SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

721

FROM: Department of Mental Health

SUBMITTAL DATE:
January 5, 2010

SUBJECT: Receive and file MHSA (Mental Health Services Act) PEI (Prevention and Early Intervention) Plan, the INN (Innovation) Plan and Agreement Modification B3 & B4

RECOMMENDED MOTION: Move that the Board of Supervisors receive and file the MHSA PEI Plan, Innovation Plan and Agreement Modification B3 & B4

BACKGROUND: On January 29, 2008, Agenda Item 3.35, the Board of Supervisors accepted and ratified the MHSA State Agreement No. 07-77333-000. Included in this agreement is funding for CSS (Community Services and Supports), WET (Workforce Education and Training), Cap Fac (Capital Facilities and Technology Needs), PEI (Prevention and Early Intervention) and INN (Innovation). Since the acceptance of the original agreement, ten (10) modifications to the agreement have been received and filed by the Riverside County Board of Supervisors. The latest agreement modification was received and filed by the Board of Supervisors on September 1, 2009. **(Continued on page 2)**

Departmental Concurrence

JW:KS

Jerry Wengerd, Director
Department of Mental Health

FINANCIAL DATA	**Current F.Y. Total Cost:**	$ 0	**In Current Year Budget:**	Yes
	Current F.Y. Net County Cost:	$ 0	**Budget Adjustment:**	No
	Annual Net County Cost:	$ 0	**For Fiscal Year:**	08/09 & 09/10

SOURCE OF FUNDS: 100% State MHSA

Positions To Be Deleted Per A-30 ☐

Requires 4/5 Vote ☐

C.E.O. RECOMMENDATION: APPROVE

County Executive Office Signature
BY: Debra Cournoyer
Debra Cournoyer

☐ Policy ☒ Consent
☒ Policy ☐ Consent

Dep't Recomm.:
Per Exec. Ofc.:

Prev. Agn. Ref.: 01/29/08, 3.35; 01/06/09, 3.19; 04/28/09, 3.21; 06/09/09, 3.33; 09/01/09, 2.29

District: All

ATTACHMENTS FILED WITH THE CLERK OF THE BOARD

Agenda Number: 3.32

SUBJECT: Receive and file MHSA (Mental Health Services Act) PEI (Prevention and Early Intervention) Plan, the INN (Innovation) Plan and Agreement Modification B3 & B4

BACKGROUND: (continued)
On April 28, 2009, the Board approved Resolution No. 2009-115, which authorizes the Director of the Riverside County Department of Mental Health to sign and enter into non-substantive MHSA Amendments with the State DMH (Department of Mental Health) for the duration of the MHSA Agreement performance period, which ends June 30, 2013.

The MHSA Agreement Modification B3 increases the amount of MHSA funding distributed to the RCDMH (Riverside County Department of Mental Health) by $20,698,197. This amount includes $20,473,248 for fiscal year 2008/09 and fiscal year 2009/10 PEI Services and Training and Technical Assistance and Capacity building, plus $224,949 for fiscal year 2008/09 INN Services.

The MHSA Agreement Modification B4 increases the amount of MHSA funding distributed to the RCDMH by $918,400. This amount includes $918,400 for INN Community Planning Process for Fiscal year 2009/10.

The PEI and INN components went through an extensive community planning process. The Plans were advertised for thirty (30) days and public hearings were held on July 1 & July 6, 2009 for the PEI Plan and on June 3, 2009 for the INN Plan.

These funds will be utilized over the next 3 years for implementation of PEI and INN programs.

FINANCIAL DATA:
The State DMH has approved to release an additional $21,616,597 of MHSA funding to the RCDMH. This MHSA funding has been budgeted in the Department's budget. No additional County funds are required.

MENTAL HEALTH SERVICES ACT (MHSA) AGREEMENT

Riverside County Department of Mental Health
P.O Box 7549
Riverside, CA 92513

Agreement No. 07-77333-000
Modification No. B3

State of California Department of Mental Health Community Services Division 1600 9th Street Sacramento, CA 95814	Funding Source: MHSA FUNDS Term of Agreement: 07/01/2004-06/30/2013

This MHSA Agreement is entered into by and between the State of California, Department of Mental Health, hereinafter referred to as the State and Riverside County, hereinafter referred to as the County. The County agrees to operate a program in accordance with the provisions of this agreement and to have an approved Three-Year Program and Expenditure Plan addressing the component(s) referenced below for the above named County filed with the State pursuant to the Mental Health Services Act. This modification consists of this sheet and those of the following exhibit, which is attached hereto and by this reference made a part hereof:

Funding Detail Chart — Exhibit A, pages 1 through 12
(Shaded areas in Exhibit A, Distribution Funding Detail, indicate the amount to be distributed to the County upon execution of the MHSA Agreement.)

Purpose: To incorporate and add MHSA funds as follows:

1. PEI Services FY 08-09
2. PEI Training, TA & Capacity Building FY 08-09
3. Innovation FY 08-09
4. PEI Services FY 09-10 – 75%
5. PEI Training, TA & Capacity Building FY 09-10 – 75%

If additional funds are awarded, they will be unilaterally incorporated into this Agreement.

Allocation(s):	
The State agrees to reimburse the County not to exceed the amount listed hereinafter as "Total Plan Approved Amount".	Total Plan Approved Amount $ 182,987,642 Prior Amount Distributed: $ 149,186,429 Increase/Decrease: $ 20,698,197 Total Distributed: $ 169,884,626

This agreement is exempt from Section 10295 of Chapter 2 of Part 2 of Division 2 of the Public Contract Code and is exempt from review or approval of the Dept. of General Services and the Dept. of Finance.

Approved for County (by signature)

NO SIGNATURE REQUIRED

Name and title:
Date Signed _____

FULLY EXECUTED

Approved for the State (DMH) (by signature)	I hereby certify that to my knowledge, the budgeted funds are available for the period and purpose of expenditure as stated herein:
DMH Procurement and Contracts Officer Date Signed 10/19/09	Signature of DMH Accounting Officer Date Signed 10/19/09

Planning Estimates (Authorized Use of Funds)

	SFY 2004-05	SFY 2005-06	SFY 2006-07	SFY 2007-08	SFY 2008-09	SFY 2009-10	SFY 2010-11	SFY 2011-12	SFY 2012-13	Total
Planning Estimate										
1. Community Program Planning (CPP)										
Planning	$475,032									$475,032
2. Community Services & Support (CSS)										
Services*		$16,710,700	$16,878,027	$24,913,600	$33,610,600	$47,117,200				$139,230,127
MHSA Housing Program				$19,077,100						$19,077,100
MHSA Housing Program Augmentation										$0
3. Workforce Education & Training (WET)										
Planning and Activities			$4,756,400	$5,941,870						$10,698,270
Discretionary CSS*										$0
Regional Partnerships										$0
Total WET			$4,756,400	$5,941,870	$0					$10,698,270
4. Capital Facilities & Technological Needs (Cap/Tech)										
Cap/Tech				$18,358,100	$5,768,100					$24,126,200
Discretionary CSS*										$0
Total Cap/Tech				$18,358,100	$5,768,100					$24,126,200
5. Prevention and Early Intervention (PEI)										
Planning and Services				$5,612,500	$11,649,500	$16,927,100				$34,189,100
Assigned Funding					$2,214,000	$2,214,000	$2,214,000	$2,214,000		$8,856,000
Training, Technical Assistance & Capacity Building					$327,100	$327,100	$327,100	$327,100		$1,308,400
6. Innovation										
Services					$3,673,500	$3,673,500				$7,347,000
Total Planning Estimate	$475,032	$16,710,700	$21,634,427	$73,903,170	$57,242,800	$70,258,900	$2,541,100	$2,541,100	$0	$169,966,129

* As requested by County and approved by DMH beginning in FY 2008-09.

