of 40 studies on rates of contact with primary care and mental health professionals by individuals before they died of suicide reported that for persons age 55 and older, an average of 58% had contact with a primary care provider within one month of suicide, significantly

PEI PROJECT SUMMARY

Form No. 3

greater than those age 35 and younger. Also, a large majority of persons 55 and older (77%) had contact with primary care providers in the year before their suicide. (Contact With Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence. Luoma J, Martin C, Pearson J, American Journal of Psychiatry June 2002).

- Nationally, in the *PRISMe* study of primary care patients 65 and older, 20% scored positive for psychological distress, 8% for at-risk drinking, and 5% had suicidal thoughts. With “the best referral process imaginable”, only 49% of the patients referred actually were engaged in specialty behavioral health services, compared to 71% in a primary care integrated model. Specifically, the engagement rate for depression in the integrated model was 76%, in the referral model, 55%; the engagement rate for alcohol in the integrated model was 72%, in the referral model, 29%. Findings also included greater engagement for more severe symptoms and worse functioning, high engagement among suicidal elderly and engagement demonstrated across different clinics and ethnicities. (Data Source: Integrating Behavioral Health and Primary Care Services, NASMHPD, 2005). Of the almost **80,000 adults 65 and over in San Mateo County, 16,000 are likely to need an intervention** to maintain their health and social functioning.

Workgroup members were also briefed on results from the extensive focus groups conducted for CSS in 2005.

- In relation to accessing care, stigma was identified in **37 of the 50** focus groups as a barrier to care.
- Many felt a sense of **shame** and **isolation** because of their mental health problems.
- Among many unserved communities, including Latino, Filipino, Chinese, Tongan, and African American communities, stigma was an especially strong deterrent to seeking mental health services
- Another barrier to care among unserved communities is lack of knowledge of mental illness, its signs and symptoms, and how to treat it.
- **29 of the 50** Adult focus groups indicated that some **new approach to outreach and community education** could help improve understanding of mental illness and improve access to the mental health system.
- Many suggestions across all age groups focused on the need for **community education** and information (same language, same culture) to demystify mental illness and to help **engage the unserved**.
- 15 of 50 adult focus groups explicitly identified lack of access in specific geographic regions. However, in communities like Coastside, Pescadero, Pacifica, EPA and Daly City, community forums were quick to identify this as a need.
- While not an issue for consumers who live near services, clearly for those who live in distant regions with lower levels of services, **geographic access** is a major problem.
- As with other age groups, the **difficulty of penetrating the mental health system** was identified as the single greatest criticism of the system. **Twenty-nine of fifty** adult focus groups discussed access points explicitly and this issue was a major focus of all ethnic/cultural/linguistic group discussions.

PEI PROJECT SUMMARY

Form No. 3

- **Cultural competence** was raised as an issue in over half of the adult focus groups and in virtually all focus groups that targeted unserved populations.
- A common concern was that **absence of linguistic capacity** with one provider noting, “**Bilingual services need to be available in the jails.**”
- Many consumers, providers and consumer members mentioned the need for **peer involvement** in services in a wide range of areas.
- Family involvement is key in path to wellness and recovery.
- More adult focus groups referenced the **need for integrated services in natural community settings** than any other issue (44 out of 50).
- The need for **integrated dual diagnosis services** was referenced in almost half of all adult focus groups.
- **Housing** was identified more than any other issue, as being central to consumer quality of life in **35 of 50** adult focus groups.
- **Financial barriers to care** are not limited to the poor. One family member noted that more coverage was needed for “**people in the middle who make too much to qualify for Medi-Cal, but can’t pay for services themselves.**”
- The need for recreation and social activities was identified as central to a good quality of life in exactly half of all adult focus groups.
- In creating a network of community drop in centers, it is important to be aware of **special needs** of individuals with disabilities, individuals from different cultures, and individuals whose sexual orientation is a stigmatizing factor.

Key points from CSS planning related to older adults included:

- The need for **easy access to services** was referenced in a wide variety of contexts and focus group participants were most critical of the system’s points of entry and re-entry.
- The primary barriers were the **need for escort services** to accompany seniors to appointments and the sheer **complexity of the system** itself.
- The primary theme concerning services was the need for those services to be distinctly different from those provided to younger adults. There is a strong need to **incorporate the unique needs of seniors in the service design.**
- It is even more important for seniors than for other age groups, that **services be co-located, ideally with primary care services.**
- Personal services coordination could play a critical role with seniors who need help negotiating the system, managing their meds, and dealing with complex insurance and eligibility requirements.
- Seniors require a wider range of **non-therapeutic services**: help with **maintaining medication**, **escorts** to get to appointments and to manage them, **home-based support**, **socialization** and recreation, and spirituality; and a range of **housing options** that respond to generally escalating medical needs as seniors grow older.

Providers, family members and Older Adults stated quite clearly what they need:

- Easy, uncomplicated access to services;

PEI PROJECT SUMMARY

Form No. 3

- Strong primary care-mental health ties;
- The knowledge that as they age, there will be housing options available; and most of all.
- Consistent human contact
- Community education, in particular, education of the medical community regarding mental health needs of seniors

3. PEI Project Description:

We will use the proven **IMPACT** model to identify and treat individuals in primary care who do not have Serious Mental Illness, and are unlikely to seek services from the formal mental health system. In one of the largest treatment trials for depression to date, a team of researchers led by Dr. Jürgen Unützer followed 1,801 depressed, older adults from 18 diverse primary care clinics across the United States for two years. The 18 participating clinics were associated with eight health care organizations in Washington, California, Texas, Indiana and North Carolina. The clinics included several Health Maintenance Organizations (HMOs), traditional fee-for-service clinics, an Independent Provider Association (IPA), an inner-city public health clinic and two Veteran's Administration clinics. Since the end of the trial, a number of organizations in the United States and abroad have adapted and implemented the IMPACT program with diverse populations, serving individuals of all ages and expanding the scope of services beyond depression to those suffering from anxiety, PTSD, ADHD and other conditions frequently found in primary care.

The five most essential elements of IMPACT are:

1. Collaborative care is the cornerstone of the IMPACT model and functions in two main ways:

- The individual's primary care physician works with a care manager/behavioral health consultant to develop and implement a treatment plan (medications and/or brief, evidence-based psychotherapy)
- Care manager and primary care provider consult with psychiatrist to change treatment plans if individuals do not improve

2. Care Manager/Behavioral Health Consultant:

This may be a nurse, social worker or psychologist and may be supported by a medical assistant or other paraprofessional. The care manager:

- Educates the individual about depression/other conditions
- Supports medication therapy prescribed by the individual's primary care provider if appropriate
- Coaches individuals in behavioral activation and pleasant events scheduling/self management plan
- Offer a brief (six-eight session) course of counseling, such as Problem-Solving Treatment in Primary Care

PEI PROJECT SUMMARY

Form No. 3

- Monitors symptoms for treatment response
- Completes a relapse prevention plan with each individual who has improved

3. Designated Psychiatrist:

- Consults to the care manager and primary care physician on the care of individuals who do not respond to treatments as expected

4. Outcome measurement:

- IMPACT care managers measure depressive or other symptoms at the start of a individual's treatment and regularly thereafter. The PHQ-9 is an effective depression measurement tool, however, there are other effective tools.

5. Stepped care:

- Treatment adjusted based on clinical outcomes and according to an evidence-based algorithm
- Aim for a 50 percent reduction in symptoms within 10-12 weeks
- If individual is not significantly improved at 10-12 weeks after the start of a treatment plan, change the plan. The change can be an increase in medication dosage, a change to a different medication, addition of psychotherapy, a combination of medication and psychotherapy, or other treatments suggested by the team psychiatrist.

Evidence for Collaborative Depression Care

The IMPACT findings are consistent with a substantial body of evidence for collaborative care for depression that has emerged over the past 10 years. A meta-analysis of the evidence for collaborative depression care was published by Gilbody, et al in the Archives of Internal Medicine in 2006. They examined 37 randomized controlled trials with 12,355 total primary care patients. They concluded, "Sufficient randomized evidence had emerged by 2000 to demonstrate the effectiveness of collaborative care beyond conventional levels of statistical significance. Further and subsequent randomized trials have only sought to increase the precision of existing estimates of effectiveness, and it is unlikely that further randomized evidence will overturn this result."⁽¹⁾

An Institute of Medicine (IOM) report, Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series, was published in 2006. It makes a series of specific recommendations that mirror the IMPACT model of care, including:

- Facilitate the delivery of coordinated care by primary care, mental health and substance-use treatment providers (section 5.2)

PEI PROJECT SUMMARY

Form No. 3

- Increase the use of valid and reliable patient questionnaires to assess the progress and outcomes of treatment systematically and reliably (section 4.2)

Similarly, an editorial published in the British Medical Journal in 2006 stated, "The evidence base is now sufficient for the emphasis to shift from research to dissemination and implementation."(2)

1. Gilbody S, Bower P, Fletcher J, et al. Collaborative Care for Depression: A Cumulative Meta-analysis and Review of Longer-term Outcomes. Arch Intern Med. 2006;166:2314-2321
2. Simon G. Collaborative care for depression. BMJ. 2006;332:249-250

Implementation of this program by San Mateo BHRS will require several phases, assuming that PEI funding becomes available in November 2008:

Pre-Project Development (Nov. 08-May 09)

- Establish criteria for selection of the community based primary care clinics where the services will be provided, and work with partners to select sites. The criteria will include selecting sites with a preponderance of geriatric patients as well as sites with a preponderance of adult patients. These may include San Mateo Medical Center Clinics, but could also include private practices that serve Medi-Cal and Medicare primary care patients in the ethnic and cultural populations that are currently underserved in the system, such as Latino and Asian/Pacific Islander populations. The practices selected will serve adult and older adult patients equally in implementing the IMPACT model, however, those with a preponderance of geriatric patients will have access to geriatric psychiatry and care managers with geriatric experience. See the attached mapping of primary care practices associated with the Health Plan of San Mateo—these represent potential sites for implementation.
- Another potential site would be the jail health facility, where care managers could follow individuals with longer stays and arrange for community follow up.
- Staff recruitment for the program, with an emphasis on individuals who represent the cultures and languages that have been targeted
- Staff and primary care provider training in the IMPACT model
- Development of screening protocols and registry tracking for the population to be served
- Collaboration with other agencies involved in serving older adults, to develop referral and outreach resources to be provided to individuals identified in primary care and requiring other supportive services

Phase I: Screening and primary care based services initiated (May 09-Jun 09)

- Implement process for screening, onsite care management and psychiatric consultation, and referral to services through existing community agencies and programs.

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	
IMPACT model in primary care	Individuals: 120	Two.
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 120	Two.

5. Alternate Programs

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

Primary care behavioral health screening is in the Resource Materials, but IMPACT is not specifically listed. As reported in the December 11, 2002 issue of the Journal of the American Medical Association (JAMA), the IMPACT model of depression care more than doubles the effectiveness of depression treatment for older adults in primary care settings.

At 12 months, about half of the patients receiving IMPACT care reported at least a 50 percent reduction in depressive symptoms, compared with only 19 percent of those in usual care. Analysis of data from the survey conducted one year after IMPACT resources were no longer available shows that the benefits of the IMPACT intervention persist after one year. IMPACT patients experienced more than 100 additional depression-free days over a two-year period than those treated in usual care.

Researchers tested the IMPACT model in a variety of settings including HMO, fee-for-service, inner-city county hospital and Veterans Administration clinics. IMPACT was more effective than "usual" care in each of the eight different health care systems. In addition, IMPACT was equally effective with diverse populations. It was also more effective than usual care for patients with and without comorbid medical illnesses or anxiety disorders. Other research studies and evaluations of ongoing programs show that IMPACT is effective with a range of depressed patients:

- Adults of all ages
- Diabetics

PEI PROJECT SUMMARY

Form No. 3

- Cancer patients
- Adolescents

The average cost of the IMPACT program was approximately \$580 per participant. This is modest compared to the high annual health care costs (approximately \$8,000) in this sample of depressed older adults. When healthcare costs were examined over a four year period, IMPACT patients had lower average costs for all their medical care – about \$3,300 less than patients receiving usual care, even when the cost of IMPACT care is included. This suggests that an initial investment in better depression care not only improves health, it can actually reduce total health care costs over 4 years (1).

