

Enclosure 3

**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: County of San Bernardino	Date:
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COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):

County Mental Health Director	Project Lead
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AUTHORIZING SIGNATURE

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

Signature _____

County Mental Health Director

Date

Executed at _____, California

County of San Bernardino, Department of Behavioral Health Mental Health Services Act Prevention and Early Intervention Plan Executive Summary

I. Introduction

The emerging view regarding how public agencies should respond to community issues is changing. In the past, government agencies have been responsible for developing services, describing how the services should operate, and defining who should receive services. This approach was not always effective in meeting the needs of individuals, families or the communities in which they live. Through the Mental Health Services Act (MHSA), government agencies now have the responsibility to ensure that the community has input and is involved in the development and implementation of programs at every step of the process.

The County of San Bernardino, Department of Behavioral Health and their stakeholder committee have determined that the plan for MHSA Prevention and Early Intervention (PEI) and the projects proposed to implement the plan are designed to meet: 1) the priorities identified by local community stakeholders, 2) the key community health needs and priority populations outlined in the MHSA PEI guidelines, and 3) the need to develop a transformational system that recognized Prevention and Early Intervention as the cornerstone to building a comprehensive, community-responsive, recovery focused system of care.

II. Background

In November 2004, California voters passed Proposition 63, which imposed a 1% tax on adjusted annual income over \$1,000,000 to adopt the Mental Health Services Act (MHSA) (effective January 1, 2005). According to the MHSA, the intent of the funding is “to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness...” In addition, local mental health delivery systems have been charged to “create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with serious mental illness and resilience for children and youth with serious emotional disorders and their families.” The MHSA identifies five primary program components for funding that work to transform the mental health services system and that will eventually be integrated into the counties’ Three-Year Program and Expenditures Plan. The components include:

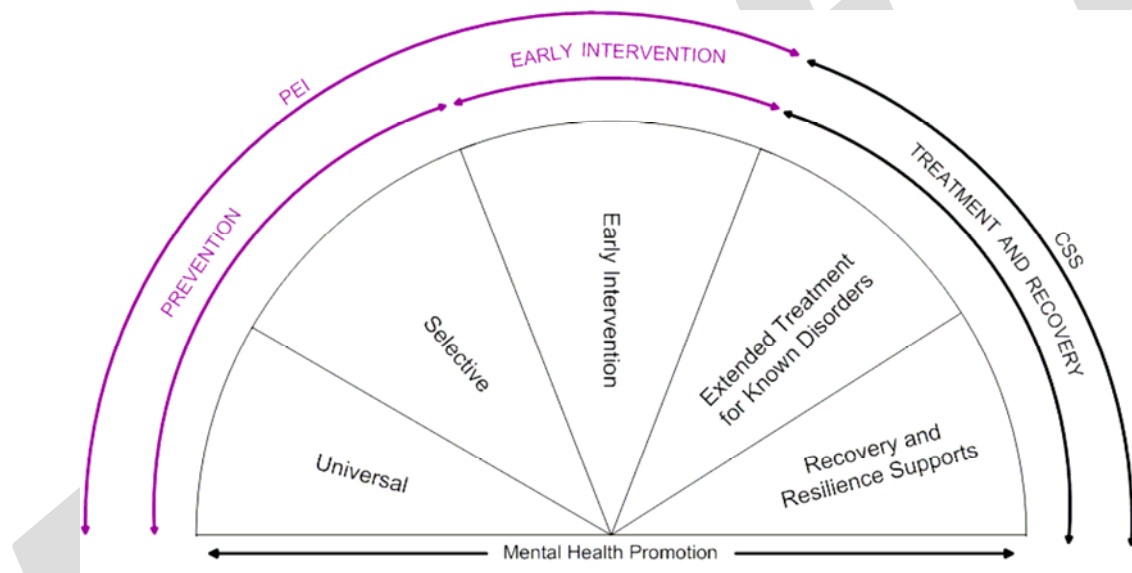
- Community Services and Supports
- Capital (buildings and housing) and Information Technology
- Workforce Education and Training
- Prevention and Early Intervention
- Innovation

Per the MHSA, each component must be developed per an intensive Community Planning Process (CPP) that utilizes the expertise of the community and involves

key stakeholders. In alignment with the Mental Health Services Act (MHSA) Transformational Framework, County of San Bernardino Department of Behavioral Health (DBH) has embraced the transformational concepts inherent to the MHSA to develop a community-driven, culturally competent, wellness focused Prevention and Early Intervention (PEI) Plan that targets individuals and families, with special attention to underserved communities.

III. Defining Prevention and Early Intervention per the MHSA

While prevention and early intervention can occur across the entire mental health intervention spectrum, the purpose of the PEI component of MHSA is to design programs at the early end of the spectrum. Prevention programs and services should fall within the Institute of Medicine’s definition of Universal and Selective (occurring prior to diagnosis), while the Early Intervention component fits the IOM’s definition of Indicated (for MHSA purposes, the operational definition is Early Intervention).



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

California Department of Mental Health describes **Prevention** programs in mental health as “*reducing risk factors and stressors, building protective factors and skills and increasing support. Prevention promotes positive cognitive, social and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances*”. Prevention interventions according to the target groups described by IOM include:

Universal: Interventions or strategies used to target an entire population group, an entire community, or the general public that has not been identified as having

a higher risk (Examples: implementation of projects that target an entire school or training gatekeepers on warning signs of suicide and how to intervene).

Selective: Interventions or strategies targeted to individuals or a subgroup with defined risk factors for the development of mental illness (Examples: targeting children of substance abusers for intervention or youth identified as truant).

Prevention activities are not generally time limited and often share costs.

Early Intervention activities are directed toward individuals and families “for whom a short-duration (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation.” These are of a relatively low intensity, a short duration, and support well-being in major life domains to avoid the need for extensive mental health services.

PEI as a whole works to include program participants and their families in planning, implementing, and evaluating of PEI programs. Programs are implemented in collaboration with other systems or organizations and delivered in natural community settings. All programs link individuals in need of additional services to appropriate mental health agencies, primary care providers, grassroots organizations, or local agencies for additional services as necessary.

IV. The Prevention and Early Intervention Framework

The State Department of Mental Health, in their instructions, proposed a PEI framework in which counties would build their PEI system. Five Key Community Mental Health Needs and six Priority Populations were identified along with a requirement that 51% of the PEI funding be allocated to projects targeting children and transitional-aged youth (TAY). (See table 1 below).