Plan Approved Amount and Remaining Unapproved Amount

	PCA	SFY 2004-05	SFY 2005-06	SFY 2006-07	SFY 2007-08	SFY 2008-09	SFY 2009-10	SFY 2010-11	SFY 2011-12	SFY 2012-13	Total
Plan Approved Amount											
1. Community Program Planning (CPP)											
Planning	27609	$475,032									$475,032
2. Community Services & Support (CSS)											
Extension of Planning	27617		$0								$0
System Improvement	27618		$345,000								$345,000
One-Time Technology	27627		$1,089,113								$1,089,113
Other One-Time	27619		$11,098,912								$11,098,912
Services	27613		$1,391,667	$16,878,027	$24,913,600	$25,245,847	$41,083,202				$109,512,343
Prudent Reserve	27621		$2,786,008	$0	$0	$8,364,753	$6,033,998				$17,184,759
MHSA Housing Program					$19,077,100						$19,077,100
Total CSS			$16,710,700	$16,878,027	$43,990,700	$33,610,600	$47,117,200				$156,307,227
3. Workforce Education & Training (WET)											
Planning and Early Implementation	27641			$713,500	$0						$713,500
WET Activities	27640			$4,042,900	$5,941,870						$9,984,770
Regional Partnerships	27642										$0
Total WET				$4,756,400	$5,941,870	$0					$10,698,270
4. Capital Facilities & Technological Needs (Cap/Tech)											
Capital Facilities	27652				$1,300,000	$0					$1,300,000
Technological Needs	27651				$4,500,000	$0					$4,500,000
Total Cap/Tech					$5,800,000	$0					$5,800,000
5. Prevention and Early Intervention (PEI)											
Planning	27631				$2,335,400	$0	$0				$2,335,400
Services	27630				$0	$11,649,500	$11,001,764				$22,651,264
State Administered Projects						$0	$0	$0	$0		$0
Training, Technical Assistance & Capacity Building	27632					$327,100	$327,100	$0	$0		$654,200
Total PEI					$2,335,400	$11,976,600	$11,328,864	$0	$0	$0	$25,640,864
6. Innovation (INN)											
Planning	27614					$918,400	$0				$918,400
Services	27616					$224,949	$0				$224,949
Total INN						$1,143,349	$0	$0	$0	$0	$1,143,349
Total Plan Approved Amount		**$475,032**	**$16,710,700**	**$21,634,427**	**$58,067,970**	**$46,730,549**	**$58,446,064**	**$0**	**$0**	**$0**	**$202,064,742**

Remaining Unapproved Amounts		SFY 2004-05	SFY 2005-06	SFY 2006-07	SFY 2007-08	SFY 2008-09	SFY 2009-10	SFY 2010-11	SFY 2011-12	SFY 2012-13	Total
1. CPP		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
2. CSS		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
MHSA Housing					$0						$0
3. WET		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
4. Cap/Tech		$0	$0	$0	$12,558,100	$5,768,100	$0	$0	$0	$0	$18,326,200
5. PEI		$0	$0	$0	$3,277,100	$0	$5,925,336	$327,100	$327,100	$0	$9,856,636
Statewide Projects						$2,214,000	$2,214,000	$2,214,000	$2,214,000	$0	$8,856,000
6. Innovation		$0	$0	$0	$0	$2,530,151	$3,673,500	$0	$0	$0	$6,203,651

Distribution Funding Detail

SFY 2004-05

		1	2	3	4=1+2+3	5	6=4+5
Funding Source	PCA	Prior Distributed Amount	Amount to be Distributed by this Agreement/ Modification	Decrease	Total Amount Distributed to Date	Total Amount to be Distributed by Future Modifications	Total Approved Amount
SFY 2004-05							
1. Community Program Planning (CPP)	27609	$475,032	$0		$475,032	$0	$475,032
Adjustment for Reversion	27609		$0				$0
Total CPP		$475,032	$0	$0	$475,032	$0	$475,032
Total SFY 2004-05		**$475,032**	**$0**	$0	$475,032	$0	**$475,032**

Distribution Funding Detail

SFY 2005-06

		1	2	3	4=1+2+3	5	6=4+5
Funding Source	PCA	Prior Distributed Amount	Amount to be Distributed by this Agreement/ Modification	Decrease	Total Amount Distributed to Date	Total Amount to be Distributed by Future Modifications	Total Approved Amount
SFY 2005-06							
2. Community Services and Supports (CSS)							
Extension of Planning	27617	$0	$0		$0	$0	$0
System Improvement	27618	$345,000	$0		$345,000	$0	$345,000
One-Time Technology	27627	$1,089,113	$0		$1,089,113	$0	$1,089,113
Other One-Time	27619	$11,098,912	$0		$11,098,912	$0	$11,098,912
Services	27613	$1,391,667	$0		$1,391,667	$0	$1,391,667
Prudent Reserve	27621	$2,786,008	$0		$2,786,008	$0	$2,786,008
Adjustment for Reversion	27613				$0		$0
Total CSS		$16,710,700	$0	$0	$16,710,700	$0	$16,710,700
Total SFY 2005-06		**$16,710,700**	**$0**	$0	$16,710,700	$0	**$16,710,700**

Distribution Funding Detail

SFY 2006-07

		1	2	3	4=1+2+3	5	6=4+5
Funding Source	PCA	Prior Distributed Amount	Amount to be Distributed by this Agreement/ Modification	Decrease	Total Amount Distributed to Date	Total Amount to be Distributed by Future Modifications	Total Approved Amount
SFY 2006-07							
2. Community Services and Supports (CSS)							
Services	27613	$16,878,027	$0		$16,878,027	$0	$16,878,027
Prudent Reserve	27621	$0	$0		$0	$0	$0
MHSA Housing Program		$0			$0	$0	$0
Adjustment for Reversion	27613				$0	$0	$0
Total CSS		$16,878,027	$0	$0	$16,878,027	$0	$16,878,027
3. Workforce Education & Training (WET)							
Planning and Early Implementation	27641	$713,500	$0		$713,500	$0	$713,500
WET Activities	27640	$4,042,900	$0		$4,042,900	$0	$4,042,900
Adjustment for Reversion	27640				$0		$0
Total WET		$4,756,400	$0	$0	$4,756,400	$0	$4,756,400
Total SFY 2006-07		$21,634,427	$0	$0	$21,634,427	$0	$21,634,427

Distribution Funding Detail

SFY 2007-08

		1	2	3	4=1+2+3	5	6=4+5
Funding Source	PCA	Prior Distributed Amount	Amount to be Distributed by this Agreement/ Modification	Decrease	Total Amount Distributed to Date	Total Amount to be Distributed by Future Modifications	Total Approved Amount
SFY 2007-08							
2. Community Services and Supports (CSS)							
Services	27613	$24,913,600	$0		$24,913,600	$0	$24,913,600
Prudent Reserve	27621	$0	$0		$0	$0	$0
MHSA Housing Program		$19,077,100	$0		$19,077,100	$0	$19,077,100
Adjustment for Reversion	27613				$0	$0	$0
Total CSS		$43,990,700	$0	$0	$43,990,700	$0	$43,990,700
3. Workforce Education & Training (WET)							
WET Activities	27640	$5,941,870	$0		$5,941,870	$0	$5,941,870
Adjustment for Reversion	27640				$0		$0
Total WET		$5,941,870	$0	$0	$5,941,870	$0	$5,941,870
4. Capital Facilities & Technological Needs (Cap/Tech)							
Capital Facilities	27652	$1,300,000	$0		$1,300,000	$0	$1,300,000
Technological Needs	27651	$4,500,000	$0		$4,500,000	$0	$4,500,000
Adjustment for Reversion TN	27651						$0
Adjustment for Reversion CF	27652						
Total Cap/Tech		$5,800,000	$0	$0	$5,800,000	$0	$5,800,000
5. Prevention and Early Intervention (PEI)							
Planning	27631	$2,335,400	$0		$2,335,400	$0	$2,335,400
Services	27630	$0	$0		$0	$0	$0
State Administered Projects		$0	$0		$0	$0	$0
Adjustment for Reversion	27630						
Total PEI		$2,335,400	$0	$0	$2,335,400	$0	$2,335,400
Total SFY 2007-08		$58,067,970	$0	$0	$58,067,970	$0	$58,067,970

Distribution Funding Detail

SFY 2008-09

		1	2	3	4=1+2+3	5	6=4+5
Funding Source	PCA	Prior Distributed Amount	Amount to be Distributed by this Agreement/ Modification	Decrease	Total Amount Distributed to Date	Total Amount to be Distributed by Future Modifications	Total Approved Amount
SFY 2008-09							
2. Community Services and Supports (CSS)							
Services	27613	$25,245,847	$0		$25,245,847	$0	$25,245,847
Prudent Reserve	27621	$8,364,753	$0		$8,364,753	$0	$8,364,753
Adjustment for Reversion	27613				$0		$0
Total CSS		$33,610,600	$0	$0	$33,610,600	$0	$33,610,600
3. Workforce Education & Training (WET)							
Regional Partnerships	27642	$0	$0		$0	$0	$0
Adjustment for Reversion	27642				$0		$0
Total WET		$0	$0	$0	$0	$0	$0
4. Capital Facilities & Technological Needs (Cap/Tech)							
Capital Facilities	27652	$0	$0		$0	$0	$0
Technological Needs	27651	$0	$0		$0	$0	$0
Adjustment for Reversion TN	27651						$0
Adjustment for Reversion CF	27652						
Total Cap/Tech		$0	$0	$0	$0	$0	$0
5. Prevention and Early Intervention (PEI)							
Planning	27631	$0	$0		$0	$0	$0
Services	27630	$0	$11,649,500		$11,649,500	$0	$11,649,500
State Administered Projects		$0	$0		$0	$0	$0
Training, TA & Capacity Building	27632		$327,100		$327,100		$327,100
Adjustment for Reversion	27630						
Total PEI		$0	$11,976,600	$0	$11,976,600	$0	$11,976,600
6 Innovation							
Planning	27614	$918,400	$0		$918,400		$918,400
Services	27616		$224,949		$224,949	$0	$224,949
Adjustment for Reversion	27616						
Total Innovation		$918,400	$224,949	$0	$1,143,349	$0	$1,143,349
Total SFY 2008-09		$34,529,000	$12,201,549	$0	$46,730,549	$0	$46,730,549