Patients with diabetes who received IMPACT care had lower total health care costs than those in usual care, even in a shorter follow-up period (2 years) (2). Lower health care costs in patients who received IMPACT care were also documented by investigators at Kaiser Permanente who tested an adapted version of the program after the original IMPACT trial (3).

1. Unützer J, Katon WJ, Fan MY, Schoenbaum M, Lin EHB, Della Penna R, Powers D. Long-term Cost Effects of Collaborative Care for Late-life Depression. *American Journal of Managed Care* (in press).
2. Katon WJ, Unützer J, Fan MY, Williams J, Schoenbaum M, Lin E, Hunkeler E. Cost-effectiveness and Net Benefit of Enhanced Treatment of Depression for Older Adults with Diabetes and Depression. *Diabetes Care*. 2006; 29(2): 265-270.
3. Grypma L, Little S, Haverkamp R, Unützer J. Taking an evidence-based model of depression care from research to practice: making lemonade out of depression. *General Hospital Psychiatry*. 2006; 28: 101-107.

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

This program is an expansion of our current primary care based services, but uses a more specific model of universal screening and tracking of primary care patients than is currently in place. Our experience in the current primary care based services is that most patients referred by primary care can be successfully served using a brief intervention model in primary care. A very small percentage are referred on to the formal mental health system. The current services, however, rely on primary care provider referrals.

The literature shows that provider identification and referral of mental health issues can be uneven—thus the use of brief, valid screening tools for all primary care patients and the support of the care manager for primary care providers who have concerns about their ability to serve these patients in their practices.

PEI PROJECT SUMMARY

Form No. 3

The other distinct difference is the use of tools for ongoing tracking of patient status and improvement. Again, the literature shows that many patients are started on psychotropic medications by primary care providers, but may have inadequate dosages or not get results from the specific medication. The IMPACT model follows patients closely, and the team of the primary care provider, care manager and consulting psychiatrist work to change treatments, including medications, in order to accomplish significant improvement. The care manager also works to assist individuals in connecting with other important community services.

7. Collaboration and System Enhancements

Collaboration is the focus of the project. It will expand on what is already in place in San Mateo County, both through the use of the evidence based model and through engagement of primary care providers outside of the San Mateo Medical Center clinic system who see populations at risk. We anticipate that this project, will fit into the current partnerships underway to serve older adults and will significantly enhance our reach into the population of vulnerable older adults.

San Mateo County's Aging and Adult Services (AAS) contracts with other County agencies, cities and community-based organizations to provide supportive services. Services include:

- The In-Home Supportive Services (IHSS) program provides services to Medi-Cal eligible aged, blind or disabled individuals that assist them to remain safely in their own homes as an alternative to out-of-home care. IHSS is the largest home and community-based program available in California and is a core component of the state's long-term care system. Types of services may include help with preparing meals, bathing, dressing, laundry, shopping or transportation. Some types of medical services may also be provided, such as wound care. IHSS can also provide protective supervision for people who need extra support to stay safe because they have dementia or a developmental disability.
- The Multipurpose Senior Services Program (MSSP) provides social and health care management to people 65 or older who are eligible for Medi-Cal. The program aims to keep clients living independently in the community and to prevent or delay placement in a nursing facility. MSSP provides services to eligible clients and their families that assist clients to remain in their homes. MSSP Case Managers work collaboratively with individuals, families and communities as well as health team members to promote the client's independence, autonomy and a sense of well-being.
- The Linkages program provides case management as well as information and assistance services to frail, at risk seniors and adults with functional impairments who are 18 and older. Linkages provides care coordination, information and assistance regarding community resources to help clients remain independent in the community. The program can also assist with the purchase of some services such as in-home care and transportation.

PEI PROJECT SUMMARY

Form No. 3

- The Healthier Outcomes through Multidisciplinary Engagement (HOME) Team offers a comprehensive case management and referral services program for adults. HOME team is designed to advocate for and promote access to medical care while reducing the number of Emergency Department visits at the San Mateo County Medical Center
- The Representative Payee Program is responsible for managing the government benefits of individuals on an on-going basis. This includes applying for government benefits on behalf of individuals, establishing budgets and paying monthly expenses, monitoring accounts to maintain eligibility for benefits, and completing Medi-Cal redetermination and Social Security reviews.
- Adult Protective Services and the Public Guardian are resources for vulnerable older adults who may require legal advocacy and assistance.
- One of the AAS roles is to serve as the Area Agency on Aging in contracting services with other County agencies, cities and community-based organizations to provide needed services. Approximately 14,000 people, who are at least 60 years of age, receive services from contracted providers such as community-based organizations and cities, funded through the Area Agency on Aging.

These services include:

- Adult Day/Adult Day Health Care
- Congregate Nutrition
- Home Delivered Meals
- Transportation
- Caregiver support and respite
- Alzheimer's Day Care Resource Centers
- Legal assistance
- HICAP (Health Insurance Counseling and Advocacy Project)
- Case management programs (underserved populations)
- Ombudsman
- Health promotion/disease prevention
- Senior employment
- The Ron Robinson Center focuses on the needs of the senior population through primary care provided at clinic or at home if it's appropriate. The interdisciplinary team includes: physicians specializing in geriatrics and internal medicine, a nurse practitioner, a social worker, an occupational therapist, a psychologist, nurses, a podiatrist, and an optometrist.

8. Intended Outcomes

- Identification and engagement of adults suffering from depression, anxiety, PTSD or other conditions into primary care based services (total number screened, total number treated)

PEI PROJECT SUMMARY

Form No. 3

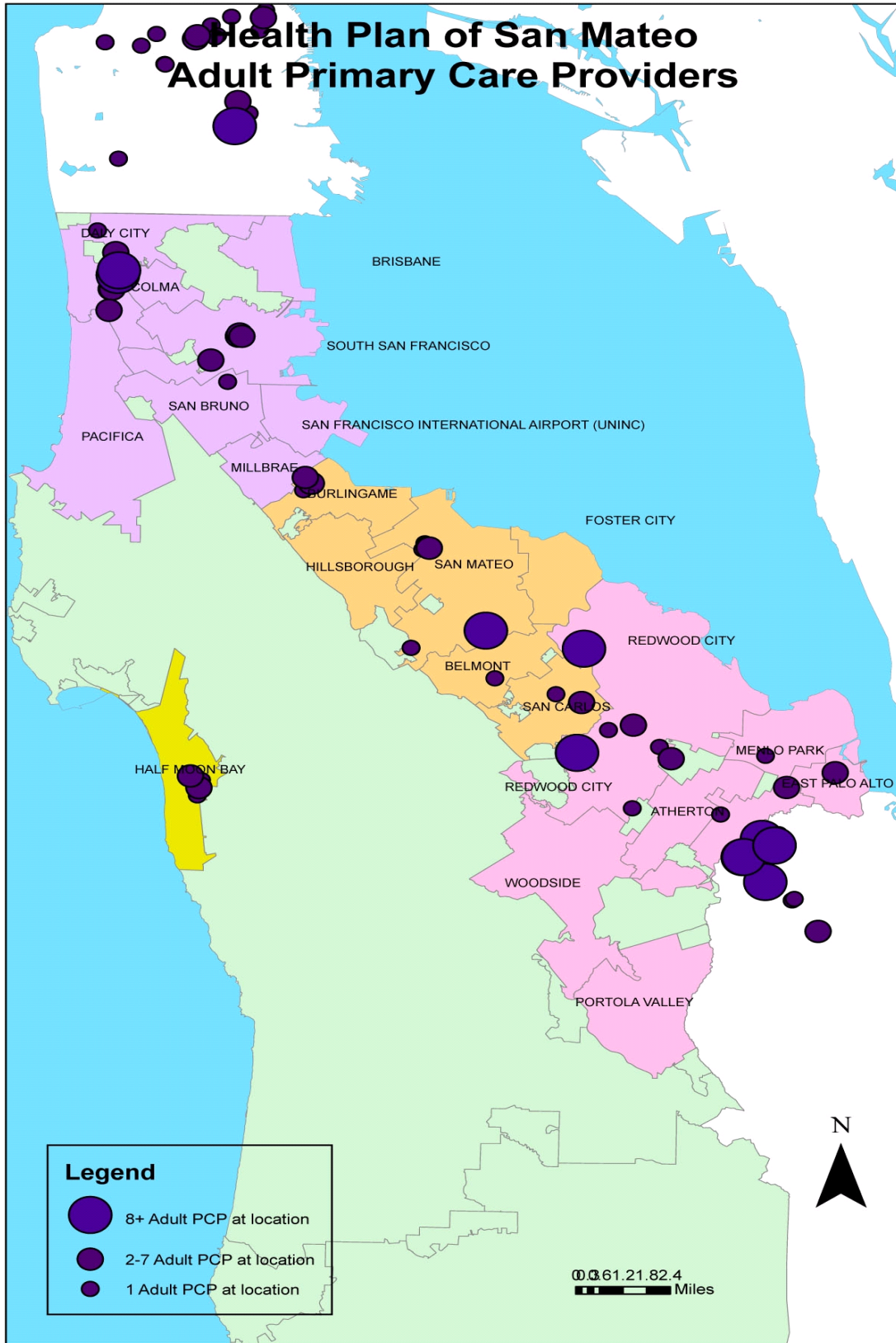
- Reduction in depression/other symptoms for those engaging in services
- Primary care provider satisfaction

9. Coordination with Other MHSA Components

As noted above, a small percentage of individuals may be referred into the formal mental health services provided by BHRS.

All training aspects involved in the implementation of the project will be carried out in coordination with the MHSA Education and Training component activities. The same is true for other components whenever applicable. For example, under the Outreach and Engagement category of Community Services and Supports of the MHSA we fund a Primary Care Interface for Older Adults; and under the System Development category, we also fund a System of Care initiative that includes a peer counselor program. When implementing this PEI project we will make sure that coordination exists with these already funded initiatives. Of note is the fact that the manager currently in charge of the existing initiatives will also oversee the proposed PEI-project, thus reinforcing the coordination piece.

In addition, as part of our continuous quality improvement practices we see coordination (of MHSA and non-MHSA programs) as a critical aspect of our service delivery philosophy, which strives to ensure a seamless service experience for all who interact with our system.



PEI PROJECT SUMMARY

Form No. 3

County: San Mateo

Project Name: Total Wellness for Adults/Older Adults⁸

Date: August 29th, 2008

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

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project: 1. Disparities in Access to Mental Health Services 2. Psycho-Social Impact of Trauma 3. At-Risk Children, Youth and Young Adult Populations 4. Stigma and Discrimination 5. Suicide Risk	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
2. PEI Priority Population(s) Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
D. 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	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>

⁸ This project has a specific component called "Integrated Training - MHSA PEI funds", which is the only component of the program we are seeking to fund through PEI dollars.

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 PEI Workgroup that focused on adults identified individuals who are in other service systems, those who are at-risk/stressed/traumatized, those who are disconnected, and those who are unidentified but need intervention among their priority populations. The PEI Workgroup that focused on older adults identified individuals who are isolated, who are unserved or underserved, and those experiencing deteriorating health and cognition (which puts them at risk of serious psychiatric illness) among their priority populations. The chair of the PEI planning process, who participated in all age focused workgroup meetings, is also the co-chair of the Co-occurring Steering Committee. Many co-occurring change agents participated in the age focused workgroups, resulting in attention to prevention and early intervention initiatives that would address both mental health and substance abuse conditions.

The Workgroup reviewed a BHRS PEI data report that updated analyses prepared during the 2005 CSS planning process. Among the findings in the data were:

All Ages

- More people of all ages were actually served by BHRS than projected by state prevalence methods when restricted to 200% of poverty.
- More males and fewer females of all ages were served than projected.
- More TAY and adults were served than projected and about the same number of older adults as projected.
- Significantly more Whites and African Americans of all ages were served than projected.
- Fewer Pacific Islanders, significantly fewer Asians and slightly more Native Americans of all ages were served than projected.
- Fewer Latinos of all ages were served than projected, however in the last two years the number of Latinos served has increased from around 3,000 to almost 4,000.
- Significantly fewer people of all ages were served in their primary language than may need it.