PEI Community Mental Health Needs	PEI Priority Populations
Disparities in access to mental health	Underserved cultural populations
Psycho social impact of trauma	Individuals experiencing onset of serious psychiatric illness
At-risk children, youth, and young adult populations	Children/youth in stressed families
Stigma and discrimination	Trauma-exposed
Suicide risk	Children/youth at risk of school failure
	Children/youth at-risk of or experiencing juvenile justice involvement

In addition, an exception for individuals experiencing at risk mental state (ARMS) or first onset of a serious psychiatric illness with psychotic features was developed. This exception allows use of PEI funding and waives the standards of

low intensity and short duration under these circumstances to allow individuals to receive transformational interventions.

V. Community Planning Process

Engagement of key stakeholders at the community level is critical to the success of implementing community-supported, sustainable mental health Prevention and Early Intervention strategies and activities. In order to ensure that this critical piece was attended to, and in alignment with the MHSA, DBH included community stakeholders to conduct an open process for the development of the PEI system from the beginning.

With nearly two million residents in a diverse landscape made up of urban centers, numerous suburban areas, rural mountain and desert regions, and remote communities, the greatest challenges that faced DBH and its partners in the development of the plan, was 1) determining how to design Prevention and Early Intervention services and resources in a meaningful way to protect those who need it most, 2) ensuring that un/underserved communities had equal voice in the development of the plan, and 3) capturing the stakeholder priorities so they would be appropriately reflected in the plan and delivery of services.

Building on lessons learned from the MHSA Community Services and Supports (CSS) planning process, efforts to target un/underserved communities were conducted. The DBH and its' partners, conducted several targeted forums in each region of the county, developed cultural coalitions, and received 1,792 responses to a community survey in effort to answer and prioritize the key PEI questions outlined below:

- How to address the needs of children and youth in stressed families?
- What kinds of trauma affect individuals and communities?
- How to help schools and families address behavioral health issues that place children at risk of school failure?
- What PEI methods should be utilized for children/youth at risk of juvenile justice involvement?
- How to strengthen efforts to deliver services to un-served and underserved cultural populations?
- How communities can help families respond to early signs of mental illness?
- Identifying suicide prevention activities that would be helpful to communities.

Stakeholders identified priorities/strategies by indicating that:

- 46% wanted help before a crisis occurred
- 50% wanted assistance for drug related trauma affecting their communities
- 49% requested consultation and training for teachers

- 45% indicated a need to train school teachers for early signs of mental health illness
- 44% suggested offering services where cultural groups meet, and
- 43% prioritized offering education about the family's role in the clients' recovery.

With community priorities in hand, along with extensive demographic, treatment, and community indicator data, DBH stakeholders embarked on the extensive process of developing concepts to be included in the PEI Plan. Four Age specific Work Groups and subcommittees had been developed during the MHSA CSS planning process which allowed DBH to build on existing resources while increasing the capacity of the community around PEI principles and concepts.

The age specific subcommittees developed a total of 37 concepts that could be utilized in the development of the plan. A smaller committee comprised of Work Group Chairs (DBH staff) and Leaders (CBO and other County agencies), peer and family advocates, a parent advocate, fiscal and evaluation staff, and a representative from the DBH's Substance Abuse Prevention unit reviewed all 37 concepts, combining and strengthening similar ideas. This process led to the development of three broad categories or initiatives to further focus the system and develop the plan. School-Based Initiatives, Community-Based Initiatives, and System Enhancement Initiatives were developed to assist in framing where and how services would be delivered. The breakdown of each initiative, in terms of allocation of funding is as follows:

Initiative	% of Budget	# of Projects	Estimated # Served Ind./Fam.
School-Based	18.8%	3	50,887/6,905
Community-Based	45.7%	4	10,390/10,250
System Enhancement	35.5%	5	6,548/1,737
Total	100%	12	67,825/18,892

Broader Initiatives and target populations were determined, along with ideas for strategies that reflected key community mental health needs, corresponding Goals and Objectives, and key considerations to be included in the Request for Proposals (RFP), were developed.

**PEI Mental Health Needs and
Priority Population Compliance Matrix**

Major Initiatives	PEI Key Community Mental Health Needs					PEI Priority Populations					
	Disparity in Access	Psycho-soc Trauma	At-Risk C,Y & Young Adult	Stigma & Discrim.	Suicide Risk	Underserved Cultural Pop.	First break	C/Y Stressed Families	Trauma Exposed	C/Y at-risk of School Failure	C/Y risk of Juv. Just.
School-Based	/	/	/	/	/	/	/	/	/	/	/
Community Based	/	/	/	/	/	/	/	/	/	/	/
Systems Enhancement Projects	/	/	/	/	/	/	/	/	/	/	/

VII. Prevention and Early Intervention (PEI) Initiatives and Strategies

The County’s MHSA Prevention and Early Intervention Plan contains twelve separate programs that were developed based on the PEI Key Community Mental Health Needs, Priority Populations, and stakeholder priorities identified through the community planning process. There is a comprehensive School-based Initiative that contains three service programs to target children and youth exclusively; four components included in the Community-based Initiative that provides services for children, youth, adults, and older adults; and five System Enhancement projects that cut across all ages, providing interventions to older adults, system involved (child welfare or juvenile justice) children and youth, military families, and even offering prenatal support. **It is estimated that over the next three years over 67,825 individuals and 18,892 families will receive prevention and early intervention services.**

Below is a brief summary of each initiative which includes the goals, related objectives and a succinct description of each project for which MHSA funding is being requested.

A. School-Based Initiatives

Goal

Strengthen student health and wellness by working to reduce risk factors, barriers and/or stressors, build protective factors and supports, and provide appropriate interventions at schools and after school programs.

Objectives

- Improved knowledge of educators in regards to identification, early signs and symptoms, and risk factors contributing to mental illness and co-occurring disorders.
- Increased opportunities to access prevention and early intervention services for students at risk of school failure, in stressed families, exposed to trauma, at risk of juvenile justice involvement, or experiencing onset of serious psychiatric illness.
- Improved school/community bonding, resilience promotion, and access to PEI services for underserved populations.
- Improved ability to provide selective prevention and early intervention services to families of young children experiencing behavior problems, experiencing grief or loss, and/or in need of early childhood evaluation.

– Student Assistance Program

The Student Assistance Program (SAP) is a science-based model that minimizes barriers to learning and supports students in developing academic and personal success through the asset development process. Students identified as stressed, at-risk, or displaying signs of high-risk substance use and/or mental health risks receive appropriate interventions at school or through referrals. Both prevention (pre-diagnosis) and early intervention services can be offered through SAP. Services can include; early intervention, counseling, substance abuse/misuse services, anger management classes, or additional curriculum based psychosocial education. It is anticipated that a portion of funding will be allocated to County Schools to administer the training component with the remainder of the allocation being contracted to community-based organizations through a Request for Proposal (RFP) process. The projected funding for this project is \$1,375,000 to serve approximately 50,467 individuals and 6,350 families.