Distribution Funding Detail

SFY 2009-10

Funding Source	PCA	1 Prior Distributed Amount	2 Amount to be Distributed by this Agreement/ Modification	3 Decrease	4=1+2+3 Total Amount Distributed to Date	5 Total Amount to be Distributed by Future Modifications	6=4+5 Total Approved Amount
SFY 2009-10							
2. Community Services and Supports (CSS)							
Services	27613	$30,812,402	$0		$30,812,402	$10,270,800	$41,083,202
Prudent Reserve	27621	$6,033,998	$0		$6,033,998		$6,033,998
Adjustment for Reversion	27613				$0		$0
Total CSS		$36,846,400	$0	$0	$36,846,400	$10,270,800	$47,117,200
5. Prevention and Early Intervention (PEI)							
Planning	27631	$0			$0		$0
Services	27630	$0	$8,251,323		$8,251,323	$2,750,441	$11,001,764
State Administered Projects		$0			$0	$0	$0
Training, TA & Capacity Building	27632	$0	$245,325		$245,325	$81,775	$327,100
Adjustment for Reversion	27630						
Total PEI		$0	$8,496,648	$0	$8,496,648	$2,832,216	$11,328,864
6. Innovation							
Planning	27614	$0	$0		$0		$0
Services	27616	$0			$0		$0
Adjustment for Reversion	27616						
Total Innovation		$0	$0	$0	$0		$0
Total SFY 2009-10		$36,846,400	$8,496,648	$0	$45,343,048	$13,103,016	$58,446,064

Distribution Funding Detail

SFY 2010-11

		1	2	3	4=1+2+3	5	6=4+5
Funding Source	PCA	Prior Distributed Amount	Amount to be Distributed by this Agreement/ Modification	Decrease	Total Amount Distributed to Date	Total Amount to be Distributed by Future Modifications	Total Approved Amount
SFY 2010-11							
2. Community Services and Supports (CSS)							
Services	27613	$0			$0	$0	$0
Prudent Reserve	27621	$0			$0	$0	$0
Adjustment for Reversion	27613				$0		$0
Total CSS		$0		$0	$0	$0	$0
5. Prevention and Early Intervention (PEI)							
Planning	27631	$0			$0	$0	$0
Services	27630	$0			$0	$0	$0
State Administered Projects		$0			$0	$0	$0
Training, TA & Capacity Building	27632						
Adjustment for Reversion	27630						
Total PEI		$0	$0	$0	$0	$0	$0
6. Innovation							
Planning	27614						
Services	27616				$0	$0	$0
Adjustment for Reversion	27616						
Total Innovation		$0	$0	$0	$0	$0	$0
Total SFY 2010-11		$0	$0	$0	$0	$0	$0

Distribution Funding Detail

SFY 2011-12

		1	2	3	4=1+2+3	5	6=4+5
Funding Source	PCA	Prior Distributed Amount	Amount to be Distributed by this Agreement/ Modification	Decrease	Total Amount Distributed to Date	Total Amount to be Distributed by Future Modifications	Total Approved Amount
SFY 2011-12							
2. Community Services and Supports (CSS)							
Services	27613	$0			$0	$0	$0
Prudent Reserve	27621	$0			$0	$0	$0
Adjustment for Reversion	27613				$0		$0
Total CSS		$0	$0	$0	$0	$0	$0
5. Prevention and Early Intervention (PEI)							
Planning	27631	$0			$0	$0	$0
Services	27630	$0			$0	$0	$0
State Administered Projects		$0			$0	$0	$0
Training, TA & Capacity Building	27632						
Adjustment for Reversion	27630						
Total PEI		$0	$0	$0	$0	$0	$0
6. Innovation							
Planning	27614						
Services	27616				$0	$0	$0
Adjustment for Reversion	27616						
Total Innovation		$0	$0	$0	$0	$0	$0
Total SFY 2011-12		$0	$0	$0	$0	$0	$0

Distribution Funding Detail

SFY 2012-13

		1	2	3	4=1+2+3	5	6=4+5
Funding Source	PCA	Prior Distributed Amount	Amount to be Distributed by this Agreement/ Modification	Decrease	Total Amount Distributed to Date	Total Amount to be Distributed by Future Modifications	Total Approved Amount
SFY 2012-13							
2. Community Services and Supports (CSS)							
Services	27613	$0			$0	$0	$0
Prudent Reserve	27621	$0			$0	$0	$0
Adjustment for Reversion	27613				$0		$0
Total CSS		$0	$0	$0	$0	$0	$0
5. Prevention and Early Intervention (PEI)							
Planning	27631	$0			$0	$0	$0
Services	27630	$0			$0	$0	$0
State Administered Projects		$0			$0	$0	$0
Training, TA & Capacity Building	27632						
Adjustment for Reversion	27630						
Total PEI		$0	$0	$0	$0	$0	$0
6. Innovation							
Planning	27614						
Services	27616				$0	$0	$0
Adjustment for Reversion	27616						
Total Innovation		$0	$0	$0	$0	$0	$0
Total SFY 2012-13		$0	$0	$0	$0	$0	$0

Funding Source PCA	Prior Distributed Amount	Amount to be Distributed by this Agreement/ Modification	Decrease	Total Amount Distributed to Date	Total Amount to be Distributed by Future Modifications	Total Approved Amount
Total All Fiscal Years						
SFY 2004-05	$475,032	$0	$0	$475,032	$0	$475,032
SFY 2005-06	$16,710,700	$0	$0	$16,710,700	$0	$16,710,700
SFY 2006-07	$21,634,427	$0	$0	$21,634,427	$0	$21,634,427
SFY 2007-08	$58,067,970	$0	$0	$58,067,970	$0	$58,067,970
SFY 2008-09	$34,529,000	$12,201,549	$0	$46,730,549	$0	$46,730,549
SFY 2009-10	$36,846,400	$8,496,648	$0	$45,343,048	$13,103,016	$58,446,064
SFY 2010-11	$0	$0	$0	$0	$0	$0
SFY 2011-12	$0	$0	$0	$0	$0	$0
SFY 2012-13	$0	$0	$0	$0	$0	$0
Total All Fiscal Years	$168,263,529	$20,698,197	$0	$188,961,726	$13,103,016	$202,064,742
Less: Assigned Funds						
MHSA Housing	$19,077,100	$0	$0	$19,077,100	$0	$19,077,100
State Administered Projects	$0	$0	$0	$0	$0	$0
Total Assigned Funds	$19,077,100	$0	$0	$19,077,100	$0	$19,077,100
Less: Total Adjustment for Reversion	$0	$0				
Net Distribution	**$149,186,429**	**$20,698,197**		$169,884,626	$13,103,016	$182,987,642

MENTAL HEALTH SERVICES ACT (MHSA) AGREEMENT

Riverside County Department of Mental Health
P.O. Box 7549
Riverside, CA 92513

Agreement No. 07-77333-000
Modification No. B4

State of California Department of Mental Health Community Services Division 1600 9th Street Sacramento, CA 95814	Funding Source: MHSA FUNDS Term of Agreement: 07/01/2004-06/30/2013

This MHSA Agreement is entered into by and between the State of California, Department of Mental Health, hereinafter referred to as the State and Riverside County, hereinafter referred to as the County. The County agrees to operate a program in accordance with the provisions of this agreement and to have an approved Three-Year Program and Expenditure Plan addressing the component(s) referenced below for the above named County filed with the State pursuant to the Mental Health Services Act. This modification consists of this sheet and those of the following exhibit, which is attached hereto and by this reference made a part hereof:

Funding Detail Chart — Exhibit A, pages 1 through 12
(Shaded areas in Exhibit A, Distribution Funding Detail, indicate the amount to be distributed to the County upon execution of the MHSA Agreement.)

Purpose: To incorporate and add MHSA funds as follows:
1. Innovation CPP – 09/10

If additional funds are awarded, they will be unilaterally incorporated into this Agreement.

Allocation(s): The State agrees to reimburse the County not to exceed the amount listed hereinafter as "Total Plan Approved Amount".	Total Plan Approved Amount $ 183,906,042 Prior Amount Distributed: $ 169,884,626 Increase/Decrease: $ 918,400 Total Distributed: $ 170,803,026

This agreement is exempt from Section 10295 of Chapter 2 of Part 2 of Division 2 of the Public Contract Code and is exempt from review or approval of the Dept. of General Services and the Dept. of Finance.