Adults

- The National Association of State Mental Health Program Directors (NASMHPD) found that 3 of 5 persons with serious mental illness die due to a preventable health condition. People with serious mental illness have significantly higher rates of diabetes, hypertension, heart disease and asthma, among other chronic health conditions. The NASMHPD report estimated that **people with serious mental illness are dying 25 years earlier** than the rest of the population. (Source: www.nasmhpd.org/medical_director.cfm)

PEI PROJECT SUMMARY

Form No. 3

- During the CATIE study of varying psychotropic medications, patients were also assessed for their physical health status. At baseline: 88% of subjects who had dyslipidemia, 62% of subjects who had hypertension, and 30% of subjects who had diabetes **were not receiving treatment for these conditions** (Source: Nasrallah HA, et al. *Schizophr Res.* 2006;86(1-3):15-22)
- A recent study in California, using claims data from the Medi-Cal system, studied individuals with a newly prescribed second generation antipsychotic medication and found that only 28% had glucose testing and 43% had lipid testing in the six months following the start of the antipsychotic medications. This is contrasted to the ADA/APA 2004 guidelines, which recommend glucose testing at baseline, when treatment begins, at 12 weeks, and then annually and lipid testing at baseline, 12 weeks, and then every 5 years if normal (Source: Barnett M, McDonald K, Wehring H, Walker V, Klein J, Perry P. Assessment of monitoring for glucose dysregulation and dyslipidemia in adult medi-cal patients newly started on antipsychotics. Paper in preparation, used with consent of the authors)
- The Health Plan of San Mateo County has reviewed data on the health status of the consumers served in the mental health system and found the following percentages of comorbid health conditions: Cancer 23%, Diabetes 34%, Asthma 15.5%, Hypertension 51.5%, Hyperlipidemia 51.4%, Obesity 15%, COPD 12/5%. Mental health consumers had more medical/surgical hospital admissions and less utilization of primary care with patterns of utilization that looked like that of a comparison group that is, on average, approximately 20 years older.

Workgroup members were also briefed on results from the extensive focus groups conducted for CSS in 2005. Key points from CSS planning related to adults included:

- In relation to accessing care, stigma was identified in **37 of the 50** focus groups as a barrier to care.
- Many felt a sense of **shame** and **isolation** because of their mental health problems.
- Among many unserved communities, including Latino, Filipino, Chinese, Tongan, and African American communities, stigma was an especially strong deterrent to seeking mental health services
- Another barrier to care among unserved communities is lack of knowledge of mental illness, its signs and symptoms, and how to treat it.
- **29 of the 50** Adult focus groups indicated that some **new approach to outreach and community education** could help improve understanding of mental illness and improve access to the mental health system.
- Many suggestions across all age groups focused on the need for **community education** and information (same language, same culture) to demystify mental illness and to help **engage the unserved**.
- 15 of 50 adult focus groups explicitly identified lack of access in specific geographic regions. However, in communities like Coastside, Pescadero, Pacifica, EPA and Daly City, community forums were quick to identify this as a need.
- While not an issue for consumers who live near services, clearly for those who live in distant regions with lower levels of services, **geographic access** is a major problem.

PEI PROJECT SUMMARY

Form No. 3

- As with other age groups, the **difficulty of penetrating the mental health system** was identified as the single greatest criticism of the system. **Twenty-nine of fifty** adult focus groups discussed access points explicitly and this issue was a major focus of all ethnic/cultural/linguistic group discussions.
- **Cultural competence** was raised as an issue in over half of the adult focus groups and in virtually all focus groups that targeted unserved populations.
- A common concern was that **absence of linguistic capacity** with one provider noting, **“Bilingual services need to be available in the jails.”**
- Many consumers, providers and consumer members mentioned the need for **peer involvement** in services in a wide range of areas.
- Family involvement is key in path to wellness and recovery.
- More adult focus groups referenced the **need for integrated services in natural community settings** than any other issue (44 out of 50).
- The need for **integrated dual diagnosis services** was referenced in almost half of all adult focus groups.
- **Housing** was identified more than any other issue, as being central to consumer quality of life in **35 of 50** adult focus groups.
- **Financial barriers to care** are not limited to the poor. One family member noted that more coverage was needed for **“people in the middle who make too much to qualify for Medi-Cal, but can’t pay for services themselves.”**
- The need for recreation and social activities was identified as central to a good quality of life in exactly half of all adult focus groups.
- In creating a network of community drop in centers, it is important to be aware of **special needs** of individuals with disabilities, individuals from different cultures, and individuals whose sexual orientation is a stigmatizing factor.

3. Total Wellness Project Description:

We will build on several promising practices (detailed in response to question 5 below) for this program we have called **Total Wellness**. BHRS studies of mortality and morbidity in the San Mateo mental health population point to the importance of giving attention to the critical issue of co-morbid conditions. As the graphic below shows, people with serious mental illness have a range of health care issues that compromise their ability to pursue recovery and the behavioral health system should function as their entry point into primary healthcare, if they are not already being served. Attention to the issue of co-morbidity is a top prevention strategy for BHRS.

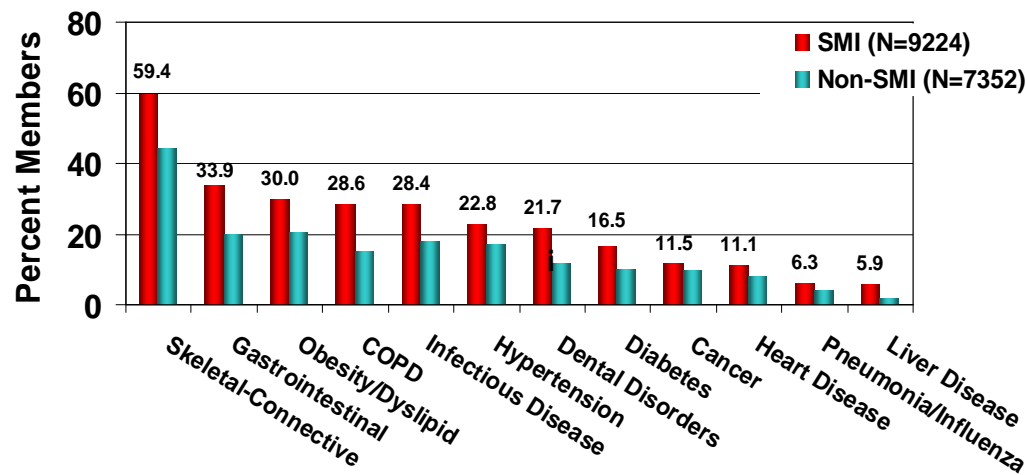
Included in the Total Wellness project is an integrated training piece that we intend to fund through a small contribution from MHSA PEI funds. This training component of Total Wellness entails a universal prevention strategy that focuses on education of professionals on co-morbidity and related issues, well within the scope of the PEI guidelines.

The **Total Wellness** model has been designed to be parallel to the IMPACT model already described, using the current evidence based practices developed in the world of primary care to improve the health status of individuals with chronic health conditions, adapting these practices for use in

the behavioral health system. It also builds upon and supports the practices of the **nurse practitioners** currently located in BHRS clinics, providing support and backup to their provision of general healthcare services in the mental health setting. The intent is to provide smooth and seamless collaboration among all care providers.

Total Wellness will assure **universal screening and registry tracking** for all BHRS consumers receiving psychotropic medications. Tracking will include blood pressure, Body Mass Index (weight), smoking status, as well as screening for glucose and lipid levels, at the time of psychiatric visits.

Maine Study Results: Comparison of Health Disorders Between SMI and Non-SMI Groups



COPD=Chronic obstructive pulmonary disease

National Association of State Mental Health Program Directors (NASMHPD) MedicalDirectors Council. In: Parks J, Svendsen D, Singer P, Foti ME, eds. Morbidity and Mortality in People with Serious Mental Illness. Technical Report, October 2006..

PEI PROJECT SUMMARY

Form No. 3

Nurse care managers will work with individuals who have elevated levels of blood pressure, glucose and lipids, assuring that:

- They are connected to ongoing healthcare in a primary care medical home (using the mental health/substance use entry point as the entry point into primary healthcare as well as access to dental services)
- Get clinical preventive screenings (for example, mammograms and other cancer screenings) and appropriate primary and specialty healthcare for chronic health conditions (by coaching and/or supporting them in primary care visits (or arranging for peers to accompany them)
- Follow up on medications prescribed for physical health conditions
- Engage in the Chronic Disease Self Management Program described below.

The nurse care manager would also link people to benefits counseling, peer mentors, the new Smoking Cessation initiative and plan and co-lead with peers ongoing groups that support weight management and physical exercise.

The centerpiece of the Total Wellness program is the Chronic Disease Self Management Program, a proven approach developed by Kate Lorig (Stanford) for people with chronic health conditions such as diabetes, which uses structured materials, trained peers and group processes that are effective in helping people take control of their chronic health conditions. BHRS will use a model now being researched in Atlanta, in which the Lorig materials have been revised for use in the mental health system, and consumer peers have been trained to be the wellness group facilitators.

It is the combination of efforts (as in the IMPACT program) that will make a difference in the health status of our consumers: regular screening and tracking of health status, nurse care managers who assure preventive clinical screening and engagement in a primary care medical home, and use of peer-led wellness groups using researched materials.

PEI-funded training component:

Es explained above, BHRS is seeking a very modest contribution from PEI dollars to fund trainings for all types of providers (county clinics and contract providers serving that population) on what are the issues related to co-morbid conditions.

The training activities would focus on providing professionals with the necessary information to help them understand the interconnectedness and the interdependence between mental and physical health. Such trainings would help bridge a much needed gap in knowledge. Narrowing this gap would be an invaluable prevention contribution to the community.

PEI PROJECT SUMMARY

Form No. 3

Implementation of the Total Wellness project by San Mateo BHRS will require several phases, assuming that PEI funding becomes available in November 2008:

Pre-Project Development (Dec 08-Jun 09)

- Development of training parameters for the PEI-funded training component of the program
- Develop screening protocols and registry tracking system for use in all BHRS psychiatric medication sites
- Develop priority mechanisms for ensuring consumer access to primary care sites
- Develop a pharmacy assistance program for uninsured consumers to support access to necessary medications for chronic health conditions
- Recruit nurse care managers for the program, with an emphasis on staff who represent the cultures and languages that have been targeted
- Train staff and psychiatric providers in the protocols, registry, and the overall program model
- Develop partnership with College of San Mateo to offer a program for peer health education facilitators, building it as an advanced certification for previously certified peer counselors
- Obtain adapted wellness materials and curriculum for peer training in health education facilitator role (coordinate with Lorig/Stanford and Druss/Emory)
- RFP for community based agency to provide wellness groups and hire peer health education facilitators
- Recruit first class of consumers for advanced certificate program in Chronic Disease Self Management Program

Phase I: Screening and nurse care manager services initiated (Jun 09-Aug 09)

- Implement process for screening, nurse care management and engagement in primary care services
- Negotiate and execute provider contract

Phase II: Chronic Disease Self Management Groups (Jul 09-Oct 09)

- Initiate Chronic Disease Self Management Program groups

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	
PEI-funded training within Total Wellness	Individuals: 17		Two.
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 17 (*)		

(*) This number refers to the number of persons trained through the PEI-funded training component of Total Wellness. However, the trainings will have a considerable multiplier effect, benefiting the numerous individuals served by each person trained. For example, if we were to train primary care professionals, and a primary care provider has, on average, a panel of approximately 1,200 patients, all of those patients stand to benefit from the proposed trainings.

5. Alternate Programs

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

Total Wellness has the same key components as the IMPACT model using promising practices recently reviewed at the SAMHSA Wellness Summit (September 2007) and The National Council for Community Behavioral Healthcare national conference (May 2008).