– Resilience Promotion in African-American Children

The Resilience Promotion in African-American Children project works to promote resilience in African American children in order to mediate the development of Post Traumatic Stress Disorder (PTSD), mood disorders, other anxiety disorders, substance abuse/misuse, and psychotic disorders through what begins as a twelve-week intensive program followed by ongoing weekly interventions. Services are delivered in a culturally appropriate method and connect children/youth to positive role models and mentors. The project will be administered by a community-based organization through a Request for Proposal (RFP) process. The projected funding for this project is \$516,000 to serve approximately 120 individuals and 120 families.

– Preschool PEI Project

The Preschool PEI Project is a comprehensive project that targets Universal, Selective, and Early Intervention preschool populations and their parents/caregivers. The project includes provisions to deliver three separate yet complimentary services. The Incredible Years program is an evidence-based model that is utilized to address aggressive behaviors in young children. The model includes training both parent/caregiver and teacher. The second component is a preschool bereavement and loss program that addresses significant trauma in a child's life (loss of a parent/caregiver, divorce, etc.). The third component is a screening and early assessment component. The project will be delivered through a partnership between DBH and the Preschool Services Department along with a local university. The projected funding for this project is \$468,289 to serve approximately 300 individuals and 435 families.

B. Community-Based Initiatives

Goal

Build and strengthen the capacity of communities to provide prevention and early intervention opportunities and community empowerment activities in natural settings

Objectives

- Improved linkages to preventative and early intervention services where cultural groups meet.
- Improved opportunity to access programs and interventions that teach good problem solving skills, leadership, optimism and hope, and that work to build and enhance resilience in children, transitional-aged youth, and adults.
- Improved local support and advocacy for un-served and underserved populations.
- Improved outcomes for transitional aged youth at risk of or experiencing school failure and/or juvenile justice involvement.

Family Resource Centers

The Family Resource Center will act as the hub in delivering community-specific prevention and early intervention services. Each Center will work to reduce stigma and discrimination by providing a variety of mental health and alcohol and drug prevention and early intervention services and programs in natural settings. In addition, each center will be able to deploy services into their local community, strengthening the bond and ability to link with additional service organizations and government agencies. All centers should partner with faith-based organizations and other culturally specific organizations and must provide Universal, Selective, and Early Intervention services on site and in the community. The projected funding for this project is \$3,227,000 to serve approximately 3,600 individuals and 10,000 families.

- American Indian Resource Center
The American Indian Resource Center will address the identified mental health needs and stressors of the Native American population that reside in San Bernardino County. The center will function as a community-based organization that will provide an extensive array of mental health resources including outreach and education, family support, counseling services, work force development and education assistance and traditional Native American programs. The setting of this pilot project would not be a traditional mental health setting; the setting will focus on assisting Native Americans in feeling comfortable seeking services from staff that are knowledgeable and capable of identifying needs and solutions for Native families and individuals. The projected funding for this project is \$650,250 to serve approximately 1,750 individuals and 250 families.

- National Curriculum and Training Institutes (NCTI) Crossroads
This project will use National Curriculum and Training Institutes, (NCTI); Crossroads curriculum in classes aimed at transitional age youth on topics including anger management, truancy, drug and alcohol, gang involvement and parenting. The project will be delivered at school sites, community centers, and probation day reporting centers removing some of the barriers to accessing care. Classes are designed to be delivered over a three-week period (twice a week for 2 hours each session for a total of 6 sessions). Each class has its own workbook to cover six weeks of curriculum related to each individual group topic. These classes offer a short-term intervention for both parents and youth simultaneously. The projected funding for this project is \$2,000,000 to serve approximately 1500 individuals.

- Promotores de Salud
The program is unique in addressing the needs of our cultural diverse community, in that it uses community members who have received services or are family members of persons who have received services and have general knowledge of the local county system, to establish channels of communication within the community they will be providing services to. The selected individuals will be trained on mental health and wellness topics, as well as available resources through the local county system and other service providers. The Promotores de Salud (Community Health Workers) will make home visits and conduct educational presentations addressing PEI needs to groups and individuals within community organizations countywide such as schools, churches, etc. on a weekly basis. The projected funding for this project is \$225,000 to serve approximately 3,840 individuals.

C. System Enhancement Initiatives

Goal:

Build and strengthen collaboration across public service organizations and work to implement efforts to promote wellness across all systems.

Objectives

- Improve collaboration with substance abuse prevention system efforts to reduce the harmful effects of substance abuse across San Bernardino County communities.
- Increase opportunities for individuals to access prevention and early intervention services and activities in natural settings.
- Improved linkages to additional needed services and navigation of other systems.
- Improve wellness, provide access to prevention and early intervention activities, and prevent substance abuse/misuse for high risk and/or trauma-exposed populations.

– Older Adult Community Services Program

This PEI Project will address the key community needs of older adults, their families or caregivers with disparities in accessing mental health services, the psycho-social impact of trauma and bereavement, stigma and discrimination and suicide risk. The priority populations to be addressed are older adults who may be experiencing an onset of a serious psychiatric illness due to the aging process and trauma and/or bereavement exposed individuals. The projected funding for this project is \$1,350,000 to serve approximately 2,140 individuals and 300 families.

– Child and Youth Connection

The project includes three components that reflect all parts of the prevention continuum. The first component is screening foster children to assess mental health needs. This component will be implemented in 3 Department of Children's Services (DCS) offices. This service will prevent severe mental health issues by addressing early concerns before they intensify. A portion of the services provided include connecting foster children/youth to mentors. The second component involves Team Decision Meetings (TDMs). Clinicians will attend TDM's held in the group and foster homes and at DCS offices to provide mental health consultation, referrals and linkage to services. The third component involves investing in a partnership between the Juvenile Public Defenders office and the DBH. DBH will fund a clinician to work for the Public Defenders Office to coordinate MSW interns. The interns will conduct in-home screenings and connect juveniles, who are not in placement, and their families to PEI services in the community. The projected funding for this project is \$726,014 to serve approximately 3,600 individuals and 1,400 families.

- Nurse Family Partnership
The Nurse Family Partnership is an evidence-based home visitation program that improves the health, well-being and self-sufficiency of low-income, first-time parents and their children. A pilot program of the Nurse Family Partnership (NFP) home visiting program is proposed to occur in the Fontana/Rialto area of the County. This area is recommended due to a data analysis that indicates a high percentage of first-time, low-income mothers residing in the zip codes in these communities. The projected funding for this project is \$396,000 to serve approximately 50 individuals and 25 families.

- Active Duty Family Support Project
This project targets active duty military families throughout the county. Data has shown a risk of suicide higher than that of the general population for those returning from active duty. Children in these families face adjustment difficulties and vulnerabilities as they live with the anxiety of having a parent serving in a time of war. These children and youth need support in coping with well founded fears. In addition, the men and women returning from active duty carry the emotional scars of prolonged battle fatigue and possibly PTSD. This pilot project would provide in-home, thorough psychosocial assessment for these families and family intervention and rehabilitative support for those families determined to have these needs. The projected funding for this project is \$450,000 to serve approximately 150 individuals and 50 families.