Approved for County (by signature)

NO SIGNATURE REQUIRED

Name and title:
Date Signed _____

FULLY EXECUTED

Approved for the State (DMH) (by signature) DMH Procurement and Contracts Officer Date Signed 11/5/09	I hereby certify that to my knowledge, the budgeted funds are available for the period and purpose of expenditure as stated herein: Signature of DMH Accounting Officer Date Signed 11/3/09

Plan Approved Amount and Remaining Unapproved Amount

	PCA	SFY 2004-05	SFY 2005-06	SFY 2006-07	SFY 2007-08	SFY 2008-09	SFY 2009-10	SFY 2010-11	SFY 2011-12	SFY 2012-13	Total
Plan Approved Amount											
1. Community Program Planning (CPP)											
Planning	27609	$475,032									$475,032
2. Community Services & Support (CSS)											
Extension of Planning	27617		$0								$0
System Improvement	27618		$345,000								$345,000
One-Time Technology	27627		$1,089,113								$1,089,113
Other One-Time	27619		$11,098,912								$11,098,912
Services	27613		$1,391,667	$16,878,027	$24,913,600	$25,245,847	$41,083,202				$109,512,343
Prudent Reserve	27621		$2,786,008	$0	$0	$8,364,753	$6,033,998				$17,184,759
MHSA Housing Program					$19,077,100						$19,077,100
Total CSS			$16,710,700	$16,878,027	$43,990,700	$33,610,600	$47,117,200				$158,307,227
3. Workforce Education & Training (WET)											
Planning and Early Implementation	27641			$713,500	$0						$713,500
WET Activities	27640			$4,042,900	$5,941,870						$9,984,770
Regional Partnerships	27642										$0
Total WET				$4,756,400	$5,941,870	$0					$10,698,270
4. Capital Facilities & Technological Needs (Cap/Tech)											
Capital Facilities	27652				$1,300,000	$0					$1,300,000
Technological Needs	27651				$4,500,000	$0					$4,500,000
Total Cap/Tech					$5,800,000	$0					$5,800,000
5. Prevention and Early Intervention (PEI)											
Planning	27631				$2,335,400	$0	$0				$2,335,400
Services	27630				$0	$11,649,500	$11,001,764				$22,651,264
State Administered Projects						$0	$0	$0	$0		$0
Training, Technical Assistance & Capacity Building	27632					$327,100	$327,100	$0	$0		$654,200
Total PEI					$2,335,400	$11,976,600	$11,328,864	$0	$0	$0	$25,640,864
6. Innovation (INN)											
Planning	27614					$918,400	$918,400				$1,836,800
Services	27616					$224,949	$0				$224,949
Total INN						$1,143,349	$918,400	$0	$0	$0	$2,061,749
Total Plan Approved Amount		**$475,032**	**$16,710,700**	**$21,634,427**	**$58,067,970**	**$46,730,549**	**$59,364,464**	**$0**	**$0**	**$0**	**$202,983,142**

Remaining Unapproved Amounts		SFY 2004-05	SFY 2005-06	SFY 2006-07	SFY 2007-08	SFY 2008-09	SFY 2009-10	SFY 2010-11	SFY 2011-12	SFY 2012-13	Total
1. CPP		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
2. CSS		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
MHSA Housing					$0						$0
3. WET		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
4. Cap/Tech		$0	$0	$0	$12,556,100	$5,768,100	$0	$0	$0	$0	$18,326,200
5. PEI		$0	$0	$0	$3,277,100	$0	$5,925,336	$327,100	$327,100	$0	$9,856,636
Statewide Projects						$2,214,000	$2,214,000	$2,214,000	$2,214,000	$0	$8,856,000
6. Innovation		$0	$0	$0	$0	$2,530,151	$2,755,100	$0	$0	$0	$5,285,251

Distribution Funding Detail

SFY 2004-05

		1	2	3	4=1+2+3	5	6=4+5
Funding Source	PCA	Prior Distributed Amount	Amount to be Distributed by this Agreement/ Modification	Decrease	Total Amount Distributed to Date	Total Amount to be Distributed by Future Modifications	Total Approved Amount
SFY 2004-05							
1. Community Program Planning (CPP)	27609	$475,032	$0		$475,032	$0	$475,032
Adjustment for Reversion	27609		$0				$0
Total CPP		$475,032	$0	$0	$475,032	$0	$475,032
Total SFY 2004-05		**$475,032**	**$0**	$0	$475,032	$0	**$475,032**

Distribution Funding Detail

SFY 2005-06

Funding Source	PCA	1 Prior Distributed Amount	2 Amount to be Distributed by this Agreement/ Modification	3 Decrease	4=1+2+3 Total Amount Distributed to Date	5 Total Amount to be Distributed by Future Modifications	6=4+5 Total Approved Amount
SFY 2005-06							
2. Community Services and Supports (CSS)							
Extension of Planning	27617	$0	$0		$0	$0	$0
System Improvement	27618	$345,000	$0		$345,000	$0	$345,000
One-Time Technology	27627	$1,089,113	$0		$1,089,113	$0	$1,089,113
Other One-Time	27619	$11,098,912	$0		$11,098,912	$0	$11,098,912
Services	27613	$1,391,667	$0		$1,391,667	$0	$1,391,667
Prudent Reserve	27621	$2,786,008	$0		$2,786,008	$0	$2,786,008
Adjustment for Reversion	27613				$0		$0
Total CSS		$16,710,700	$0	$0	$16,710,700	$0	$16,710,700
Total SFY 2005-06		**$16,710,700**	**$0**	$0	$16,710,700	$0	**$16,710,700**

Distribution Funding Detail

SFY 2006-07

		1	2	3	4=1+2+3	5	6=4+5
Funding Source	PCA	Prior Distributed Amount	Amount to be Distributed by this Agreement/ Modification	Decrease	Total Amount Distributed to Date	Total Amount to be Distributed by Future Modifications	Total Approved Amount
SFY 2006-07							
2. Community Services and Supports (CSS)							
Services	27613	$16,878,027	$0		$16,878,027	$0	$16,878,027
Prudent Reserve	27621	$0	$0		$0	$0	$0
MHSA Housing Program		$0			$0	$0	$0
Adjustment for Reversion	27613				$0	$0	$0
Total CSS		$16,878,027	$0	$0	$16,878,027	$0	$16,878,027
3. Workforce Education & Training (WET)							
Planning and Early Implementation	27641	$713,500	$0		$713,500	$0	$713,500
WET Activities	27640	$4,042,900	$0		$4,042,900	$0	$4,042,900
Adjustment for Reversion	27640				$0		$0
Total WET		$4,756,400	$0	$0	$4,756,400	$0	$4,756,400
Total SFY 2006-07		**$21,634,427**	**$0**	$0	$21,634,427	$0	**$21,634,427**

Distribution Funding Detail

SFY 2007-08

Funding Source	PCA	1 Prior Distributed Amount	2 Amount to be Distributed by this Agreement/ Modification	3 Decrease	4=1+2+3 Total Amount Distributed to Date	5 Total Amount to be Distributed by Future Modifications	6=4+5 Total Approved Amount
SFY 2007-08							
2. Community Services and Supports (CSS)							
Services	27613	$24,913,600	$0		$24,913,600	$0	$24,913,600
Prudent Reserve	27621	$0	$0		$0	$0	$0
MHSA Housing Program		$19,077,100	$0		$19,077,100	$0	$19,077,100
Adjustment for Reversion	27613				$0	$0	$0
Total CSS		$43,990,700	$0	$0	$43,990,700	$0	$43,990,700
3. Workforce Education & Training (WET)							
WET Activities	27640	$5,941,870	$0		$5,941,870	$0	$5,941,870
Adjustment for Reversion	27640				$0		$0
Total WET		$5,941,870	$0	$0	$5,941,870	$0	$5,941,870
4. Capital Facilities & Technological Needs (Cap/Tech)							
Capital Facilities	27652	$1,300,000	$0		$1,300,000	$0	$1,300,000
Technological Needs	27651	$4,500,000	$0		$4,500,000	$0	$4,500,000
Adjustment for Reversion TN	27651						$0
Adjustment for Reversion CF	27652						
Total Cap/Tech		$5,800,000	$0	$0	$5,800,000	$0	$5,800,000
5. Prevention and Early Intervention (PEI)							
Planning	27631	$2,335,400	$0		$2,335,400	$0	$2,335,400
Services	27630	$0	$0		$0	$0	$0
State Administered Projects		$0	$0		$0	$0	$0
Adjustment for Reversion	27630						
Total PEI		$2,335,400	$0	$0	$2,335,400	$0	$2,335,400
Total SFY 2007-08		**$58,067,970**	**$0**	$0	$58,067,970	$0	**$58,067,970**