The HOPEs (Helping Older People with SMI Experience Success) is an NIMH 3 year (randomized controlled trial) study conducted in three sites on the east coast. The model uses Nurse Care Managers working with standard protocols and curriculum to provide the following services

- Intake Assessment
- Health examination
- Medication list
- Vital signs monitoring
- Preventive health care

PEI PROJECT SUMMARY

Form No. 3

- Disease specific goals
- Action plan
- Health care proxy
- Health Education
- Accompany visit to physician with consumer
- Medical information communication
- Monthly (or more frequent) visits

The HARP project (Health and Recovery Peer Project) is an NIMH-funded study (NIMH R34MH078583) to adapt a peer-led medical self-management program for mental health consumers in Atlanta, Georgia. It utilizes proven materials developed by Lorig at Stanford for engaging individuals in managing their chronic health conditions, and has been adapted for use in the mental health setting, with peers serving as the group facilitators. The Georgia Mental Health Consumer Network and Appalachian Consulting Group are building wellness skills into their peer training programs (2)

1. Bartels, S. A Model of Rehabilitation and Health Care for Older Adults with Serious Mental Illness: The HOPES Model, National Council for Community Behavioral Healthcare Conference, 5/08.
2. Druss, B. Addressing the Primary Medical Care of Mental Health Consumers. National Council for Community Behavioral Healthcare Conference, 5/08.

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

The Total Wellness model will be initiated with the goal of helping consumers become connected with primary care services in the community for their ongoing healthcare and with wellness groups offered by a community based organization. People may also be linked with the specialized teams sponsored by San Mateo County's Aging and Adult Services, which are described in detail in the IMPACT proposal.

7. Collaboration and System Enhancements

Collaboration is the point of this project. It will expand on what is already in place in San Mateo County (such as BHRS' Interface, Health Plan of San Mateo's Chronic Care Clinic), through the use of the evidence based models and through engagement of primary care providers who see populations at risk. A potential collaboration would be to work with Schools of Nursing to serve as a placement for BSN or Masters level nursing students, working with the Nurse Care Managers. This will both expand the reach of the Total Wellness program and train new health care professionals in working with individuals with SMI.

An additional collaboration will be with the College of San Mateo, in development of the advanced certificate program for peer health education facilitators.

8. Intended Outcomes for overall Total Wellness program

- Identification of consumers with SMI and chronic health conditions and engagement in primary care and ongoing wellness groups
- Improvement on health status indicators such as blood pressure, weight, smoking, glucose and lipid levels
- Improvement in community functioning
- Improvement in self-efficacy
- Greater acquisition of health care advance directives

Outcomes specific to the PEI-funded component of Total Wellness

- Number of persons trained on issues related to co-morbid conditions.

9. Coordination with Other MSHA Components

The consumers served by the Total Wellness program will be active in BHRS services. It is unlikely that Nurse Care Manager services will be offered to those enrolled in the FSP program, as these intensive services are able to incorporate most aspects of the nurse care manager role. However, the total wellness groups will be open to all consumers in the system, including FSP enrollees.

San Mateo County's Behavioral Health and Recovery Services Division places great value in service coordination as an essential driver for leveraging resources; we also believe in ensuring a seamless service experience for all who interact with our system. The Total Wellness model will be implemented as part of an integrated system. A natural synergy will occur with the IMPACT program. People served through Total Wellness may also be linked with the specialized teams sponsored by San Mateo County's Aging and Adult Services, which are described in detail in the IMPACT proposal. The next item (7 - Collaboration and System Enhancements) offers some additional insights on coordination and interaction with other parts of our system.

In addition, we see opportunity for coordination with other MSHA CSS-funded initiatives such as our Primary Care Interface and our Older Adult System of Care Initiative.

**BHRS is seeking a modest contribution for Total Wellness from PEI funds,
for leverage in pursuing other funding sources to address this critical need.**

PEI PROJECT SUMMARY

Form No. 3

County: San Mateo

PEI Project Name: Stigma Initiative

Date: August 29th, 2008

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

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

2. PEI Priority Population(s) Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
E. 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	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>

PEI PROJECT SUMMARY

Form No. 3

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

This Stigma Initiative was developed with the participation of each of the age cohort workgroups. The workgroups reviewed a BHRS PEI data report that updated analyses prepared during the 2005 CSS planning process. Among the findings in the data were:

- More people of all ages were actually served by BHRS than projected by state prevalence methods when restricted to 200% of poverty.
- More males and fewer females of all ages were served than projected.
- Slightly fewer children/youth were served than projected.
- More TAY and adults were served than projected.
- Significantly more Whites and African Americans of all ages were served than projected.
- Fewer Pacific Islanders, significantly fewer Asians and slightly more Native Americans of all ages were served than projected.
- Fewer Latinos of all ages were served than projected, however in the last two years the number of Latinos served has increased from around 3,000 to almost 4,000.
- Significantly fewer people of all ages were served in their primary language than may need it.

Workgroup members were also briefed on results from the extensive focus groups conducted for CSS in 2005. Key points from CSS planning related to all age groups included

- In relation to accessing care, stigma was identified in **37 of the 50** focus groups as a barrier to care.
- Many felt a sense of **shame** and **isolation** because of their mental health problems.
- Among many unserved communities, including Latino, Filipino, Chinese, Tongan, and African American communities, stigma was an especially strong deterrent to seeking mental health services
- Another barrier to care among unserved communities is lack of knowledge of mental illness, its signs and symptoms, and how to treat it.
- **29 of the 50** Adult focus groups indicated that some **new approach to outreach and community education** could help improve understanding of mental illness and improve access to the mental health system.
- Many suggestions across all age groups focused on the need for **community education** and information (same language, same culture) to demystify mental illness and to help **engage the unserved**.
- 15 of 50 adult focus groups explicitly identified lack of access in specific geographic regions. However, in communities like Coastsides, Pescadero, Pacifica, EPA and Daly City, community forums were quick to identify this as a need.

PEI PROJECT SUMMARY

Form No. 3

- While not an issue for consumers who live near services, clearly for those who live in distant regions with lower levels of services, **geographic access** is a major problem.
- As with other age groups, the **difficulty of penetrating the mental health system** was identified as the single greatest criticism of the system. **Twenty-nine of fifty** adult focus groups discussed access points explicitly and this issue was a major focus of all ethnic/cultural/linguistic group discussions.
- **Cultural competence** was raised as an issue in over half of the adult focus groups and in virtually all focus groups that targeted unserved populations.
- A common concern was that **absence of linguistic capacity** with one provider noting, **“Bilingual services need to be available in the jails.”**
- Many consumers, providers and consumer members mentioned the need for **peer involvement** in services in a wide range of areas.
- Family involvement is key in path to wellness and recovery.
- More adult focus groups referenced the **need for integrated services in natural community settings** than any other issue (44 out of 50).
- The need for **integrated dual diagnosis services** was referenced in almost half of all adult focus groups.
- **Housing** was identified more than any other issue, as being central to consumer quality of life in **35 of 50** adult focus groups.
- **Financial barriers to care** are not limited to the poor. One family member noted that more coverage was needed for **“people in the middle who make too much to qualify for Medi-Cal, but can’t pay for services themselves.”**
- The need for recreation and social activities was identified as central to a good quality of life in exactly half of all adult focus groups.
- In creating a network of community drop in centers, it is important to be aware of **special needs** of individuals with disabilities, individuals from different cultures, and individuals whose sexual orientation is a stigmatizing factor.

The additional relevant information that follows is summarized from a presentation on the BHRS partnership with the East Palo Alto community and their shared learning as recently presented at a statewide meeting: **A Community Partnership: Transforming San Mateo County Mental Health Services**. The East Palo Alto work teaches us that addressing stigma must be done with the full involvement and participation of the community, making it relevant to their strengths and needs.

The intermediary steps included recognition of significant community assets and that it was critical to have a community intermediary representing community leaders and convening community stakeholders. BHRS established funding for this function and contracted with One East Palo Alto; this organization has played a key role in regard to:

PEI PROJECT SUMMARY

Form No. 3

- Legitimizing the effort
- Community capacity
- Network inclusive of faith community
- Strategies, advocacy and systems change
- History
- Multi-cultural—by-laws
- Agenda for Mental Health
- Convened monthly advisory group

Bridging Elements identified as key for this collaboration include:

- Bringing credibility to the mix
 - Importance of leadership participation and demonstrated commitment to the process
 - Importance of collaborative staying the course through a splinter group
- Importance of multi-cultural leadership on both sides
- Defining community of learners and teachers, united in learning about cross-cutting issues
- Identifying shared values
- Importance of focus on language, communication within the group, e.g.
 - Consumer and family member concepts
- Creating a safe space for the collaboration
 - Importance of multi-cultural and consumer and family participation
 - A Retreat as an opportunity to step back
 - Challenge of consumer and family participation and striving for shared power
 - Stigma and shame pose significant barriers
- Momentum and incremental progress—it was important to show results in terms of the process of collaboration
 - Retreat check-in and framework for shared values and investment to lean on
- Progress with multiple initiatives on different fronts
 - Outreach workers through community partners
 - Clinic same day access--welcoming

PEI PROJECT SUMMARY

Form No. 3

- Wellness Center
- Community awareness events and fairs
- Agenda for the collaboration stays relevant to participants and shifts as necessary through give and take
 - Recruited membership for community response team
 - Involving community representatives in leadership for other initiatives
 - Expanded to co-occurring focus

3. PEI Project Description:

There are several components to this initiative regarding stigma, which is designed to form the foundation for a long term effort to focus specific activities within San Mateo County, and not duplicate MHSA statewide initiatives and media campaigns.

- 1) There is a need for ongoing **coordination and oversight of local anti-stigma initiatives**, as well as coordination with state level media and other projects. The creation of an **Anti-Stigma Advisory Council** will provide an ongoing point of focus. Membership would include representatives from different regions and constituencies, as well as providers, consumers, advocates and community leadership.
- 2) The Advisory Council will actively seek and engage external foundation and grant funding to support an ongoing infrastructure for stigma initiatives sponsored by the Council as a key strategy for sustainability.
- 3) Among the PEI projects proposed by San Mateo County, some have a significant outreach and public education component to them (replication of the PIER program for early identification of psychosis, primary care based services, Early Childhood Community Team). The initial work in the community, creating connections with community groups, schools, the healthcare system, and other key partners will be substantial in a county as densely populated and complex as San Mateo, and it requires **substantial investment in community mobilization**, as we have learned in East Palo Alto.

This is a significant challenge when launching several projects at once, creating the risk that the community involvement work will not be well coordinated. The PEI project start up costs that are one time or short term (materials, community mobilization) can be funded as a one time cost, while the ongoing operational costs of the projects themselves would be funded from ongoing PEI resources. Short term community mobilization includes contacting and mobilizing either specific ethnic or geographic communities or large and complex systems (schools and colleges, businesses, healthcare providers), working with BHRS and contracted community based agencies to launch these initiatives.

In addition, the cost of developing and printing local materials for these projects would be funded from this one time allocation. **The materials that are developed need to be language and culture appropriate**, which will require working with community representatives. In addition, there must be **two levels of community materials**—the one most frequently discussed is targeted for older children, youth, adults and older adults and has **recovery and resiliency** as its focus. These materials will not be useful in reaching families with young children—the messages for this population must be focused on **healthy social/emotional development**, parent stress and the need for support (including outreach for

PEI PROJECT SUMMARY

Form No. 3

postpartum depression), and supporting children/families that are challenged or have experienced any overwhelming event. Both types of materials need to be coordinated with the County's health disparities initiative, and the materials for families with young children should be developed in coordination with planned statewide First Five social marketing campaign.

- 4) Participants in the PEI planning process agreed that within schools, health, human services, criminal justice and benefits organizations (social security, health plans), there is **stigma that needs to be addressed through staff development and training**. BHRS has already identified stigma as an issue in its overall MHSA training plan. The intention is to expand access to the planned BHRS training, engaging individuals employed in schools health, human services and benefits agencies throughout the San Mateo community. Related efforts would be to expand current efforts to train police officers in San Mateo County with Crisis Intervention Training (CIT); and that community outreach workers/navigators working in other service systems are provided with training in the behavioral health system and how to connect people to services—development of this training will benefit from the learning in the East Palo Alto community.
- 5) San Mateo County supports anti-stigma programs that provide **trainings and presentations featuring consumers and family members as presenters**. The presenters are paid a small stipend for their work. Funding would be used to recruit more presenters, especially from the ethnic and language communities that are under-served. Funding would also support stipends for additional presentations, some of which might be as part of the training described in above.
- 6) Community Colleges are a resource for reaching young people at the beginning of their career development as well as reaching young leaders from ethnic and language communities. As the initial efforts above are launched, we will seek the opportunity for placement of a **curriculum component that educates individuals about mental health and substance use issues**, the services that are available and how to support friends and family members with a mental health and/or substance use issue.
- 7) Following the successful community building process and launch of PEI projects, the Anti-Stigma Advisory Council could focus on creating **ongoing, local media programs that get out the message to the broader community**. This might take the form of a regular talk show on local TV or radio stations as well as stations that target specific cultural, ethnic and language groups.