- Community Wholeness and Enrichment Project (WE)
The WE Program will deliver these services via two components: an early intervention for psychosis component emphasizing self-awareness, leadership and resiliency for trauma exposed individuals and a preventive mental health services for those experiencing the onset of psychiatric illness. This project targets mental health prevention and early intervention services to the TAY (16-25 y/o) and adult (26-59 y/o) population which currently accounts for 62.2% of San Bernardino County residents. The program is designed to target adults and TAY currently experiencing early onset of mild mental health issues, families of adults and TAY who are experiencing early onset of mild mental health issues, identified county residents who are experiencing mild to moderate mental health issues which could be addressed prior to any hospitalization, incarceration, or contact with criminal justice system. The projected funding for this project is \$1,375,000 to serve approximately 608 individuals and 312 families.

Conclusion

The development and preparation of the County of San Bernardino's Prevention and Early Intervention Plan resulted from concentrated efforts from the community, consumers, family members, service providers, county agencies, and representatives of interested organizations throughout the county. The PEI Plan will be proposed to State Department of Mental Health for funding under MHSA and will be reviewed by the Mental Health Services Oversight and Accountability Commission (MHSOAC).

The MHSOAC is responsible for providing overarching oversight and accountability for implementation of the MHSA. MHSOAC is responsible for redirecting California's mental health system toward transformation, such that all mental health activities and programs stress prevention, early intervention, wellness, recovery and resilience. PEI Plans are reviewed by OAC staff, interested MHSOAC commissioners, and expert consultants. Post review, plans are recommended for final approval per MHSOAC consent agenda with the assurance that DMH can execute a contract.

In conclusion, while the PEI Plan cannot meet the demand for all services, it can work to continue the transformation of mental health services at the local level. The Prevention and Early Intervention concept begins the important work of changing the mental health system from a fail first system to a help first system.

COMMUNITY PROGRAM PLANNING PROCESS

Part VII: Appendices 2 Program & Expenditure Worksheets Enclosure 3, Form # 2

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

County: San Bernardino

Date: January 9, 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:

During 2005, San Bernardino (SB) County's Mental Health Services Act (MHSA) Community Program Planning (CPP) process for Community Services and Supports (CSS) included extensive MHSA orientation/training, community public forums, targeted interagency forums, consumer/family-driven and staff focus groups, survey tools and strategic outreach throughout our large and culturally diverse county. Thus, the development of SB County's CSS component of the Mental Health Services Act (MHSA) reflected a comprehensive planning process which involved consumers and their families as full partners, along with stakeholders from partner agencies, community organizations, community members and mental health system staff.

While SB County moved from the CPP process to the CSS implementation effort in 2006, the established network of stakeholder engagement channels/structures were strengthened and expanded. These resources have continued to serve as feedback mechanisms, fulfilling a variety of evaluation, planning, needs assessment and program implementation support roles. Among these resources are the Community Policy Advisory Committee (CPAC), the MHSA Executive Planning Committee, the MH Commission, four (4) age-specific MHSA Work Groups, the Clubhouse Consumer Peer Support Groups, the Parent Partners Network, DBH Peer and Family Advocate employees, the Older Adult Peer Counselor Support and Outreach System, the evolving Transitional Age Youth (TAY) Network and the MHSA Planning, Development, Community Education and Outreach Services unit. These ongoing MHSA implementation and transformation supports have been accessible as SB County focused attention on Prevention and Early Intervention (PEI) planning in early 2007. An overview of the PEI-CPP effort, which involved these system resources, is outlined below.

a. The overall Community Program Planning Process.

- The DBH Director, in conjunction with Community Policy Advisory Committee (CPAC), assumed central responsibility for the overall Prevention and Early Intervention (PEI)-Community Program Planning (CPP) process. *Attachment A* shows CPAC membership.
- The MHSA Executive Planning Committee, in weekly meetings, provided oversight, guidance and support to SB County's PEI-CPP process. See *Attachment B* for MHSA Executive Planning Committee membership.

- The standing MHSA Age-Specific Work Groups, in meetings during 2007, provided members and stakeholders with PEI plan-to-plan information and opportunities. Membership on these MHSA Work Groups is reflected in *Attachment C*.
- The Prevention and Early Intervention Subcommittee (of the CPAC) first convened on February 27, 2007 in order to build on prior MHSA Community Services and Supports (CSS) community program planning efforts, expand outreach and stakeholder input opportunities and include a broad set of voices in the anticipated PEI plan development process. Ultimately, the membership of this subcommittee grew to over 100 and established its own age-specific work groups. These work groups collaborated with the MHSA Age-Specific Work Group Chairs to ensure that PEI data and stakeholder input analysis and plan development would remain consistent with overall MHSA implementation, transformation and integration. Membership of the PEI Subcommittee and its PEI Age-Specific Work Groups is shown in *Attachment D*.

b. Coordination and management of the Community Planning Process.

- The MHSA Planning, Development, Community Education and Outreach Services unit assumed responsibility for coordination and management of the PEI-CPP process, building upon existing stakeholder engagement components, mechanisms and collaborative networks within the mental health system and evolving out of the CSS-CPP initiated in 2005.
- Specifically, this unit's MHSA Coordinator, Mental Health (MH) Program Manager II (0.25 FTE) managed the PEI-CPP effort while two 0.5 FTE MH Program Managers II (returning retiree/consultants) coordinated the stakeholder engagement, training/orientation, input and PEI project planning process.
- One FTE MH Education Consultant coordinated the deployment of MHSA outreach staff in the PEI stakeholder engagement process.
- One FTE MH Specialist served as a PEI outreach coordinator, linking with all facilitators of stakeholder input/engagement activities and ensuring that participant input was recorded, compiled and reported to the age-specific work groups of the PEI Subcommittee and to the Chairs of the MHSA Age-Specific Work Groups.
- Clerical staff (1.25 FTEs) was dedicated to the extensive process of creating PEI and demographic/ educational materials, written tools and protocols for community public forums and targeted/specialty forums, flyers, documentation/minutes, monitoring systems, and data compilation and reporting formats.
- In addition, 0.2 FTE Program Specialist from the department's Alcohol and Drug program served as a key consultant to the PEI Subcommittee and its

work groups on Prevention and Early Intervention issues, particularly in the areas of reaching out to and designing PEI models for communities affected by and individuals with co-occurring disorders.