Distribution Funding Detail

SFY 2008-09

Funding Source	PCA	1 Prior Distributed Amount	2 Amount to be Distributed by this Agreement/ Modification	3 Decrease	4=1+2+3 Total Amount Distributed to Date	5 Total Amount to be Distributed by Future Modifications	6=4+5 Total Approved Amount
SFY 2008-09							
2. Community Services and Supports (CSS)							
Services	27613	$25,245,847	$0		$25,245,847	$0	$25,245,847
Prudent Reserve	27621	$8,364,753	$0		$8,364,753	$0	$8,364,753
Adjustment for Reversion	27613				$0		$0
Total CSS		$33,610,600	$0	$0	$33,610,600	$0	$33,610,600
3. Workforce Education & Training (WET)							
Regional Partnerships	27642	$0	$0		$0	$0	$0
Adjustment for Reversion	27642				$0		$0
Total WET		$0	$0	$0	$0	$0	$0
4. Capital Facilities & Technological Needs (Cap/Tech)							
Capital Facilities	27652	$0	$0		$0	$0	$0
Technological Needs	27651	$0	$0		$0	$0	$0
Adjustment for Reversion TN	27651						$0
Adjustment for Reversion CF	27652						
Total Cap/Tech		$0	$0	$0	$0	$0	$0
5. Prevention and Early Intervention (PEI)							
Planning	27631	$0	$0		$0	$0	$0
Services	27630	$11,649,500	$0		$11,649,500	$0	$11,649,500
State Administered Projects		$0	$0		$0	$0	$0
Training, TA & Capacity Building	27632	$327,100	$0		$327,100		$327,100
Adjustment for Reversion	27630						
Total PEI		$11,976,600	$0	$0	$11,976,600	$0	$11,976,600
6. Innovation							
Planning	27614	$918,400	$0		$918,400		$918,400
Services	27616	$224,949	$0		$224,949	$0	$224,949
Adjustment for Reversion	27616						
Total Innovation		$1,143,349	$0	$0	$1,143,349	$0	$1,143,349
Total SFY 2008-09		**$46,730,549**	**$0**	$0	$46,730,549	$0	**$46,730,549**

Distribution Funding Detail

SFY 2009-10

Funding Source	PCA	1 Prior Distributed Amount	2 Amount to be Distributed by this Agreement/ Modification	3 Decrease	4=1+2+3 Total Amount Distributed to Date	5 Total Amount to be Distributed by Future Modifications	6=4+5 Total Approved Amount
SFY 2009-10							
2. Community Services and Supports (CSS)							
Services	27613	$30,812,402	$0		$30,812,402	$10,270,800	$41,083,202
Prudent Reserve	27621	$6,033,998	$0		$6,033,998		$6,033,998
Adjustment for Reversion	27613				$0		$0
Total CSS		$36,846,400	$0	$0	$36,846,400	$10,270,800	$47,117,200
5. Prevention and Early Intervention (PEI)							
Planning	27631	$0			$0		$0
Services	27630	$8,251,323	$0		$8,251,323	$2,750,441	$11,001,764
State Administered Projects		$0			$0	$0	$0
Training, TA & Capacity Building	27632	$245,325	$0		$245,325	$81,775	$327,100
Adjustment for Reversion	27630						
Total PEI		$8,496,648	$0	$0	$8,496,648	$2,832,216	$11,328,864
6. Innovation							
Planning	27614	$0	$918,400		$918,400		$918,400
Services	27616	$0			$0		$0
Adjustment for Reversion	27616						
Total Innovation		$0	$918,400	$0	$918,400		$918,400
Total SFY 2009-10		**$45,343,048**	**$918,400**	**$0**	**$46,261,448**	**$13,103,016**	**$59,364,464**

Distribution Funding Detail

SFY 2010-11

		1	2	3	4=1+2+3	5	6=4+5
Funding Source	PCA	Prior Distributed Amount	Amount to be Distributed by this Agreement/ Modification	Decrease	Total Amount Distributed to Date	Total Amount to be Distributed by Future Modifications	Total Approved Amount
SFY 2010-11							
2. Community Services and Supports (CSS)							
Services	27613	$0			$0	$0	$0
Prudent Reserve	27621	$0			$0	$0	$0
Adjustment for Reversion	27613				$0		$0
Total CSS		$0		$0	$0	$0	$0
5. Prevention and Early Intervention (PEI)							
Planning	27631	$0			$0	$0	$0
Services	27630	$0			$0	$0	$0
State Administered Projects		$0			$0	$0	$0
Training, TA & Capacity Building	27632						
Adjustment for Reversion	27630						
Total PEI		$0	$0	$0	$0	$0	$0
6. Innovation							
Planning	27614						
Services	27616				$0	$0	$0
Adjustment for Reversion	27616						
Total Innovation		$0	$0	$0	$0	$0	$0
Total SFY 2010-11		$0	$0	$0	$0	$0	$0

Distribution Funding Detail

SFY 2011-12

		1	2	3	4=1+2+3	5	6=4+5
Funding Source	PCA	Prior Distributed Amount	Amount to be Distributed by this Agreement/ Modification	Decrease	Total Amount Distributed to Date	Total Amount to be Distributed by Future Modifications	Total Approved Amount
SFY 2011-12							
2. Community Services and Supports (CSS)							
Services	27613	$0			$0	$0	$0
Prudent Reserve	27621	$0			$0	$0	$0
Adjustment for Reversion	27613				$0		$0
Total CSS		$0	$0	$0	$0	$0	$0
5. Prevention and Early Intervention (PEI)							
Planning	27631	$0			$0	$0	$0
Services	27630	$0			$0	$0	$0
State Administered Projects		$0			$0	$0	$0
Training, TA & Capacity Building	27632						
Adjustment for Reversion	27630						
Total PEI		$0	$0	$0	$0	$0	$0
6. Innovation							
Planning	27614						
Services	27616				$0	$0	$0
Adjustment for Reversion	27616						
Total Innovation		$0	$0	$0	$0	$0	$0
Total SFY 2011-12		$0	$0	$0	$0	$0	$0

Distribution Funding Detail

SFY 2012-13

Funding Source	PCA	1 Prior Distributed Amount	2 Amount to be Distributed by this Agreement/ Modification	3 Decrease	4=1+2+3 Total Amount Distributed to Date	5 Total Amount to be Distributed by Future Modifications	6=4+5 Total Approved Amount
SFY 2012-13							
2. Community Services and Supports (CSS)							
Services	27613	$0			$0	$0	$0
Prudent Reserve	27621	$0			$0	$0	$0
Adjustment for Reversion	27613				$0		$0
Total CSS		$0	$0	$0	$0	$0	$0
5. Prevention and Early Intervention (PEI)							
Planning	27631	$0			$0	$0	$0
Services	27630	$0			$0	$0	$0
State Administered Projects		$0			$0	$0	$0
Training, TA & Capacity Building	27632						
Adjustment for Reversion	27630						
Total PEI		$0	$0	$0	$0	$0	$0
6. Innovation							
Planning	27614						
Services	27616				$0	$0	$0
Adjustment for Reversion	27616						
Total Innovation		$0	$0	$0	$0	$0	$0
Total SFY 2012-13		$0	$0	$0	$0	$0	$0

Funding Source PCA	Prior Distributed Amount	Amount to be Distributed by this Agreement/ Modification	Decrease	Total Amount Distributed to Date	Total Amount to be Distributed by Future Modifications	Total Approved Amount
Total All Fiscal Years						
SFY 2004-05	$475,032	$0	$0	$475,032	$0	$475,032
SFY 2005-06	$16,710,700	$0	$0	$16,710,700	$0	$16,710,700
SFY 2006-07	$21,634,427	$0	$0	$21,634,427	$0	$21,634,427
SFY 2007-08	$58,067,970	$0	$0	$58,067,970	$0	$58,067,970
SFY 2008-09	$46,730,549	$0	$0	$46,730,549	$0	$46,730,549
SFY 2009-10	$45,343,048	$918,400	$0	$46,261,448	$13,103,016	$59,364,464
SFY 2010-11	$0	$0	$0	$0	$0	$0
SFY 2011-12	$0	$0	$0	$0	$0	$0
SFY 2012-13	$0	$0	$0	$0	$0	$0
Total All Fiscal Years	$188,961,726	$918,400	$0	$189,880,126	$13,103,016	$202,983,142
Less: Assigned Funds						
MHSA Housing	$19,077,100	$0	$0	$19,077,100	$0	$19,077,100
State Administered Projects	$0	$0	$0	$0	$0	$0
Total Assigned Funds	$19,077,100	$0	$0	$19,077,100	$0	$19,077,100
Less: Total Adjustment for Reversion	$0	$0				
Net Distribution	**$169,884,626**	**$918,400**		$170,803,026	$13,103,016	$183,906,042

EXHIBIT A

INNOVATION WORK PLAN
COUNTY CERTIFICATION

County Name: Riverside County

County Mental Health Director	Project Lead
Name: Jerry Wengerd Telephone Number: 951-358-4500 E-mail: wengerd@rcmhd.org	Name: Bill Brenneman Telephone Number: 951-358-4563 E-mail: bhbrenneman@rcmhd.org
Mailing Address: 4095 County Circle Drive Riverside, CA 92503	Mailing Address: 4095 County Circle Drive Riverside, CA 92503

I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this Innovation Work Plan. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and Title 9, California Code of Regulations (CCR), Section 3410, Non-Supplant.