Implementation of this program by San Mateo BHRS will require several phases, assuming that PEI funding becomes available in November 2008:

Pre-Project Development (Dec 08-Apr 09)

- Develop coordinated Community Mobilization strategy in collaboration with BHRS leads on age specific PEI projects, to support launching of the projects
- Initiate Anti-Stigma Advisory Council
- Design and implement the anti-stigma training for health, human services, criminal justice and benefits organizations, including presentations from consumers

PEI PROJECT SUMMARY

Form No. 3

- Design and implement the training for community outreach workers/navigators
- Design the detailed project evaluation plan for one PEI project

Phase I: Detailed planning to support projects (Apr 09-Jun 09)

- Collaborate with PEI projects (BHRS staff and community based contractors) to plan for implementation of the program, with a focus on community mobilization and development of targeted materials for community outreach and engagement
- Work with leadership of specific cultural, ethnic and language groups regarding development of appropriate PEI materials and identify consumers representing those communities to make presentations
- Work on appropriate PEI materials for families with young children

Phase II: Education/outreach, assessment and treatment services (Jul 09-ongoing)

- Collaborate with PEI projects to support the implementation of their services, including provision of well designed and appropriate materials
- Coordinate ongoing training for health, human services, criminal justice and benefits organizations
- Coordinate with community colleges regarding anti-stigma curriculum or related initiatives
- Develop newspaper, radio and TV media relationships
- Plan for ongoing focused media coverage that is specific to San Mateo County and aligns with statewide activities

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	
Stigma Initiative	General population: 1,500 Staff/providers: 500	Three.
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	General population: 1,500 Staff/providers: 500	Three.

PEI PROJECT SUMMARY

Form No. 3

5. Alternate Programs

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

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

The linkages will be specific to planning for and implementing PEI projects led by BHRS and community based providers, assuring the community outreach and materials development necessary to support their work, as well as offering widespread training in the community.

7. Collaboration and System Enhancements

The focus of this project is to support extensive collaboration in a complex community with many stakeholders, as outlined in the other BHRS PEI proposals. This work will be integrated into an ongoing BHRS effort to create a larger prevention framework that builds upon the MHSA PEI projects, expanding into larger policy initiatives, including the work by San Mateo County to reduce health disparities. There is an opportunity to develop social marketing through health disparities outreach efforts, especially through the training of community outreach workers/navigators. As noted earlier, there is also the opportunity to collaborate on the development of social marketing materials for families with young children.

8. Intended Outcomes

- Successful launch of PEI initiatives, with community support and appropriate materials
- Ongoing Anti-Stigma Advisory Council
- Extensive training in the community
- Ongoing media connections and processes
- Reduce stigma in the population
- Reduce stigma within staff and providers
- Increase inclusiveness of clients and family members

9. Coordination with Other MHSA Components

As noted in the specific PEI proposals, a small percentage of those served through PEI services may be referred into formal mental health services provided by BHRS. However, most individuals will use community based health and human service supports, and it is not anticipated that there would be significant utilization of the MHSA services. The MHSA Training initiative will be coordinated with the Stigma Reduction work.

PEI PROJECT SUMMARY

Form No. 3

County: San Mateo

PEI Project Name: Youth/Transition Age Youth Identification and Early Referral

Date: August 29th, 2008

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

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project: 1. Disparities in Access to Mental Health Services 2. Psycho-Social Impact of Trauma 3. At-Risk Children, Youth and Young Adult Populations 4. Stigma and Discrimination 5. Suicide Risk	(Ages 12-15) <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	(Ages 16-25) <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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
F. 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	(Ages 12-15) <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	(Ages 16-25) <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

NOTA BENE: As mentioned in our response to a comment received during the public comment period (see APPENDIX D – Form No. 2), based on the overall order of priorities coming from the planning process we are including The “Youth/TAY Identification and Early Referral” project in our proposal, although PEI funds are not available at this time --the proposed projects described up to this point in the proposal add up to the maximum amount of funds available. The inclusion of the “Youth/TAY Identification and Early Referral” project in the present proposal intends to submit the project for approval so that it can be funded in the future if sufficient expansion funds were to become available and priorities remain unchanged.

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 PEI workgroup that focused on ages 6-25 worked in subgroups focused on 6-17 and 18-25. They identified students at risk, youth who are unserved or underserved, and those experiencing early onset of psychotic illnesses among their priority populations. The chair of the PEI planning process, who participated in all age-focused workgroup meetings, is also the co-chair of the Co-Occurring Steering Committee. Many co-occurring change agents participated in the age-focused workgroups, resulting in attention to prevention and early intervention initiatives that would address both mental health and substance abuse conditions.

The workgroup reviewed a BHRS PEI data report that updated analyses prepared during the 2005 CSS planning process. Among the findings in the data were:

All Ages

- More people of all ages were actually served by BHRS than projected by state prevalence methods when restricted to 200% of poverty.
- More males and fewer females of all ages were served than projected.
- Slightly fewer children/youth were served than projected.
- More TAY and adults were served than projected.
- Significantly more Whites and African Americans of all ages were served than projected.
- Fewer Pacific Islanders, significantly fewer Asians and slightly more Native Americans of all ages were served than projected.
- Fewer Latinos of all ages were served than projected, however in the last two years the number of Latinos served has increased from around 3,000 to almost 4,000.
- Significantly fewer people of all ages were served in their primary language than may need it.

Children/Youth/Young Adults

- There were 356 drop-outs in grades 9-12 for the 2005-06 school year. The populations with the highest rate of drop-out are Latinos at 2.3% and African Americans at 2.5%. (Source: California Department of Education Educational Demographics Unit).
- In 2005, there were 890 juvenile felony arrests, 93% of juveniles arrested for felony offenses were ages 13-17. The number of juvenile felony arrests per 1,000 youth ages 10-17, by race/ethnicity were 94.7 percent African American and 16.1 Latino. (Data Source: State of California Department of Justice, California Criminal Justice Profiles.)

PEI PROJECT SUMMARY

Form No. 3

- The National Co-morbidity Survey Replication, reported in the June 2004 issue of Archives of General Psychiatry, focused on studying the prevalence of mental health need in those 18 and above, and found that mental disorders “gain the strongest foothold” by attacking youth—50% of all cases start by age 14 and 75% by age 24.

Workgroup members were also briefed on results from the extensive focus groups conducted for CSS in 2005. Key points from CSS planning related to transition age youth included

- More counselors are needed at schools.
- Transportation support is needed to access services.
- Age-appropriate housing options.
- System perceived as unwelcoming.
- Need for culturally competent services beyond translation of materials.
- Need for an integrated service experience (all systems working together).

Providers, family members and TAY youth stated that what they need is:

- Easy access
- Continuity of care
- Trusting, enduring relationships
- Respect for the individual, family and culture

Empowerment for families and youth to define their goals and have input into their services.

3. PEI Project Description:

In the United States, the **average duration of untreated psychosis is one to three years**--the longer duration the worse the outcome, while the periods before and after the onset of psychosis are a time with great potential for change. If we intervene before onset, during the time of at-risk mental state, the first onset of psychosis can be delayed for many people and may be prevented entirely for some people. At least 80% of individuals can be treated in the community, avoiding the need for hospitalization. This project will be modeled on the **Portland Identification and Early Referral Program (PIER)**, a research program with the mission of reducing the incidence of psychotic illnesses (such as schizophrenia and bipolar disorder) in the Greater Portland, Maine area. The PIER Program is based on earlier studies conducted in the United Kingdom, Australia, United States and Scandinavia that focused on interrupting the very early progression of schizophrenia and other severe psychotic disorders. The goals of these studies were to improve outcomes and prevent the onset of the psychotic phase of these illnesses.

PEI PROJECT SUMMARY

Form No. 3

PIER provides treatment, support and guidance at the very first sign of symptoms in young people between the ages of 12 and 25. Research shows that when the public, educators and health professionals have information about the early warning signs of psychosis, young people who are at risk get help early. Consequently, their chances greatly improve for staying in school, working, maintaining friendships and planning for the future. PIER is comprised of a team of highly trained and well-experienced mental health professionals available to residents of the Greater Portland area to:

- Educate and train the provider community, the school professional work force and other key professionals who encounter young persons in the early stages of deterioration toward psychosis. This effort extends to the education of the entire area population.
- Identify, and help others to identify, young people who are manifesting prodromal (early, pre-illness signs) or active symptoms and signs of schizophrenia and other major psychotic disorders.
- Evaluate individuals' risk for actual psychosis.
- Treat those who are at substantial risk with an empirically-tested package of psychosocial and psychopharmacological interventions.
- Maintain a long-term relationship with individuals and their families to assure the clinical and human support needed to achieve a full secondary prevention effect.

Education comes in a variety of formats: newspaper and movie theater ads; mailings to schools and families; and educational presentations to pediatricians, family practitioners, mental health professionals, educators, school special services staff, graduate students, high school health class students and parent groups.

The PIER Program is staffed by a multidisciplinary team with special training in the area of early identification and treatment of psychosis. Young people who are showing the warning signs of a psychotic illness and their families are offered services once the young person has met criteria for inclusion in the program (the average age of referrals was 15 years old, and males were represented 2 to 1). A typical team configuration may include the following functions: Psychiatrist; Nurse; Occupational Therapist; Case Management/Counselor; Resource Coordinator/Mentor; Supported Employment/Education Specialist; Clinical Coordinator; Program Coordinator; Office Coordinator/Billing Specialist. Examples of tasks performed by the team, are: Psychiatrist – Works with clinical coordinator to treat those who are at substantial risk, with an empirically-tested package of psychosocial and psychopharmacological interventions; Nurse – Is part of outreach and education team for professionals and for the community at large; also assists clients with illness management; Occupational Therapist – Collaborates with assessment and treatment of psychiatric conditions using specific, purposeful activities to prevent disability and promote independent function in all aspects of daily life; Supported Employment/Education Specialist - Supports young people to take important steps toward independence, financial security and self confidence through successful experiences in work and education. (The goal of supported education is to help clients reach their educational goals; tasks include assisting families in navigating their way through the educational system. Services provided through supported employment include providing

PEI PROJECT SUMMARY

Form No. 3

assistance and mentorship regarding résumé creation, job search and interview skill development, connection to resources, etc.). Clinical Coordinator – Coordinates all clinical aspects of treatment with other team members (case manager, psychiatrist; occupational therapist, etc.); Case Management/Counselor - Conducts comprehensive assessments for mental health treatment; provides individual and group counseling; develops and maintains relationships with clients and other to support individuals in attaining services; Program Coordinator – This function leads the community education piece in which other team members also participate; Office Coordinator/Billing Specialist – Manages administrative aspects of the program, including insurance billing.

The experience of the PIER Program demonstrates that it is possible to intervene in and counteract the acute onset of major psychotic disorders. One major change that allows these effects to occur is the advent of clear premorbid indicators for the likely onset of psychosis. The other is the development of highly effective psychosocial and drug treatments that can be tailored and used at dosage levels that do not subject young people and their families to unacceptable risks. This combination of family psychoeducational groups, supported education and employment and pharmacologic treatment, has a powerful effect on mediating the symptoms that place a young person at risk for the onset of psychosis. Early experience is showing that this approach clearly and dramatically reduces morbidity. The departure is not actually in the area of the treatments, which are standard, empirically validated approaches: medication (especially newer atypicals in low doses) and family psychoeducation (modified for use when diagnosis is less clear). The critical feature is the educational outreach by a clinical team to general practitioners and pediatricians, guidance counselors and the population at large to educate and inform about the early signs of psychosis. This project is using state-of-the-art treatments in a new application: secondary prevention of psychosis in vulnerable individuals. For a population base of 330,000, PIER has received 966 referrals over a 5 year period. Of these, 259 (27% of referrals) were screened into the assessment phase, and of these 149 (60% of those screened) met criteria for services.