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

The process of coordinating the PEI Community Program Planning process began in February 2007 with a “plan-to-plan” phase. This entailed pulling together a network of active participants in SB County’s MHSAs implementation and transformation to specifically address the key component of prevention and early intervention. Existing MHSAs outreach staff built upon the 2005 CPP, expanding our linkages and partnerships with community and faith-based organizations, interagency partners, other services providers, underserved communities, and community constituents.

As part of the CSS implementation, county Peer and Family Advocate (PFA) positions were established, and deployed throughout SB County. These employees play a significant role in ensuring continued advocacy, needs assessment and nontraditional approaches to addressing those mental health needs.

The establishment of the PEI Subcommittee was met with enthusiastic support throughout the year, as this group studied MHSOAC materials regarding PEI policy, principles and priorities and then developed a comprehensive PEI stakeholder engagement and input plan prior to the release of the draft, proposed and final PEI Guidelines.

The department’s Research and Evaluation unit initiated an updating of demographic data for review during the February to July “plan-to-plan” period so that the expanded CPP process would appropriately focus on unserved/underserved individuals and family members, trauma-exposed individuals/communities, our diverse regional challenges, children and youth at risk, stressed families/communities, and marginalized communities and/or individuals.

With each of these priorities, the issues of stigma and discrimination were appropriately highlighted as challenges for those needing, seeking and offering help to at risk and un/underserved populations. The department’s Cultural Competence Office provided thought-provoking guidance on these issues throughout the plan-to-plan and community program planning phases. The following collaborative partners joined the effort to build a PEI-CPP that would ensure an expanded and meaningful PEI-Community Program Planning process.

- The MHSAs unit coordinated community public forums, held in the five major regions of SB County which includes the West Valley, the San Bernardino/Mid-Valley, the Victor Valley desert region, the lower desert/Morongo Basin region and the mountain communities. These forums were co-hosted by the regional DBH management staff and the MH Commission.

- A consultant from the California Institute for Mental Health (CiMH), familiar and involved with SB County's 2005 CSS-CPP process, co-facilitated these events. Support staff from the MHSA unit, DBH regions, DBH contractors and the PEI subcommittee were involved in this opportunity for community members of each region to receive overview information on MHSA, PEI Guidelines and to engage in discussion on PEI policy, principles and priorities pertinent to their regions. *Attachment E* reflects Community Public Forum Protocols, discussion questions and Minutes formats.
- To ensure that stakeholders could fully benefit from the community public forums, Cultural Competence staff arranged for Spanish interpretation and American Sign Language for each event and, in one region where Vietnamese approaches "threshold language" status, Vietnamese interpretation was arranged.
- In addition to the MHSA staff principally responsible for coordinating PEI-CPP activities (referenced above), 0.25 FTE MHSA outreach staff linked with community, faith and interagency partners and co-facilitated targeted forums to elicit stakeholder input. See *Attachment F* for Targeted Forum Protocols, discussion questions and Minutes formats.
- The 0.1 FTE Office of Consumer Affairs Peer and Family Advocates (PFA) served in a leadership capacity, assisting the department-wide PFA network to convene and co-facilitate targeted forums with consumers/clients in local communities.
- Targeted forums were convened throughout SB County in a variety of community venues. Facilitators of these forums primarily came from the PEI subcommittee which included Cultural Competence Office staff members, consumers, consumer/family advocates, parent partners, social services, schools, juvenile justice/public defender, DBH and DBH contractor staff, and other stakeholders.
- The MHSA unit, in collaboration with the PEI Subcommittee and the DBH Research and Evaluation staff, developed a stakeholder input survey to serve as an alternative stakeholder engagement tool. The survey was made available online and as a hard copy survey. Thus, stakeholders unable to participate in face-to-face events could respond to these PEI-related survey questions during the CPP process.
- MHSA outreach staff utilized the tool in informal briefings/meetings with agency partners, "spreading the word" and inviting input from stakeholders such as primary health care providers, nursing staff, military veteran peer support networks, partners within the Native-American community, other ethnic/cultural communities, and individuals in natural community gathering places and community resource locations. This tool was also distributed at DBH/contractor clinics, facilities and sites, and at a variety of community events/fairs including the visible "Recovery Happens" event in San Bernardino and a major powwow Native-American gathering/event. In all, nearly 900 responses were received online, directly from respondents or via

the postage-paid envelope provided. See *Attachment G* for multilingual PEI input survey tools.

- *Attachment H* shows several sample publicity flyers and *Attachment O* includes press releases announcing SB Countywide regional PEI community public forums.

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

A first step in assessing SB County's CPP process in relation to PEI was to review stakeholder input collected during the CSS Community Program Planning process. While CSS-CPP stakeholder events held in 2005 primarily focused on the planning of CSS programs, documentation of stakeholder input reflected an intense interest among participants in the principles and priorities guiding Prevention and Early Intervention in California.

During our CSS-CPP process, we made a commitment to those stakeholders most interested in prevention and early intervention issues, strategies and settings that we would include their input during the PEI Community Program Planning process.

(*Attachment I* is a compilation of 2005 stakeholder input reflecting PEI concerns.) In addition, we made a commitment to utilize a similar array of outreach, large and small input forums, and survey tools with a specific emphasis on PEI priorities, in accordance with MHSOAC and State DMH guidance.

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

- A variety of community program planning partners and facilitators utilized strategies found to be effective during SB County's CSS-CPP process and to re-double efforts to reach those not more fully engaged during the 2005 CSS-CPP. Members of the PEI Subcommittee, the MHSA outreach staff, the Cultural Competence Office and the Consumer and Family Affairs Office Peer and Family Advocates were provided training in the principles/priorities of MHSA PEI as well as protocols, forum discussion process and documentation of input. Further, each of these teams were provided with paper survey tools in English, Spanish and Vietnamese in order to bring back input from events in un/underserved communities in which a forum event was not feasible.

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 and race/ethnicity.

- Because SB County is geographically the largest county in the 48 contiguous United States, making stakeholder input experiences available in the remote areas of SB County presents a challenge. For this reason, a variety of approaches were undertaken. We tapped into service delivery staff throughout the mental health system that could pull together forums among consumers and family members. In areas where services are not provided or

accepted, outreach staff partnered with community/faith based agencies or other community/peer leaders or attended community events in order to distribute/collect input surveys. In addition, the PEI input survey was posted on SB County website to reach community members interested in contributing to the discussion.