This Work Plan has been developed with the participation of stakeholders, in accordance with Title 9, CCR Sections 3300, 3310(d) and 3315(a). The draft Work Plan was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board or commission. All input has been considered with adjustments made, as appropriate. Any Work Plan requiring participation from individuals has been designed for voluntary participation therefore all participation by individuals in the proposed Work Plan is voluntary, pursuant to Title 9, CCR, Section 3400 (b)(2).

All documents in the attached Work Plan are true and correct.

Jerry Wengerd — Signature (Local Mental Health Director/Designee)

9-14-09 — Date

Mental Health Director — Title

Exhibit B

INNOVATION WORK PLAN
Description of Community Program Planning and Local Review Processes

County Name: Riverside County
Work Plan Name: Recovery Arts Core Project

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this Annual Update.

1. **Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. It shall include the methods for obtaining stakeholder input. (suggested length – one-half page)**

   The proposed Arts Core Project is put forward prior to the rest of the Innovation plan because it surfaced through all of our previous planning processes. Specifically the idea stemmed out of three key Community Planning Processes: (1) Community Services and Supports (CSS), (2) Prevention and Early Intervention, and (3) Annual Update Public Hearings. All groups, within these processes, consisted of a wide range of age and cultural diversity representation.

   The original CSS and PEI Planning Process included consumers, family members, staff, key agencies, specialty groups, and general community stakeholders. The methods for obtaining their input included focus groups, community forums, surveys, interviews, facilitated workgroups, and public hearings.

   In CSS, approximately 1,500 individuals participated in the Stakeholder Process. There were 81 consumer, family and community Focus Groups conducted, 15 of which were specifically held for Spanish-speaking individuals. There were 15 additional Focus Groups for staff and 3 for housing providers. Approximately 124 individuals participated in the Spanish speaking Focus Groups.

   During the PEI Planning Process, an additional 108 Focus Groups were conducted with 1,147 participants. Of these Focus Groups, 12 were conducted in Spanish with 111 participants. Input surveys, both in Spanish and English, were also completed by 2,354 individuals.

   The Public Hearings for the Annual Updates were open community meetings advertised in regional and local Spanish newspapers, and through mental health clinics and County libraries. Spanish translation services were available at all hearings and all documents were translated into Spanish.

The idea of a creative arts program, which surfaced in all of the three community processes, is to test out mobility in diverse and non-traditional settings. This concept was then taken to special Innovation planning meetings for feedback and input and it received unanimous support. Those meetings included representation from the Mental Health Board, Peer Center Advisory Committee, and MHSA Planning Committees. The Mental Health Board includes the perspectives of consumer and family members. The Peer Advisory Committee included 26 consumers which represented Caucasian, Hispanic, African-American, and Native American communities. The MHSA Planning Group included 19 individuals representing all age groups, representatives from the Cultural Competency Committee, the LGBTQ community, public and private community based agencies and consumer and family members. The MHSA Committee Planning Group suggested that the Department consider the underserved communities during the implementation phase, although the primary purpose would be to establish better quality of services and outcomes.

All survey and feedback forms were provided in English and Spanish. All documents related to the Innovation project were posted on the Department website, at County clinics, and County libraries in both English and Spanish. Advertisement for the Innovation Public Hearing included the Spanish version of the Press Enterprise newspaper called La Prensa, which is distributed in all regions of the County. A Spanish translator was also available at the Public Hearing for this component. Spanish is the only threshold language in Riverside County.

2. Identify the stakeholder entities involved in the Community Program Planning Process.

The Innovation project proposal was presented and input solicited from the MHSA Planning Committees and Mental Health Board (MHB).

Both the CSS and PEI Planning Process involved consumers, family members, and parents affected by mental illness, as well as stakeholders which included service providers and system partners, representatives from community-based organizations, Social Services, Probation, Office on Aging, County Office of Education, Health Department, Board of Supervisors, Executive Office, Law Enforcement, Public Defender and the Stakeholder Leadership Committee to name a few. Key stakeholders were the National Alliance for the Mentally Ill (NAMI), Family Advocate, and Parent Partners representatives. In addition, consultants worked with the Department to provide Gay, Lesbian, Bi-sexual, Transgender, and Questioning (GLBTQ), Native American, African American, and Deaf community perspectives.

The additional planning groups included a MHB AdHoc Committee, a Peer Advisory Committee, and a MHSA Planning Group. The MHB AdHoc was comprised of consumers and family members. The Peer Advisory Committee included consumers receiving services through the Peer Support and Resource Centers, and MHSA Planning Group included cross representation from the Adult System of Care, Transition Age Youth, Older Adult, Cultural Competency, and GLBTQ committee representatives.

3. List the dates of the 30-day stakeholder review and public hearing. Attach substantive comments received during the stakeholder review and public hearing and responses to those comments. Indicate if none received.

The Recovery Arts Core Project was posted for public review and comment from May 1 through June 2, 2009 on the Department's website and distributed to County clinics and libraries as well as to the Stakeholder Leadership and MHSA Committees. A Public Hearing was held on June 3, 2009 by the Mental Health Board and all community input and comments were documented The MHB Executive Committee met on June 9, 2009 to review input and determine if changes to the project were necessary. All input, comments, and Board recommendations are documented and included in Attachment 1.

EXHIBIT C

Innovation Work Plan Narrative

Date: 9/2/09

County: Riverside County

Work Plan #: INN-01

Work Plan Name: Recovery Arts Core Project

Purpose of Proposed Innovation Project (check all that apply)

☐ INCREASE ACCESS TO UNDERSERVED GROUPS
☒ **INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES**
☐ PROMOTE INTERAGENCY COLLABORATION
☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s)

Increase the quality of services, including better outcomes: The primary purpose of the Recovery Arts Core (RAC) Project will be to increase the Quality of Services, including the development of more systematic outcomes to measure the effectiveness of the program. This Innovation Project will contribute to learning by closely measuring the impacts of peer-delivered arts services on consumers receiving services through the Riverside County Department of Mental Health (RCDMH). Peer-delivered services and expressive arts opportunities have continually been recommended through MHSA Community Planning activities and have helped to inform the Department on the selection of this particular Innovation Project.

Currently there is only anecdotal evidence to support the impact of peer-delivered art education within the Riverside County Mental Health system and relation to consumer's recovery. By adapting the 'Art Core' Project to be a mobile, community-based approach, and then systematically evaluating its effectiveness, the Department will be able to determine it's usefulness in future programmatic decision making. In difficult economic times, the Department has identified the need to pilot and explore services that are more cost effective and less intensive but are proven effective models. This Innovation Project allows Mental Health the opportunity to measure the direct impact that community based peer-delivered art education has on our consumers, their recovery, and the mental health system.

The Department acknowledges that the Arts Core Project will have many additional benefits to our system and consumers as described below:

Expected secondary outcomes of the project are lessons regarding activities to **increase access to underserved groups** within Riverside County Department of Mental Health. As stakeholders reviewing this project have noted, the nature of the intervention (a mobile unit with a focus on underserved groups) can provide lessons about how to better engage consumers from underserved groups throughout the community. The project's planned outreach includes groups such as Hispanic, GLBTQ, Native American, and other identified underserved communities.

Additionally, the study can provide lessons regarding activities to **increase access to services**. As the project involves a mobile unit, it will speak to the effectiveness of bringing peer-delivered services, recovery education, and occupational therapist services (helping individuals develop meaningful roles and activities by identifying specific strengths and functional challenges) to organizations that currently offer little to none of these supports.

The study can also provide lessons on activities to **promote interagency collaboration**. This study will work with many different organizations within the community to leverage not only funding, but also programming and other essential support, thus building broader community support for the mentally ill. For example, the project relies on art teachers and consultants from different universities in the area (Cal State San Bernardino, University of California Riverside, and Loma Linda School of Occupational Therapy) for programming as well as the Riverside Arts Council, the Riverside Cultural Consortium for funding and marketing. In addition, to reach the goal of outreaching to underserved populations, interagency collaboration is essential to the success of this project. These agencies can include schools, primary care organizations, including community clinics and health centers, housing and homeless services, employment programs, law enforcement, spiritual organizations, and other pertinent organizations.

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)

The Department believes that by piloting a mobile community-based peer delivered Arts Core Project it will not only increase the Quality of Services offered to our consumers, but will provide an opportunity to develop systematic measures and outcomes to prove its effectiveness. Based on the outcomes, the Department can then make more informed decisions about the use of this promising model in future program and implementation planning. The Department firmly believes that the Arts Core Project fits uniquely within the parameters outlined in the Innovation guidelines as well as meeting the General Standards required of MHSA.

The Recovery Arts Core Project, which is managed out of the peer-run centers, creates a mobile unit of peer support specialists, peer artists, local artists, professional educators, and occupational therapist interns who together facilitate a 6 - 8 week program of peer-based recovery and creative arts activities within community organizations throughout Riverside County. The curriculum consists of peer presentations on recovery (such as “In Our Own Voice” and an original play written and performed by peer artists); two peer-taught “Recovery Pathways” classes; and two to four art classes (art fundamentals, drama, creative writing, music, and/or dance). At the end of the 6 - 8 week program, the curriculum is provided to the organization, so they may continue to teach these methods after the initial program is completed.