The PIER model is being adopted for use in California at programs such as PART (Prodrome Assessment Research and Treatment) Program at University of California, San Francisco and EDAPT (Early Diagnosis and Preventive Treatment) at University of California, Davis. San Mateo BHRS would adapt the program to community application without the research component included in the University based replications. An example of a community application is the Early Assessment Support Team or EAST, operated in Oregon in the five counties just south of Portland. The EAST clinical team works with people in four phases:

Phase 1 (up to 6 months): Assessment and stabilization

- Outreach to young person and family
- Get to know the young person and family
- Provide comprehensive assessment
- Complete needed medical tests (as soon as possible!)

PEI PROJECT SUMMARY

Form No. 3

- Begin treatment for identified medical conditions, including psychosis and alcohol/drug dependency where feasible
- Identify strengths, resources, needs and goals
- Begin multi-family group process
- Stabilize the situation: symptoms, economic situation, housing, relationships, school, work, etc.
- Provide support and education to the young person, family, friends and other supporters
- Provide opportunities for peer involvement, physical fitness, etc.
- Assess need for ongoing services from EAST

Phase 2 (approximately 6 months): Adaptation

- Provide more extensive education to the individual and family
- Continue treatment with doctor and counselor
- Address adaptation issues
- Refine and test the relapse plan
- Engage in alcohol and drug treatment if needed
- Continue multi-family group process
- Move forward proactively on living and/or vocational goals
- Identify and establish necessary accommodations as needed at work or school
- Identify and develop stable long-term economic and social support
- Provide opportunities for peer involvement, physical fitness, etc.

Phase 3 (approximately 6 months): Consolidation

- Continue multi-family group, vocation support and individual treatment
- Continue to work toward personal goals
- Develop advanced directive
- Develop long-term plan

Phase 4 (approximately 6 months): Transition

- Maintain contact with EAST doctor and counselor
- Continue multi-family group
- Participate in individual and group opportunities
- Establish ongoing treatment relationship and treatment plan

PEI PROJECT SUMMARY

Form No. 3

Phase 5: Post-graduation

- Continue multi-family group (in some situations)
- Continue with ongoing providers
- Invitation to participate in events and mentoring
- Invitation to participate in EAST Community Network

Implementation of this program by San Mateo BHRS would require several phases, as follows:

Pre-Project Development (5 months)

- Either develop the program internal to BHRS or RFP for community-based agency to operate the program (this may or may not be an agency currently participating in the county mental health program)--a significant requirement will be the ability to outreach into the ethnic and cultural populations that are currently underserved in the system, such as Latino and Asian/Pacific Islander populations
- Staff recruitment for the multidisciplinary team
- Staff training in the evidence based outreach, assessment and treatment approaches proven to be successful

Phase I: Targeted outreach to health and educational professionals (3 months)

- Collaborate with health and education organizations to plan for and deliver the targeted outreach training to staff in these settings (schools, colleges, primary care and pediatric practices, county and community based behavioral health providers)

Phase II: Community education (Month after end of Phase I and ongoing)

- Coordinate with local anti-stigma efforts to plan for and distribute materials specific to the PIER model (in coordination with San Mateo's PEI Anti-Stigma Campaign)

Phase III: Assessment and treatment services (Three months after end of Phase I and ongoing)

- Initiate process for receiving inquiries and conducting assessments of potential program participants—it is assumed that the program will serve youth from throughout the County rather than a specific geographic region, and that it will prioritize services to Latino and Asian/Pacific Islander populations.
- Service planning and delivery for those meeting program criteria (anticipated participation time in the program of 24 months).

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
	Early Intervention	
PIER Replication: Phase I - Outreach and education to health and education professionals	N/A	N/A
PIER Replication: Phase II - Community education	N/A	N/A
PIER Replication: Phase III - Assessment for risk	N/A	N/A
PIER Replication: Phase III - Enrollment in services	N/A	N/A
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	N/A	N/A

5. Alternate Programs

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

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

During the course of participation in the program, individuals will be connected to services identified in their treatment plans. At the point that individuals graduate from the program, they will be connected with ongoing medical and support services. Whenever possible, these services will be in the community rather than in the public mental health system.

7. Collaboration and System Enhancements

This program will require the broad collaboration of the public and private healthcare delivery system: primary care/pediatric providers as well as the 23 San Mateo County school districts and the community colleges. Ideally, Stanford University will also become a partner in the project. The training

of key staff in these organizations in a community with the complexity of San Mateo County will be a significant effort, but will integrate well with our proposed Anti-Stigma Campaign, as well as other PEI initiatives.

As the program develops, it will develop relationships with training programs to afford interns and peer trainees the experience of working within the program.

8. Intended Outcomes

- Reduce/avoid psychotic episodes (PIER has shown that, after one year, 80% of at-risk clients had no psychotic episodes and only 6% developed schizophrenia, compared to other studies in which 40-50% of those at risk, without intervention, had the onset of a psychotic disorder)
- Improve social functioning
- Improve school or work functioning

9. Coordination with Other MHSA Components

EAST has identified the need for transitional housing and is currently developing "EAST Place", a five-unit apartment complex which will provide transitional living for participants age 18 and over in the EAST Program. The MHSA housing initiative may present an opportunity to develop a similar support in San Mateo County, where access to safe and affordable housing can be a barrier to living with stability in the community.

PEI Revenue and Expenditure Budget Worksheets

Form No. 4

County Name: San Mateo

Date: August 29, 2008

PEI Project Name: Early Childhood Community Team

Provider Name (if known):

Intended Provider Category: Mental health treatment/service provider and/or family resource center and or ethnic or cultural organization

Proposed Total Number of Individuals to be served: FY 07-08 _____ FY 08-09 15

Total Number of Individuals currently being served: FY 07-08 _____ FY 08-09 0

Total Number of Individuals to be served through PEI Expansion: FY 07-08 _____ FY 08-09 _____

Months of Operation: FY 07-08 _____ FY 08-09 1

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages: 2 FTE MFT/PSW licensed; 1 FTE Community Worker; 0.25 FTE Services Assistant	\$0	\$221,250	\$221,250
b. Benefits and Taxes @ % 30	\$0	\$66,375	\$66,375
c. Total Personnel Expenditures	\$0	\$287,625	\$287,625
2. Operating Expenditures			
a. Facility Cost	\$0	\$4,000	\$4,000
b. Other Operating Expenses	\$0	\$98,525	\$98,525
c. Total Operating Expenses	\$0	\$102,525	\$102,525
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$0
4. Total Proposed PEI Project Budget	\$0	\$390,150	\$390,150
B. Revenues (list/itemize by fund source)			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$390,150	\$390,150
6. Total In-Kind Contributions		\$11,646	\$11,646

BUDGET NARRATIVE for "EARLY CHILDHOOD COMMUNITY TEAM" PROJECT

A. Expenditures, 1. Personnel

The basis for all salary determinations corresponds to San Mateo County's Job Classification table. The staffing was developed based on the project description and model requirements. The childcare consultant/clinical positions will be filled with 2 FTEs MFT/PSW -licensed, annual salary: \$80,000 each; the outreach/group education function will be filled with 1 FTE Community Worker, annual salary: \$50,000. Also included is a 0.25 FTE direct support function, (professional classification: Services Assistant), minimum necessary to ensure appropriate administrative support for the program, annual salary: \$45,000. The benefits were estimated at 30% of the total. Following County customary practices, the facility cost was estimated at \$2 per square foot (2,000 square feet).

A. Expenditures, 2. Operating Expenditures

While creating the budget worksheets for the Community Services and Supports proposal, we developed a formula to calculate operating expenses, which takes into account all operating costs including supplies, travel (local), equipment, and indirect expenses. In our estimation, operating expenses fall between 20 and 25% of total personnel costs. For this program we estimated operating expenses at 20%. In addition, this line item also includes transportation support for families and childcare providers (\$5,000), staff training (\$6,000), and project evaluation costs (\$30,000) –please see page Form No. 7 for details of the evaluation project. Facility costs were calculated at \$2 per square foot (2,000 square feet) per County's customary facility cost estimation formula.

B. Revenues

We don't expect to draw any additional revenues from other sources, and our in-kind contribution is estimated as a percentage (8%) of a Clinical Services Manager II.

PEI Revenue and Expenditure Budget Worksheets

Form No. 4

County Name: San Mateo

Date: August 29, 2008

PEI Project Name: Community Interventions for School Age and Transition Age Youth

Provider Name (if known): Unknown

Intended Provider Category: Mental health treatment/service provider and/or Youth Center and/or Pre K-12 school and/or other (community-based org.)

Proposed Total Number of Individuals to be served: FY 07-08 _____ FY 08-09 0

Total Number of Individuals currently being served: FY 07-08 _____ FY 08-09 0

Total Number of Individuals to be served through PEI FY 07-08 _____ FY 08-09 _____

Expansion: FY 07-08 _____ FY 08-09 _____

Months of Operation: FY 07-08 _____ FY 08-09 1

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages (For reasons of space we have listed the staffing details in the budget narrative).	\$0	\$336,400	\$336,400
b. Benefits and Taxes @ _____ %	\$0	\$100,920	\$100,920
c. Total Personnel Expenditures	\$0	\$437,320	\$437,320
2. Operating Expenditures			
a. Facility Cost	\$0	\$4,000	\$4,000
b. Other Operating Expenses	\$0	\$142,414	\$142,414
c. Total Operating Expenses	\$0	\$146,414	\$146,414
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$0
4. Total Proposed PEI Project Budget	\$0	\$583,734	\$583,734
B. Revenues (list/itemize by fund source)			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$583,734	\$583,734
6. Total In-Kind Contributions	\$0	\$10,396	\$10,396

BUDGET NARRATIVE for “COMMUNITY INTERVENTIONS FOR YOUTH AND TRANSITION AGE YOUTH” PROJECT

As we explained in the project description, participants in the planning process conceived this project as a set of interventions focusing on school age and transition age youth, reaching out to them in non-traditional settings such as schools and community based agencies, such as substance abuse programs, drop-in centers, youth focused and other organizations operating in communities with a high proportion of underserved populations. While we are proposing three different interventions, we see this as one cohesive project that uses community-based agencies to provide population and group-based interventions to at-risk children and youth 6-25.

A. Expenditures, 1. Personnel

The basis for all salary determinations corresponds to San Mateo County’s Job Classification table. The staffing was developed based on the project description and model requirements.

- Teaching Prosocial Skills staffing: 1 FTE MFT/PSW –licensed (group facilitator), hourly cost \$50; 1 Counselor (group co-facilitator), hourly cost \$24. Target: 30 groups
- Seeking Safety staffing: 1 FTE MFT/PSW –licensed (group facilitator), hourly cost \$50; 1 Counselor (group co-facilitator), hourly cost \$24. Target: 21 groups
- Project SUCCESS staffing: 0.10 FTE Project Supervisor –planning and supervision (annual salary: \$60,000); 1FTE Lead Counselor –direct services (annual salary: \$50,000); and 2 FTE Counselor – direct services (annual salary: \$44,000).

A. Expenditures, 2. Operating Expenditures

While creating the budget worksheets for the Community Services and Supports proposal, we developed a formula to calculate operating expenses, which takes into account all operating costs including supplies, travel (local), equipment, and indirect expenses. In our estimation, operating expenses fall between 20 and 25% of total personnel costs. We estimate operating costs for this project at 20%. In addition, this line item also includes the following:

- Teaching Prosocial Skills: The training component is budgeted at \$18,000, including follow up training for trainers (one of the advantages of TPS is that it has a “train the trainer” component that allows for relatively easy replication); also included are incentives for participating youth estimated at \$120 per 10-week group, for a total of \$3,600 for targeted 30 groups.
- Seeking Safety: \$8,000 for training of facilitators and co-facilitators.
- Project SUCCESS: training costs estimated at \$8,000; included is also the sum of \$17,350 for school-wide activities (called by the practice).

Facility costs were calculated at \$2 per square foot (2,000 square feet) per County’s customary facility cost estimation formula.

B. Revenues

We don’t expect to draw any additional revenues from other sources, and our in-kind contribution is estimated as a percentage (10%) of a Clinical Manager.