- While SB County has mechanisms to provide incentives such as gift cards, bus passes and other supports, these incentives were not needed due to the wide use of community-friendly forum meeting locations and flexible scheduling. All events included the provision of refreshments and facilitators offered future opportunities for forums and inclusion in PEI planning activities. In addition, the PEI outreach presence at community events and the use of prizes, refreshments and family/child activities served to help engage participants.
- Because SB County's age and ethnic demographics are particularly interesting when viewed in combination with the varied regional characteristics, CPP strategies have been necessarily flexible and comprehensive. The five community public forums purposely sought to reach specific regional areas. Within these regions, varying age-specific and racial/ethnic/cultural/linguistic issues emerged. Thus, these larger forums themselves served as a needs assessment process early in the CPP. We could follow up with targeted forums, designed to provide smaller, issue-specific forums for exploration of the impact of these issues in relation to PEI needs in target communities.
- During the PEI "plan to plan" phase starting in February 2007, the PEI subcommittee noted that gender and gender identity issues should receive attention during the PEI-CPP. Plans were made to facilitate the targeted forum format, specifically focusing on the network of domestic violence providers, on female consumers as a "focus", and recognizing the Lesbian Gay Bi-sexual, Trans-gender and Queer (LGBTQ) community as important in terms of PEI priority language (trauma, risk, suicide risk, cultural competence, stigma and discrimination). The PEI Subcommittee, among other resources within the planning collaborative, included representatives from individuals and advocates around these issues. In addition, the survey tool was made available for use in venues that would reach any of these at risk populations.
- SB County family includes the Department of Veterans Affairs. Representatives from this partner agency have been at the MHSA "table" since the beginning of the CSS-CPP process in 2005. The PEI priorities, especially those focusing on trauma, stigma/discrimination, cultural issues, early onset and "first break", and children/youth in stressed families, have enabled us to partner in expanding the participation by military veterans in SB County.
- An ongoing MHSA Native-American collaborative partnership lent itself to responsive stakeholder engagement through the use of the PEI input survey and targeted discussions.

- Throughout the months of the stakeholder input and engagement phase, representatives of unserved/underserved populations and communities emerged, articulating issues around PEI priorities and identifying existing resources and strengths within those communities. As a result, SB County dedicated several staff resources to coordinating and formalizing links between various racial, ethnic and cultural coalitions and the PEI process.
- A concerted effort to convene formal collaborative coalitions with the African-American, Asian-American and Latino communities was initiated. While these coalitions will partner with the local MH system on an ongoing basis around a variety of system transformation, continuum of care, collaboration and service integration issues, it was immediately important to ensure direct participation in the PEI Planning process. The PEI Age-Specific Work Groups and representatives of these “cultural coalitions” worked together to ensure clear focus on needs assessment, resource assessment and plan development around these priority populations in our culturally diverse county. The department’s Research and Evaluation staff and Cultural Competence staff were directly involved in supporting and consulting in this endeavor.

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

- The multiple strategies designed for the PEI CPP process were developed to be adaptable and conducive to active engagement with clients and their families. The region-based community public forums were broadly publicized through the network of DBH and contractor clinics and programs, including the existing clubhouse network. The Peer and Family Advocate employees within the DBH Consumer Affairs Unit have served as active members of the CPAC, its PEI Subcommittee and the PEI Subcommittee work groups.
- These staff members were oriented and trained in PEI Policy, Principles and Priorities throughout 2007 and participated in the planning of targeted forums for clients and their families. Our Peer and Family Advocates facilitated PEI targeted forums with consumer/client groups in various client-operated network settings.
- In addition, the existing Parent Partners network, in place in SB County through the Children’s System of Care since 1997, engaged parents/families of seriously emotionally disturbed children and youth in targeted forums.
- The MHSA staff unit specifically worked to publicize and facilitate forum and outreach events via NAMI and other client advocacy groups, including the distribution and collection of the PEI-related input survey, which offered an alternative source of stakeholder engagement.

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, CCR, 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
- As indicated in the section above, the CPAC created the PEI Subcommittee in February 2007 in order to embark on a focused “plan to plan” process. The Subcommittee took advantage of guidance materials provided by the State DMH and the MHSOAC, devising strategies for recruiting stakeholders to the Subcommittee including, but certainly not limited to, those categories of partners listed above.
- An encouraging level of interest in planning to plan emerged among a variety of CPAC members and through continual recruitment. From February until the release of the PEI draft requirements in July 2007, the subcommittee’s size doubled. Represented are clients, family members, Peer and Family Advocate staff, Parent Partners, mental health clinical, case management and administrative staff representatives from the physical health care arena, social services, law enforcement/juvenile justice/public defender, schools, children’s network, early childhood education, community based organizations, substance abuse providers/advocates, drug court advocates, LGBT advocates, domestic violence advocates, military veterans and other stakeholders and organizations. With this broad level of representation in the group charged with “planning to plan”, there has been a major commitment to inclusion of all levels of stakeholders, existing, potential and new.
- Attachment J, a “partnership grid”, reflects the breadth of stakeholder participation during the PEI-CPP across consumers groups, advocacy groups, community resources and public agencies.

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

Beginning in January 2007, the CPAC agenda included the MHSA Prevention and Early Intervention component as a regular discussion item in order to begin conceptualizing PEI in the context of overall MHSA transformation. MHSOAC policy guidance materials were reviewed and discussed on a monthly basis. PEI Subcommittee members utilized a portion of monthly meetings to concentrate on the policies, principles and priorities that had already emerged over some months of statewide stakeholder input and planning.

Subcommittee training included review of MHSOAC/CMHDA/CiMH policy forum literature, updating of county demographic data, self-assessment of existing resources/networks and potential stakeholders, assessment of service gaps, discussion of the various types of cultural issues existing in SB County, the PEI-priority risk factors affecting different regions and the importance of utilizing a varied community program planning process. With the release of the PEI draft Guidelines, training of an expanded network of stakeholders began as preparations were made for embarking on the CPP.

MHSA outreach staff, Cultural Competence Office staff, Peer and Family Advocate Staff, Parent Partners, DBH management staff, and PEI Subcommittee members attended focused training on the PEI policy/principles/priorities, PEI-CPP and the process for facilitating PEI targeted forums. (*Attachments E and F* for Community Public Forum and Targeted Forum Protocols/Minutes formats)

Informational materials prepared for distribution at all stakeholder engagement events contained background information regarding the Mental Health Services Act, SB County's Community Services and Supports planning and implementation efforts, the current PEI community program planning process and the importance of stakeholder participation and input.

In addition, a community-friendly brochure presented county demographic data along with a discussion of PEI policy, principles and priorities. Forums included an overview of the link between PEI and the overall mental health system transformation within the Mental Health Services Act. (See *Attachment K* for forum stakeholder data collection and informational materials and brochures.)

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

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

Throughout the 2005 CSS-CPP, the varied strategies devised to reach and engage stakeholders were felt to be relevant for reaching a culturally and geographically diverse population. However, the CSS stakeholder engagement process was, in many ways, an intense learning and coalition-building process.

The CSS-CPP strategies were found to be effective within existing networks and brought in new participants interested in CSS-oriented concerns. We remained concerned, however, about difficulties in linking to un/underserved communities. During the CSS-CPP, outreach efforts were made to reach into these additional groups and communities with face-to-face consultations, input surveys and planning for subsequent partnership.