Additionally, the artwork and other projects created by the peers, family members and friends will be exhibited (for visual arts) and performed (for performance art) throughout Riverside County.

The Recovery Arts Core Project proposes to impact the quality of service and achieve better outcomes by:

- Providing a proactive mobile unit that will go into the community and reach people of all ages and socioeconomic status rather than wait for them to come into clinics for services.
- Providing value, not only to the consumers receiving the arts services, but enhancing recovery to those who provide the services, as well. The other main benefit is to the consumers in the community organizations that are trained in the model and become facilitators themselves.
- Being structured, so the core team is assembled to best suit specific populations' needs and the program can be customized to explore the richness of specific cultures. A bi-lingual peer support specialist will also be a member of the team for Spanish-speaking populations.
- Facilitating a new paradigm in the professional-client relationships of health care with its peer-based recovery and wellness environment. This new paradigm enlists the essential support of peer-driven activities that can address the multiple, ongoing, psychological, social, emotional, and spiritual needs among individuals who have similar life experiences.
- Expanding engagement and introduction to peer support for consumers through expressive art.
- Bringing additional paths and assistance for recovery to more consumers, especially those in underserved communities.
- Moving beyond arts and crafts as a pastime and using creative expression to teach recovery principles. It enhances a sense of recovery, identity, and self-worth through the development of personal interests, which are essential to development for community integration and independence.
- Bringing the arts into the mental health setting. Arts have been proven to work for individuals in finding and expressing their own individuality, and for communities to express a group's identity and accomplishments.
- Creating community support and involvement of consumers in community activities.
- Building bridges within the community, encouraging interagency collaboration, by involving local artists, art organizations, schools, and other nonprofits at the grassroots level. The arts are a point around which groups from many different organizations collaborate, which is an essential part of a civic community.
- Incorporating a preventive and early intervention element that teaches individuals about adopting positive activities as well as providing locations for healthy expression within the community. Additionally, it encourages individuals to seek help when needed and provides education on where to find help.

- Providing services for individuals when other treatment or services have not previously worked.
- Addressing stigma issues through community education and other non-traditional methods such as exhibitions and performances.
- Being designed for individuals of all age groups and at all stages of life.
- Presenting a creative approach to persistent, seemingly intractable challenge of fighting stigma through stories of recovery and hope as well as stressing the talent of individual artists through exhibitions and performances targeted for the general community. It focuses on the individual as an artist rather than a person with a diagnosis.
- Encouraging participants to speak about mental illness in a different medium - that of art.
- Using Occupational Therapists, who have a holistic view of each individual, and are instrumental in helping individuals address their diagnosis and lead fulfilling lives.

This project supports and stems from the General Standards identified in the MHSA (as set forth in CCR, Title 9, section 3320) and supports following the guiding principles of Innovation:

- **Wellness, Resilience, Recovery:** The Recovery Arts Core Project will be a working recovery model that empowers individuals to thrive by developing wellness roles and activities that are meaningful to them and of value in the larger community. Peers receive mental health services in a normalizing role (artist) and context (taking art classes, learning creative expression skills), learning recovery concepts while developing strengths and skills that connect them to the larger community.
- **Individual/Family Driven:** The project will work to empower peer artists and peer support specialists to use their talents and life experiences to encourage, inspire, model wellness recovery practices, and teach wellness recovery concepts through creative expression. Families will be invited to all performances and exhibitions and will be encouraged to participate whenever possible.
- **Community Collaboration:** Through displaying their artwork in public venues and sharing their personal story of recovery through or alongside their art, peers can decrease stigma and increase public awareness of mental illness and recovery. The art project enriches the network of community support and increases community acceptance and integration. It promotes community collaboration as it is leveraged significantly with local Inland Empire organizations such as the universities, the Riverside Arts Council, the Riverside County Transportation Commission, and Riverside Community Health Foundation - all entities not traditionally defined as part of mental health care.
- **Cultural Competency**: The project will be evaluated with special attention given to diverse populations and will work to address their needs.
- **Outcome Based**: This project focuses on taking a promising community-based approach in order to monitor the evaluations and performance indicators throughout the project to ensure outcomes.

- **Focus on underserved communities:** The project will provide special attention to populations who are marginally engaged in services and will create a different type of outreach to them and will work to address their needs.

The expected positive outcome of the project is to see evidence on the impact to the Riverside County Department of Mental Health system. For example, one outcome will be to see a reduction of individuals being reliant on core system services, such as clinics, and instead transitioning to utilizing peer-run centers and/or community supports where they can find self-help and self-sustaining resources for their recovery.

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)

The project is expected to contribute to learning by evaluating a new application to the mental health system for a promising mobile community-driven practice/approach. It will demonstrate an integration of three components into the mental health curriculum – art, peer-delivered educational opportunities, and mobility – and work to engage individuals to take the next steps in their recovery and to utilize peer centers and supports, thereby becoming less reliant on core RCDMH services.

If positive outcomes are established that impact the mental health system, improve quality of services, and establish better outcomes, then the RCDMH will learn that this type of program is an evidence-based practice and could be eligible for funding through other sources within RCDMH.

Additional expected lessons also include the effects of a mobile-unit that outreaches to underserved populations in non-traditional settings, increases access to services, and connects consumers with community organizations.

- This project is expected to demonstrate how actively outreaching to, and educating, individuals can increase general knowledge of mental health recovery with a long-term outcome of reducing mental health stigma.
- This project is expected to introduce the importance of linking the creative arts, a nontraditional mental health activity, and the community with Riverside County Department of Mental Health. It will show how bridging partnerships with local arts communities, organizations, and schools can create programs that promote essential aspects of mental health recovery: individual expression, positive community recognition, group participation, introduction to community roles and responsibilities (outside the mental health system), educational opportunities, vocational training, and paid employment.
- This project is expected to show how art can enhance recovery and be a key component of recovery-based practice and how creative arts can improve recovery for not only those who participate, but those who teach and perform.

- This project is expected to demonstrate an effective means of anti-stigma outreach, as it uses non-traditional methods such as exhibitions and performances to communicate the experiences, thoughts, and feelings of individuals with a mental health diagnosis. Moreover, the public recognizes the individual in the role of artist, performer, and creator before the role of "mentally ill".
- This project is anticipated to increase involvement of consumers from underserved populations and increase involvement in the peer support system.
- This project is expected to contribute to ideas of how peer-run programs can encourage community integration. Additionally, this project can show how arts can be incorporated into the peer-run centers and how these activities are a positive way to participate in civic life.
- This project is anticipated to show how creative arts are a valuable means of community education and how they arts can bring together consumers and community organizations to integrate consumers into the community and to create supportive networks.

The Core Project builds upon those approaches not currently considered part of the traditional mental health delivery system. It reflects a collaborative effort of artists, peers, professionals, educators, occupational therapists and community organizations.

The project organizers will publish reports with their findings and share their results by participating in the NAMI conferences, the Depression Bipolar Support Alliance (DBSA) Conference, as well as other pertinent conferences and will publish in pertinent journals whenever possible. The project organizers will be available for training to educate and support the current mental health workforce on the principles of recovery-based creative arts.

The Department anticipates favorable outcomes as a result of implementing the Recovery Arts Core Project such as improved quality of life, increased self-esteem, increased knowledge, and application of recovery principles and less reliance on acute mental health crisis and/or intensive services. Testing and evaluating this Innovation Project, will increase understanding of the impact and relations between art and recovery as part of our mental health system. See the 'Project Measures' section on page 8 for outcome methodology.

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page).

The time line for the Recovery Arts Core Project implementation is from October 2009 through December 2010 as outlined below.

Implementation/Completion Dates:	MM/YY – MM/YY
Develop Evaluation Methodology, Participant and Staff Surveys, and Measurement Tools	9/09 – 10/09
Finalize Curriculum, Train Staff, and Begin Scheduling Workshops	10/09
Begin Program Implementation	11/09
Review First Round Evaluations and Performance Indicators, Make Recommendations/Changes	12/09 – 01/10
Review Second Round Evaluations and Performance Indicators, Make Recommendations/Changes	3/10 – 04/10
Review Third Round Evaluations and Performance Indicators, Make Recommendations/Changes	5/10 – 7/10
NAMI Conference Presentation	8/10
Year-End and Fourth Round Evaluations and Performance Indicators, Make Recommendations/Changes, Conduct Focus Groups	9/10 – 11/10
DBSA Conference Presentation	10/10
Evaluate and Communicate Final Results and Lessons Learned	11/10 – 12/10
Share Results w/Stakeholder Meetings	12/10

Four to six weeks will be utilized prior to program implementation to prepare curriculum, hire staff, develop evaluation and methodology surveys, measurement tools, etc.

The Recovery Arts Core mobile outreach program implementation is scheduled to run for a 12-month period. This will allow sufficient time to outreach to a number of different organizations, programs, and individuals within the diverse communities throughout Riverside County to ensure a reliable and valid sampling of program participation and outreach and engagement methods.