PEI Revenue and Expenditure Budget Worksheets

Form No. 4

County Name: San Mateo

Date: August 29, 2008

PEI Project Name: Primary Care/Behavioral Health Integration for Adults and Older Adults

Provider Name (if known): Unknown

Intended Provider Category: Primary health care

Proposed Total Number of Individuals to be served: FY 07-08 0 FY 08-09 120

Total Number of Individuals currently being served: FY 07-08 0 FY 08-09 0

Total Number of Individuals to be served through PEI

Expansion: FY 07-08 _____ FY 08-09 _____

Months of Operation: FY 07-08 _____ FY 08-09 2

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	\$0	\$399,000	\$399,000
	\$0	\$0	\$0
b. Benefits and Taxes @ % 30	\$0	\$119,700	\$119,700
c. Total Personnel Expenditures	\$0	\$518,700	\$518,700
2. Operating Expenditures			
a. Facility Cost	\$0	\$2,000	\$2,000
b. Other Operating Expenses	\$0	\$117,740	\$117,740
c. Total Operating Expenses	\$0	\$119,740	\$119,740
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$0
4. Total Proposed PEI Project Budget	\$0	\$638,440	\$638,440
B. Revenues (list/itemize by fund source)			
MediCal and insurance billing	\$0	\$145,194	\$145,194
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
1. Total Revenue	\$0	\$145,194	\$145,194
5. Total Funding Requested for PEI Project	\$0	\$493,246	\$493,246
6. Total In-Kind Contributions		\$12,995	\$12,995

BUDGET NARRATIVE for "PRIMARY CARE/BEHAVIORAL HEALTH INTEGRATION" PROJECT

Budget assumptions: Each primary care provider has a panel of approximately 1,200 patients, about 20% of which will have some level of mental health need during the year. Our initial target is 15 to 18 primary care providers.

A. Expenditures, 1. Personnel

The basis for all salary determinations corresponds to San Mateo County's Job Classification table. The staffing was developed based on the project description and model requirements. The model calls for 0.20 FTE Psychiatrist (annual salary: \$155,000); 4FTE PSW –licensed (annual salary \$80,000 each); and 1FTE Services Assistant II (for direct support, annual salary: \$48,000).

A. Expenditures, 2. Operating Expenditures

While creating the budget worksheets for the Community Services and Supports proposal, we developed a formula to calculate operating expenses, which takes into account all operating costs including supplies, travel (local), equipment, and indirect expenses. In our estimation, operating expenses fall between 20 and 25% of total personnel costs. We estimate operating costs for this project at 20%. In addition, this line item also includes \$14,000 for training costs.

Facility costs were calculated at \$2 per square foot (1,000 square feet) per County's customary facility cost estimation formula.

B. Revenues

We expect to draw \$145,194 in revenues from Medical and insurance billing, and our in-kind contribution is estimated as a percentage (10%) of a Clinical Manager.

PEI Revenue and Expenditure Budget Worksheets

Form No. 4

County Name: San Mateo

Date: August 29, 2008

PEI Project Name: Total Wellness for Adults and Older Adults

Provider Name (if known): Mental health treatment/service provider and/or County Agency

Intended Provider Category: Unknown

only): FY 07-08 _____ FY 08-09 17

Total Number of Individuals currently being served: FY 07-08 _____ FY 08-09 0

Total Number of Individuals to be served through PEI Expansion: FY 07-08 _____ FY 08-09 17

Months of Operation: FY 07-08 _____ FY 08-09 2

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages: Nurse Care Manager (6 FTE); Peer educators (6.75 FTE); Services Assistant II (0.75 FTE)	\$0	\$879,750	\$879,750
b. Benefits and Taxes @ 30 %	\$0	\$263,925	\$263,925
c. Total Personnel Expenditures	\$0	\$1,143,675	\$1,143,675
2. Operating Expenditures			
a. Facility Cost	\$0	\$2,000	\$2,000
b. Other Operating Expenses	\$0	\$270,919	\$270,919
c. Operating Expenses for PEI-funded training only	\$0	\$5,000	\$5,000
d. Total Operating Expenses	\$0	\$277,919	\$277,919
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
PEI-funded trainer(s)' fee	\$0	\$14,000	\$14,000
Web-based training application	\$0	\$11,000	\$11,000
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$25,000	\$25,000
4. Total Proposed Budget	\$0	\$1,446,594	\$1,446,594
B. Revenues (list/itemize by fund source)			
Medi-Cal and insurance billing	\$0	\$288,919	\$288,919
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
1. Total Revenue	\$0	\$288,919	\$288,919
5. Total Funding Requested for PEI Project	\$0	\$30,000	\$30,000
6. Total In-Kind Contributions		\$6,498	\$6,498

BUDGET NARRATIVE for "TOTAL WELLNESS" PROJECT

Budget assumptions:

- Approximately 3,000 individuals who receive BHRS mental health services receive medication services. 30% (900) will need nurse care manager services for varying lengths of time. Nurse Care Manager ratio: 1:50-75.
- Final mix of Nurse Care Managers/Licensed Practical Nurses to be determined.
- All individuals using nurse care manager services will also participate in Total Wellness groups. Total Wellness groups are for 6 sessions, each for 2.5 hours or a total of 15 hours.
- Peer educators spend 1,000 hours per year in groups, per FTE.

A. Expenditures, 1. Personnel

The basis for all salary determinations corresponds to San Mateo County's Job Classification table. The staffing was developed based on the project description and model structure. Staffing: 6 FTE Nurse Care Managers (annual salary: \$90,000); 6.75 FTE Peer Educators (annual salary: \$45,000); 0.75 FTE Services Assistant II (annual salary: \$48,000).

A. Expenditures, 2. Operating Expenditures

While creating the budget worksheets for the Community Services and Supports proposal, we developed a formula to calculate operating expenses, which takes into account all operating costs including supplies, travel (local), equipment, and indirect expenses. In our estimation, operating expenses fall between 20 and 25% of total personnel costs. We estimate operating costs for this project at 25%. In addition, this line item also includes \$15,000 for training costs.

The amounts for the PEI-funded trainings are calculated on the basis of 4 trainings per year. The cost per training includes: \$3,500 for trainer(s)' fee (both, preparation and training delivery as well as expenses); \$1,250 for all other costs associated with each training session (training materials, venue, etc.). In addition, \$11,000 will be used to develop a web-based application that will serve two purposes: provide online training on co-morbidity issues and become a web-based clearinghouse on the topic.

Facility costs were calculated at \$2 per square foot (1,000 square feet) per County's customary facility cost estimation formula.

B. Revenues

We expect to draw \$285,919 in revenues from Medical and insurance billing, and our in-kind contribution is estimated as a percentage (5%) of a Clinical Manager. BHRS is seeking a modest contribution from PEI funds in the amount of \$30,000; in contrast, the amount to be developed with community partners/foundations is \$1,127,675.

PEI Revenue and Expenditure Budget Worksheets

Form No. 4

County Name: San Mateo Date: August 29, 2008
 PEI Project Name: Stigma Initiative
 Provider Name (if known): Unknown
 Intended Provider Category: Other (community based organization)
 Proposed Total Number of Individuals to be served: FY 07-08 _____ FY 08-09 2000
 Total Number of Individuals currently being served: FY 07-08 _____ FY 08-09 _____
 Total Number of Individuals to be served through PEI Expansion: FY 07-08 _____ FY 08-09 _____
 Months of Operation: FY 07-08 _____ FY 08-09 3

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages (Community Workers)	\$0	\$180,000	\$180,000
	\$0	\$0	\$0
b. Benefits and Taxes @ % 30	\$0	\$54,000	\$54,000
c. Total Personnel Expenditures	\$0	\$234,000	\$234,000
2. Operating Expenditures			
a. Facility Cost	\$0	\$2,400	\$2,400
b. Other Operating Expenses	\$0	\$236,800	\$236,800
c. Total Operating Expenses	\$0	\$239,200	\$239,200
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$0
4. Total Proposed PEI Project Budget	\$0	\$473,200	\$473,200
B. Revenues (list/itemize by fund source)			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$473,200	\$473,200
6. Total In-Kind Contributions	\$0	\$6,675	\$6,675

BUDGET NARRATIVE for "STIGMA INITIATIVE" PROJECT

As was explained in the project description, this initiative was conceived as a multifaceted project that has several components designed to form the foundation for a long term effort to focus specific activities within San Mateo County, and not duplicate MHSa statewide initiatives and media campaigns. These components involve an ambitious community mobilization, outreach and public education effort; anti-stigma advisory council; culture, language, age-appropriate materials for PEI projects; anti-stigma training for county and provider staff; consumer/family member presentations, Community College initiative (please see project description for details of each component).

A. Expenditures, 1. Personnel

The basis for all salary determinations corresponds to San Mateo County's Job Classification table. The staffing was developed based on the project description. Staffing: Community Worker (3.6 FTE). Benefits calculated at 30% of total staffing costs.

A. Expenditures, 2. Operating Expenditures

While creating the budget worksheets for the Community Services and Supports proposal, we developed a formula to calculate operating expenses, which takes into account all operating costs including supplies, travel (local), equipment, and indirect expenses. In our estimation, operating expenses fall between 20 and 25% of total personnel costs. We estimate operating costs for this project at 20%. In addition, this line item also includes \$5,000 for the creation and initial support of the anti-stigma advisory council; culture, language, age-appropriate materials for PEI projects (\$30,000); anti-stigma training for county and provider staff; consumer-led presentations (\$50,000); Community College initiative (\$20,000).

Facility costs were calculated at \$2 per square foot (1,200 square feet) per County's customary facility cost estimation formula.

B. Revenues

We plan on seeking funding support from community partners and foundations to make this effort sustainable.

PEI Revenue and Expenditure Budget Worksheets

Form No. 4

County Name: San Mateo

Date: August 29, 2008

PEI Project Name: Youth/Transition Age Youth Identification and Early Referral

Provider Name (if known): Unknown

Intended Provider Category: Mental health treatment/service provider

Proposed Total Number of Individuals to be served: FY 07-08 _____ FY 08-09 0

Total Number of Individuals currently being served: FY 07-08 _____ FY 08-09 0

Total Number of Individuals to be served through PEI Expansion: FY 07-08 _____ FY 08-09 _____

Months of Operation: FY 07-08 _____ FY 08-09 0

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages: (For reasons of space, positions are listed in the budget narrative for this project.)	\$0	\$908,750	\$908,750
b. Benefits and Taxes @ _____ % 30	\$0	\$272,625	\$272,625
c. Total Personnel Expenditures	\$0	\$1,181,375	\$1,181,375
2. Operating Expenditures			
a. Facility Cost	\$0	\$2,000	\$2,000
b. Other Operating Expenses	\$0	\$319,344	\$319,344
c. Total Operating Expenses	\$0	\$321,344	\$321,344
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$0
4. Total Proposed Budget	\$0	\$1,502,719	\$1,502,719
B. Revenues (list/itemize by fund source)			
Medi-Call billing		\$445,000	\$445,000
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
1. Total Revenue	\$0	\$445,000	\$445,000
5. Total Funding Requested for PEI Project	\$0	\$1,057,719	\$1,057,719
6. Total In-Kind Contributions		\$18,277	\$18,277

BUDGET NARRATIVE for "IDENTIFICATION AND EARLY REFERRAL" PROJECT

As was already explained, based on the overall order of priorities coming from the planning process we are including The "Youth/TAY Identification and Early Referral" project in our proposal, although PEI funds are not available at this time. The inclusion of the "Youth/TAY Identification and Early Referral" project in the present proposal intends to submit the project for approval so that it can be funded in the future if sufficient expansion funds were to become available and priorities remain unchanged.

A. Expenditures, 1. Personnel

The basis for all salary determinations corresponds to San Mateo County's Job Classification table. The staffing was developed based on the project description and model requirements. Please see following table for detail:

Personnel⁹	Total # FTEs	Annual Salary	Salary
Psychiatrist	0.75	\$155,000	\$116,250
Nurse	1	\$90,000	\$90,000
Occupational Therapist	1	\$80,000	\$80,000
Case Management/Counselor	4.5	\$65,000	\$292,500
Resource Coordinator/Mentor	1	\$45,000	\$45,000
Supported Employment/Education Specialist	1	\$80,000	\$80,000
Clinical Coordinator	1	\$80,000	\$80,000
Program Coordinator	1	\$80,000	\$80,000
Office Coordinator/Billing	1	\$45,000	\$45,000
TOTALS	12.25	-	\$908,750

Benefits calculated at 30% of total staffing costs, totaling 1,181,375.