While this initiated the development of new coalitions and partnerships with faith centers, Native-American groups, African-American community groups, Latino and Asian-American populations and others, our findings suggested that issues relevant to PEI were resonating even during the CSS-CPP. Thus, the planning of the PEI CPP was informed by the early knowledge that un/underserved communities will partner and engage when we find them in nontraditional

gathering places, when we work through alternative community agencies and organizations and when a multicultural, multilingual outreach staff are deployed to make contact.

All strategies were utilized and offered according to the needs and desires of each group or community involved. Importantly, the planning of the PEI-CPP was also informed by the early knowledge that un/underserved communities have been eager to discuss MHSa Prevention and Early Intervention and would contribute significantly to the planning process. While individuals from un/underserved communities remain underrepresented during the PEI-CPP, their advocates and community-based organizations have been assertively present during this stakeholder input process. Stakeholder input reflects that our stakeholder communities can effectively relate to the principles and priorities highlighted in this effort, have articulated individual and community concerns clearly and have ably identified opportunities for partnership and system transformation. (See *Attachment L* for compiled PEI forum input and *Attachment M* for an executive summary of the PEI input survey findings)

CSS stakeholder demographic data showed that, in 2005, we reached higher proportions of all racial/ethnic communities than are represented in this county's 200% of poverty population with the exception of the Latino community. Thus, the PEI-CPP effort immediately focused on the need for strategic and specialized outreach to this population through bilingual consumers/family members, advocates, community organizations and interagency partners. In addition, we intentionally planned to seek PEI input from those advocates and agencies which serve the Latino community.

The CSS-CPP successfully reached adult stakeholders while stakeholder demographic data suggest that outreach to older adults needed to be adapted for better access. Likewise, demographic data suggest that strategies for reaching TAY stakeholders should be adapted to reach advocates and agencies which serve TAY while also enhancing TAY participation during the PEI-CPP.

The CSS-CPP showed low participation by children. For obvious reasons of child protection and confidentiality for at risk child groups, we anticipated that direct participation by children might continue to be a challenge. However, a CSS-PEI "lesson learned" has been that aggressively expanding our PEI planning work with family members, parent partners, schools, child advocates, social services, primary care providers, public defenders, law enforcement, faith centers and other community support networks has assured that children's PEI needs have been surfaced and considered strongly.

During the CSS-CPP, the gender specific and gender identity issues raised tended to fall into the "early end of the spectrum." These issues have re-emerged as the PEI-CPP was initiated. Stakeholders from the CSS-CPP who brought concerns about community and individual PEI risk factors and needs were assured that their concerns would be reviewed during the PEI-CPP.

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 Transitional Age Youth.

- *Attachment N*, entitled MHSА-PEI 2007 Survey Data Results, provides an overview of demographic characteristics of the 1,792 participants reached throughout the PEI stakeholder engagement process. Some of the data show that targeted outreach into partner agencies and natural gathering places facilitated participation by higher proportions of African-Americans, Native-Americans and “others” than are represented in the general poverty population.
- While children are underrepresented (2%) as direct participants in the stakeholder input process, our assessment of PEI planning partners shows that child-serving agencies and advocates were well represented. Nevertheless, we plan to continue working with schools and child-serving agencies to facilitate focus groups with willing children and youth around issues of prevention and early intervention on an ongoing basis.
- While Transitional Age Youth (TAY) constitute 16% of the target population, 8% of stakeholders identified within that age range. Fortunately, TAY agencies and advocates participated on behalf of this population in large numbers. In addition, the MHSА CSS TAY network program continues to expand forums for future and ongoing TAY participation.
- Asian-American individuals are 5% of the poverty population but constituted 3% of PEI-CPP participants. Latino individuals are 51% of the poverty population but constituted 30% of PEI-CPP participants. To ensure continued progress in the direct participation by these populations, formal community-based Asian-American and Latino coalitions have been forged and are serving in advisory and consultative capacities throughout PEI planning, pre-implementation, implementation phases and subsequent MHSА development, transformation and integration processes. In addition, similar coalitions have been developed with the Native-American and African-American communities. These advisory and consultative partnerships will continue to assist in transforming the mental health system by identifying existing relevant resources, community priorities and partnership opportunities.
- We have been pleased to see that PEI-CPP participants include significant proportions of consumers. (Of 1,482 stakeholders choosing to respond to survey/data collection form self-identification categories, twenty-two percent were consumers.)
- SB County’s active network of Peer and Family Advocate (PFA) county employees, led by the Office of Consumer Affairs PFA’s, facilitated several very successful targeted forums among consumers/clients. While these stakeholders have historically received long-term and higher intensity services, their input on PEI issues was thoughtful and insightful. Participants willingly used their own experiences, ready to show the way and offer ideas

and alternatives for addressing issues such as “early onset,” stigma and trauma.

- Mental health system staff participated in large numbers. Participation also included partners such as faith-based centers, primary health care providers, foster care providers, the local and district schools, family members, advocates, community-based organizations and community members.
- In addition, the “partnership grid” mentioned above (again, *Attachment J*), reflects the array of “required” sectors, agencies, organizations and partners joining us in the PEI-CPP. We are pleased to have joined with a broadened array of community and interagency partners through this phase of the community program planning process.
- A review of the compiled stakeholder forum input (again, *Attachment L*) reflects comments articulating “specialty” population needs. For example, military veterans and their advocates were very helpful in expressing PEI priorities which affect this community and the strategies that would be accepted and effective. Likewise, the needs of domestic violence survivors, LGBTQ individuals, and other underserved groups were clearly described by participants.
- Simultaneously, we have been pleased to see that our stakeholders and communities have advocated for each other, have identified PEI strategies that would benefit many target populations within communities and that are adaptable within communities of stakeholders. A significant theme within the stakeholder forums was that communities embrace the PEI policies, principles and priorities and wish to join the transforming mental health system in addressing community needs.