A. Expenditures, 2. Operating Expenditures

While creating the budget worksheets for the Community Services and Supports proposal, we developed a formula to calculate operating expenses, which takes into account all operating costs including supplies, travel (local), equipment, and indirect expenses. In our estimation, operating expenses fall between 20 and 25% of total personnel costs. We estimate operating costs for this project at 25%. In addition, this line item also includes \$24,000 for staff training.

Facility costs were calculated at \$2 per square foot (1,000 square feet) per County's customary facility cost estimation formula.

B. Revenues

We expect to draw \$445,000 in revenues from Medical and insurance billing.

⁹ For examples of tasks performed by each one of the positions in this category please refer to the last paragraph of page #89 (continued on page #90).

PEI Administration Budget Worksheet

Form No. 5

County: San Mateo

Date: August 29th, 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				\$0	\$0
b. PEI Support Staff (Office Specialist)		0.5		\$24,876	\$24,876
c. Other Personnel (list all classifications)				\$0	\$0
Director of Alcohol and Other Drug Services, BHRS		0.1		\$14,500	\$14,500
_____				\$0	\$0
_____				\$0	\$0
d. Employee Benefits				\$15,404	\$15,404
e. Total Personnel Expenditures			\$0	\$54,780	\$54,780
2. Operating Expenditures					
a. Facility Costs				\$2,000	\$2,000
b. Other Operating Expenditures				\$30,956	\$30,956
c. Total Operating Expenditures			\$0	\$32,956	\$32,956
3. County Allocated Administration					
a. Total County Administration Cost			\$0	\$13,160	\$13,160
4. Total PEI Funding Request for County Administration Budget			\$0	\$100,896	\$100,896
B. Revenue					
1 Total Revenue			\$0	\$0	\$0
C. Total Funding Requirements			\$0	\$100,896	\$100,896
D. Total In-Kind Contributions			\$0	\$20,024	\$20,024

BUDGET NARRATIVE for PEI Administration

A. Expenditures, 1. Personnel

The basis for all salary determinations corresponds to San Mateo County's Job Classification table. Staffing: Director of Alcohol and Other Drug Services -Behavioral Health and Recovery Services Division (0.10 FTE, annual salary: \$145,000); Office Specialist for administrative support function (0.5 FTE, annual salary: \$49,752).

The Director of Alcohol and Other Drug Services oversees all aspects of BHRS' AOD operation –which has a significant prevention component. In addition, the Director is a key member of the PEI Core Planning Design Team, the MHSA Implementation Group, a senior manager within the BHRS Division, and the leader of the BHRS prevention framework development currently underway. All these considerations were taken into account when including a portion of this position's salary in the PEI Administration Budget.

A. Expenditures, 2. Operating Expenditures

While creating the budget worksheets for the Community Services and Supports proposal, we developed a formula to calculate operating expenses, which takes into account all operating costs including supplies, travel (local), equipment, and indirect expenses. In our estimation, operating expenses fall between 20 and 25% of total personnel costs. We estimate operating costs for this project at 20%. In addition, this line item also includes \$2,000 for the provision of stipends for clients and family members to participate in the RFP writing process, and \$18,000 for consulting services (RFP writing).

Facility costs were calculated at \$2 per square foot (1,000 square feet) per County's customary facility cost estimation formula.

A. Expenditures, 3. County Allocated Administration

Calculated as a 15% of salaries and operating expenditures, this amount includes centralized accounting and other administration costs.

D. Total In-Kind Contributions

We plan on seeking funding support from community partners and foundations to make this effort sustainable.

PREVENTION AND EARLY INTERVENTION BUDGET SUMMARY

Form No. 6

County:	San Mateo
Date:	August 29, 2008

#	List each PEI Project	Fiscal Year			Funds Requested by Age Group			
		FY 07/08	FY 08/09	TOTAL	Children, Youth and their Families	Transition Age Youth	Adults	Older Adults
1	Early Childhood Community Team	0	\$390,150	\$390,150	\$390,150	0	0	0
2	Community Interventions for School-Age and Transition Age Youth	0	\$583,734	\$583,734	\$451,427	\$132,307	0	0
3	Primary Care/Behavioral Health Integration for Adults and Older Adults	0	\$493,246	\$493,246	0	\$98,649	\$251,555	\$143,042
4	Total Wellness	0	\$30,000	\$30,000	0	\$6,000	\$15,300	\$8,700
5	Stigma Initiative	0	\$473,200	\$473,200	\$118,300	\$118,300	\$118,300	\$118,300
6	Identification and Early Referral	0	0	0	0	0	0	0
		0	0	0	0	0	0	0
		0	0	0	0	0	0	0
	Administration	0	\$100,896	\$100,896	\$25,224	\$25,224	\$25,224	\$25,224
		0	0	0	0	0	0	0
Total PEI Funds Requested:		0	\$2,071,226	\$2,071,226	\$985,101	\$380,480	\$410,379	\$295,266

- A recent study by the San Mateo Medical Center (SMMC) with demographic information of 47,409 clients served in primary care settings indicated the following age breakdown: 60 and above = 13%; 30 to 59 years old = 33%; 18 to 29 years old = 19%; 18 and under = 35%. We have estimated that programs #3 and #4 above would follow a similar breakdown, although this varies from practice to practice therefore should not be considered a hard indicator but an informed estimate.
- For program #5 as well as for Administration we have allocated an even amount to each age group.

LOCAL EVALUATION OF A PEI PROJECT

Form No. 7

County: San Mateo

Date: August 22nd, 2008

PEI Project Name: Early Childhood Community Team

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

Upon thorough consideration, the Early Childhood Community Team PEI project has been selected as the project to be evaluated by San Mateo County.

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

This project is focused on the healthy social emotional development of children 0-5. It was selected because:

- It has been **developed in partnership** with many of the organizations in San Mateo County that focus on Early Childhood issues.
- It is testing a specific model of a community based team comprised of a **community outreach worker**, an **early childhood mental health consultant**, and a **licensed clinician**.
- BHRS PEI funding will support at least one team; if additional partnership funding for community outreach worker(s) can be developed, there might be two teams, and **if the model is demonstrated as successful, other funding sources might support replication** with additional teams serving additional communities.
- Each team would be targeted to serve a **specific geographic community** within San Mateo County, in order to build close networking relationships with local community partners also available to support young families.

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

Person/family-level outcomes

- Increased knowledge, skills and competence among early childhood caregivers regarding how to support healthy social emotional development
- Increased knowledge and confidence among families with very young children regarding how to support healthy social emotional development
- Early identification of families that require more assistance and support, with documented connections to additional services

Program/system-level outcomes

- Improved coordination among countywide agencies and local community based services in the selected community, as demonstrated by development of a local Early Childhood Mental Health Collaborative.

LOCAL EVALUATION OF A PEI PROJECT

Form No. 7

3. Describe the numbers and demographics of individuals participating in this intervention. Indicate the proposed number of individuals under each priority population to be served by race, ethnicity and age groups.

PERSONS TO RECEIVE INTERVENTION

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/DISCRIMINATION
<u>ETHNICITY/CULTURE</u>							
African American	Subset of 180		Subset of 180	Subset of 180			
Asian Pacific Islander	Subset of 180		Subset of 180	Subset of 180			
Latino	Subset of 180		Subset of 180	Subset of 180			
Native American							
Caucasian							
Other (Indicate if possible)							
<u>AGE GROUPS</u>							
Children & Youth (0-17)	Subset of 180		180	Subset of 180			
Transition Age Youth (16-25)							
Adult (18-59)							
Older Adult (>60)							
TOTAL	Subset of 180		180	Subset of 180			

Total PEI project estimated *unduplicated* count of individuals to be served: 180 for 12 months
 Calculated as average family size of 3 x 60 children. Ethnicity will depend on the community selected for the team(s). Based on caseload size for community worker. The early childhood MH consultant and the clinician will mostly see families identified by the community worker.

LOCAL EVALUATION OF A PEI PROJECT

Form No. 7

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

Person/family-level outcomes

- Increased knowledge, skills and competence among early childhood caregivers regarding how to support healthy social emotional development.

Measure	Tool	When Used	Frequency
Knowledge and confidence regarding healthy social emotional development	Tool based on Arnett Global Rating Scale, used for case consultations	Pre and post consultation	Every case consultation
Satisfaction with consultation in child care setting	Early Childhood Mental Health Services Project Child Care Provider Response Questionnaire (adapted)	With every child care provider who receives consultation	Annually
Demographics of teachers/families served	Tracking log	For every contact with child care providers by early childhood consultant	Each contact (with ability to provide unduplicated count)

- Increased knowledge and confidence among families with very young children regarding how to support healthy social emotional development

Measure	Tool	When Used	Frequency
Knowledge and confidence regarding healthy social emotional development	Survey related to Touchpoints or other group curricula content	Pre and post parent group sessions	Will depend on tools selected
Satisfaction with consultation in child care setting	Early Childhood Mental Health Services Project Parent's Response Questionnaire (adapted)	With every family that receives consultation in the child care setting	Every case consultation
Postpartum depression	PHQ-9	At intake with clinician and each subsequent contact, if depressed	Each subsequent contact, if depressed
Trauma exposure	Lieberman Child-Parent Psychotherapy tools	At intake with clinician and as recommended	At intake and as recommended

LOCAL EVALUATION OF A PEI PROJECT

Form No. 7

- Early identification of families that require more assistance and support, with documented connections to additional services

Measure	Tool	When Used	Frequency
Identification of families needing additional supports	Tracking log for community outreach worker	For each new family contacted	Daily
Referrals for services	Tracking log for community outreach worker, child care consultant, clinician	For every referral made to community supports, by type of referral	Daily
Direct services	Tracking log for community outreach worker, child care consultant, clinician	For every group conducted, consultation provided, clinical service provided	Daily
Local collaboration	Tracking log for community outreach worker, child care consultant, clinician	For related community planning meetings focused on a specific family/child	Daily

Program/system-level outcomes

- Improved coordination among countywide agencies and local community based services in the selected community, as demonstrated by development of a local Early Childhood Mental Health Collaborative.

Measure	Tool	When Used	Frequency
Project support	Documented shared financing for team positions	Budget tracking	Annually
Local collaboration	Tracking log for community outreach worker, child care consultant, clinician	For regular meetings of local collaborative as well as related community planning meetings not focused on a specific family/child	Daily

5. How will data be collected and analyzed?

The members of the community team will be employees of community based agencies that are successful in response to a RFP. The requirements for tracking logs and use of tools as outlined above will be part of the contractual responsibilities of the agencies.

BHRS will contract for an external evaluation and will convene agency and community representatives early in the planning process to develop a detailed evaluation work plan with timelines. This group will be responsible for final selection of the tools to be used, the key elements of the tracking log, and the timetable for submission of documentation.

The evaluator will be responsible for collecting and analyzing the information and developing an interim (6 month) report and a final report (after 12 months of a fully implemented program).

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

The initial BHRS PEI team site will be targeted to serve a community with a high proportion of Latino and/or isolated farm worker families or a community experiencing a high degree of interpersonal violence, which has significant impact on families and young children. A requirement of the RFP will be the ability to outreach into the ethnic and cultural populations that are currently underserved in the system, such as Latino and Asian/Pacific Islander populations. Staff recruitment for the team members will be for individuals who have the language and cultural capacity to provide culturally competent services in the community that is selected.

The evaluation planning team described above will include representation from the community, to assure their engagement in and support for the evaluation process.

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

The community team will be using a combination of models, including models for mental health consultation in child care settings, the Child-Parent Psychotherapy intervention model, and application of the PHQ-9 for tracking the depression status of postpartum mothers. The RFP and contracts will spell out the details regarding fidelity to the models used.

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

BHRS will utilize the local collaborative as well as the countywide Early Childhood Mental Health Collaborative as a main dissemination site. In addition, key stakeholders in the selected communities, some already involved in the evaluation team, will be invited to review and comment on the evaluation and the implications for next steps in their community and countywide.