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

- The date of the public hearing
- 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
- A summary and analysis of any substantive recommendations for revisions
- The estimated number of participants

School Based Initiatives Program Summary Sheet

Form 3	Brief Summary
Comprehensive Student Assistance Program	The Comprehensive Student Assistance Program minimizes barriers to learning and supports students in developing academic and personal success. This is accomplished through training selected educators in a five (5) day workshop on effective curriculum, promoting resiliency through asset development, identification of students who need additional intervention, the referral process, developing a menu of services, and developing a crisis plan. Additional supports to provide early intervention and prevention counseling services at schools for identified at risk, stressed, and underserved students will be implemented by Community Based Organizations (CBO). Multidisciplinary teams with mental health specialists and alcohol and drug counselors will be able to provide prevention/early intervention activities on school sites.
Resilience Promotion in African-American Children	The Resilience Promotion in African-American Children Program promotes resilience in African-American children in order to mediate the development of Post Traumatic Stress Disorder (PTSD), Mood Disorders, other Anxiety Disorders, Substance Abuse, and Psychotic Disorders through a 12 week intensive program followed by ongoing weekly interventions and tracking off site at youth centers, churches, or other community settings until adulthood. Includes a mentoring component. The Resilience Promotion in African-American Children Program will be administered through a community-based organization.
Preschool PEI Project	The Preschool PEI Project is a multi-faceted project that targets HeadStart children through facilitation of the Incredible Years program to address young children displaying aggressive behaviors. The Preschool Bereavement & Loss program addressing significant trauma in a child's life, and the Mental Health component helps identify and assess those who will need referrals to mental health for more intensive services. This provides direct service to the preschool child, their caregivers (parents and teachers) as well as support and consultation to the teacher as necessary.

PEI PROJECT SUMMARY

Form No. 3

County: *San Bernardino*

Date: 4/10/08

PEI Project Name: *Student Assistance Program (SAP)*

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
<p><i>Select as many as apply to this PEI project:</i></p> <ol style="list-style-type: none"> Disparities in Access to Mental Health Services Psycho-Social Impact of Trauma At-Risk Children, Youth and Young Adult Populations Stigma and Discrimination 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"/> <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"/>

2. PEI Priority Population(s): Note: All PEI projects must address underserved racial/ethnic and cultural populations.	Age Group			
	Child and Youth	Transition Age Youth	Adult	
<p>A. <i>Select as many as apply to this PEI project:</i></p> <ol style="list-style-type: none"> Trauma Exposed Individuals Individuals Experiencing Onset of Serious Psychiatric Illness Children and Youth in Stressed Families Children and Youth at risk for School Failure Children and Youth at risk of or Experiencing Juvenile Justice Involvement 	<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"/> <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"/>

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 Student Assistance Program (SAP) Prevention and Early Intervention (PEI) Project described is the result of a collaborative planning effort between the San Bernardino County Department of Behavioral Health (DBH), school districts, community-based mental health organizations, parents, teachers and students. As part of the PEI planning process, a subcommittee dedicated to promoting school-based mental health prevention and early intervention services subcommittee was formed following the completion of the San Bernardino (SB) County's Community Services and Support (CSS) planning process in recognition of the need for the two systems to collaborate on issues related to children's mental health.

The data analysis and stakeholder processes used for the PEI plan are an extension and augmentation of those developed during the CSS planning process. These included an extensive needs assessment process that captured input across San SB and a stakeholder process that contained recommendations for prevention and early intervention services in addition to those developed for the CSS priority populations.

Data Review and Analysis

Representatives from both San Bernardino County mental health services and the education system were identified to review the needs assessment data from the initial CSS process, and to identify additional data sources needed for prevention and early intervention. For this priority population, the data that was reviewed included school district data as well as community level data from the SB County's "Community Indicators of Alcohol & Drug Abuse." This latter source was used because while mental health prevention and early intervention is a new endeavor for SB County, alcohol and drug prevention efforts have been underway for several years in the community. This project will build upon and use lessons from those prevention efforts to guide the project. The data that was reviewed and analyzed included the following:

- California Healthy Kids Survey results
- School attendance/expulsion rates
- Rainbow Referral Guide to locate areas with fewer mental health services
- Review of SB County's districts and schools low Academic Performance Index (API) scores, Adequate Yearly Progress (APY) Standings,
- Review of juvenile arrest data

PEI PROJECT SUMMARY

Form No. 3

- Community Risk Indicators for Alcohol and Drug Abuse Risk (including review of San Bernardino County Department of Children's Services (DCS) data and data on the number of children in foster care).

Stakeholder Input

The stakeholder input for selecting programs and strategies for this population began with a review of recommendations gathered as part of the CSS planning process. These recommendations were determined to be relevant to prevention and early intervention, more so than CSS. A list of recommendations for relevant services to address the needs of children and youth at risk for school failure was drafted for stakeholders' review and comment. Key partners in reviewing and providing input into draft recommendations were representatives from school districts and community-based child and Transitional Age Youth (TAY) advocacy and service organizations.

The Mental Health Services Act (MHSA) unit then convened five (5) community public forums in the five (5) major regions of the county. The regions are: West Valley, Mid-Valley/San Bernardino, High Desert/Victorville, Low Desert/Morongo Basin, and Mountain Communities. In addition, targeted forums were held throughout the planning process to include children and TAY serving agencies and advocates. A web-based survey was posted on the DBH website, and an email address made available where stakeholders could provide additional comment and input. The comments received from all the input were reviewed to develop priority recommendations. A key factor that led to program selection was the evidence of strong community support for projects providing school-based programs that will address the needs of students at risk of school failure. Program selection was also based on a combination of other factors of:

- High rates of mental health risk factors,
- Low test scores in schools, and
- High levels of other community risk factors.

Sites will be chosen when the SAP PEI Project is funded, and will take these factors into consideration when deciding which school districts will participate. A key factor that led to program selection was the evidence of strong community support for school-based programs to address the problem of students at-risk of school failure.

3. PEI Project Description:

PEI PROJECT SUMMARY

Form No. 3

Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community planning process.

The Student Assistance Program (SAP) PEI Project addresses the key community need of at risk children, youth and young adult populations, and their families or caregivers. The priority population to be addressed is children at risk of school failure.

Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

San Bernardino County currently has thirty-three school districts with a total of 523 school sites. There are currently 427,234 students enrolled countywide with a faculty of 71,721. Even though programs such as SAP have proven to be effective over time, in recent years state and federal funding has been re-directed to other areas of concern such as homeland security and school safety. As a result the SAP programs have suffered. Only eleven (11) out of thirty-three (33) districts have functioning programs at this time. Those eleven districts will possibly need some technical assistance in gearing back up to fully functioning programs.

During the 2008-2009 school year San Bernardino County Superintendent of Schools could offer SAP trainings for 140 schools. These five-day trainings will provide all materials needed to start an effective program and the appropriate instruction to support school site and district efforts. With teams of at least five (5) people from each school site DBH can expect to train a minimum of 700 participants within a calendar year. From these trainings an estimated 47,000 students and 3,500 parents will receive prevention education while 3,467 students and 2,850 families will receive intervention services.

DBH will target priority schools and school districts with:

- High number of children and youth from underserved ethnic/cultural groups
- High poverty
- Low academic achievement
- High rates of suspension, expulsions and drop out
- High number of children and youth in foster care
- High number of children and youth at risk of experiencing juvenile justice involvement
- High rates of violence in the community

The following table describes demographic data for children in San Bernardino County.