At the conclusion of program implementation, approximately 4-6 weeks will be required to allow for data collection, research and analysis, and the evaluation necessary to assess and communicate the program effectiveness. At that time, the Department will determine if the learning goals of the project were achieved and whether more time is necessary to determine its effectiveness.

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

The main learning goals of the Recovery Arts Core Innovation project are:

1. Will consumers be more likely to access and respond to Peer Support activities if the program is “mobile” and delivered to them in their own communities?
2. Are there positive impacts and increased participation, including reaching diverse communities, if consumers receive peer driven services in non-traditional settings?
3. Are there positive outcomes associated with including expressive arts in consumer’s recovery and program curriculums?

To properly measure the intended learning goals, outcome measures will focus on the impact on consumers receiving the mobile service in non traditional settings, as well as for consumers providing the services. It will also address the impact on the consumer’s own recovery and on those individuals in the agencies were services are being provided.

Several measurement instruments will be under development, including pre and post surveys for consumers participating and providing the service and agencies hosting the service, as well as outcomes derived from FSP and Key Event tracking data bases or other assessment/discharge documentation.

Project measurement will be administered and monitored by the contractor’s Occupational Therapist (OT), who with the aid of RCDMH Research Department and Loma Linda School of Occupational Therapy, will create and refine the system of evaluations. In addition, the OT will interface with RCDMH Research Department to follow a core sample group of individuals who are concurrently enrolled in the Full Service Partnership programs.

See the table below for types of activities, outcomes, and measures the Department will focus on for the Recovery Arts Core project.

EXHIBIT C

Group	Activities	Outcomes	Measurements
RCDMH: Staff-Level	Recovery Arts Core (RAC) Project brought to organizations within RCDMH continuum of care.	Increased acknowledgement of effectiveness of recovery education and importance of fostering consumer choice and self-direction by Mental Health professionals.	A survey for staff at organizations where the program is facilitated will ask their perceptions of the program and their likelihood to incorporate peer-delivered, recovery, and/or creative arts activities in the future. It will also obtain their perceptions of effectiveness of recovery education courses. Designed to bring peers into the peer-run centers.
	Peer Support Specialists and peer artists hired to outreach within the RAC to consumers.	Increased acceptance for employment and integration of Peer Specialists into the Public Mental Health System. Positive impact on recovery for those providing the services.	
Participants: Group Level	Art curriculum customized to meet needs of groups, especially for underserved populations.	Decreased stigma regarding mental health and increased engagement in mental health recovery opportunities.	A longitudinal study of project participants by using pre-and post-program surveys, and a follow up study, will measure the benefits of the project as perceived by the peer.
Participants: Consumer-Level	Participants learn self-help skills through recovery arts education.	Fewer individuals being reliant on core system services, such as clinics, and instead transitioning to utilizing peer-run centers where they can find self-help and self-sustaining resources for their recovery.	A longitudinal study of project participants by using pre-program, post-program surveys, and a follow up study, will measure the benefits of the project as perceived by the peer. This study will use both a qualitative and a quantitative approach. It will be life-based, not diagnosis-based, and look for perceptions of hope, empowerment, self-responsibility, the attainment of meaningful roles apart from the illness, and other indicators of perceived improvement of quality of life (subjective measures). It will also measure participation (activity in the various domains) and utilization of peer-run centers.
	Program comes to the participants.		
	Participants observe peers modeling wellness and recovery.		
	Development of wellness roles by participants through learning news skills, exhibitions, and presentations.		

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

The Recovery Arts Core Project expands collaboration and linkages between Riverside County Mental Health systems along with organizations and other practitioners not traditionally defined as part of the mental health care. Specifically, the following Recovery Arts Core Project strategic partners extend the program's reach and impact:

- Riverside Arts Council - The Riverside Arts Council is a private, nonprofit corporation whose mission is "to provide, develop, support, and sustain the arts." It is Riverside County's central source for arts-related services, information, education, and outreach. This organization will help develop and market the Recovery Arts Core Project as well as team artists and art educators with the program.
- The Riverside Cultural Consortium - The Riverside Cultural Consortium is a collaboration of community organizations working together to raise the profile of arts and culture in Riverside through shared resources, networking and joint programming. Through participation in the Riverside Cultural Consortium, the RAC Project will meet supporters, be able to participate in community-wide events, and promote the project.
- Cal State San Bernardino Department of Theatre Arts - Michelle Ebert Freire, associate professor in California State San Bernardino's Theatre Arts Department, has experience as an educator, actor and director, as well as drama therapist. She has worked with the peer-run centers in Riverside to develop a pilot drama program that pulls from various drama therapy philosophies, as well as creative drama, playmaking, Playback Theater, and the Theater of the Oppressed. In addition to coordinating the graduate program at CSUSB, teaching theater studies, and directing University Theater productions, Michelle volunteers at San Bernardino Juvenile Hall and the Rainbow Pride Youth Alliance. Michelle will be a consultant for the RAC Project, advising on drama curriculum, as well as teaming graduate arts students and interns as volunteers in the program.
- Loma Linda School of Occupational Therapy - Occupational therapy can be very effective in the mental health setting. Since 2003, Occupational Therapists have interned at the peer-run centers advising on curriculum development, program methodology, and volunteer program structure. The goal of the Occupation Therapists in the RAC Project will be "to help people develop the skills and obtain the supports necessary for independent, interdependent, productive living (American Occupational Therapy Association).
- Riverside Community Health Foundation - This mission of this nonprofit organization is to improve the health and well-being of the community of Riverside. They have provided funding for an Occupational Therapist position at the peer-run centers that will be integral to working with the Occupational Therapist interns in the RAC Project.

- Riverside County Transportation Commission - Through Measure A and New Freedom funding, the Riverside County Transportation Commission is enabling the peer-run centers to create a transportation program to pick up and drop off participants throughout Riverside County at the peer-run centers. For the RAC Project, this means involving more individuals in the program.
- National Alliance on Mental Illness (NAMI) - NAMI is the National Alliance on Mental Illness, the nation's largest grassroots organization for people with mental illness and their families. The Recovery Arts Core Project presents NAMI's "In Our Own Voice: Living with Mental Illness" which is a multi-media, interactive, public education program presented by consumers for both consumers and other community audiences. Through example and discussion, participants learn how people with serious and persistent mental illness cope with the realities of their own disorders while recovering and reclaiming productive and meaningful lives.

In addition to these supporters, the Recovery Arts Core project will work to increase funding by writing grants, organizing fundraising events, and selling artwork.

EXHIBIT D

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Riverside County

Work Plan Name

Recovery Arts Core Project

Annual Number of Clients to Be Served (If Applicable)
650 Total

Population to Be Served (if applicable):

The Core Project will provide services to Transition Age Youth, Adults, and Older Adults with serious emotional disorder and/or serious mental illness, and their families. It will also provide supports for individuals who have co-occurring substance abuse disorders, are dually diagnosed, or have other disabilities. The Project will target, and outreach to, underserved populations including Hispanic, Native American, Gay, Lesbian, Bi-Sexual, and Transgender (GLBT) populations. The project's services will be tailored to address each community's specific needs.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

The Recovery Arts Core (RAC) Project creates a mobile unit of peer support specialists, peer artists, local artists, professional educators, and occupational therapist interns who together facilitate a 6 - 8 week program of peer-based recovery and creative arts activities throughout Riverside County. This Innovation Project will contribute to learning by closely measuring the impacts of peer and community delivered arts services on consumers receiving services through the Riverside County Department of Mental Health (RCDMH). The primary purpose of the RAC Project will be to increase the quality of services, including the development of more systematic outcomes to measure the effectiveness of the program. The Department believes that by piloting a mobile community-based, peer-delivered, recovery oriented arts program, it will not only increase the quality of services offered to our consumers, but will provide an opportunity to develop systematic measures and outcomes to prove its effectiveness.

The project is expected to contribute to learning by evaluating a new application to the mental health system for a promising community-driven practice/approach. It will demonstrate a combination of three components – art, peer-delivered educational opportunities, and mobility – and work to engage individuals to take the next steps in their recovery and to utilize peer centers and thereby become less reliant on core RCDMH services.

EXHIBIT D

The curriculum consists of peer presentations on recovery (such as “In Our Own Voice” and an original play written and performed by peer artists); two peer-taught “Recovery Pathways” classes; and two to four art classes (art fundamentals, drama, creative writing, music, and/or dance) according to the community needs. At the end of the 6 – 8 week program, the curriculum is provided to the organization, so they may continue to teach these principles after the initial program is completed. Additionally, the artwork and other projects created by the peers, family members and friends will be exhibited (for visual arts) and performed (for performance art) throughout Riverside County.

The RAC Project is a proactive mobile unit that will outreach to people of all ages and socioeconomic status rather than wait for them to seek services at traditional mental health sites. It will bring these services not only to programs within Riverside County Mental Health, but also to locations where individuals with mental health diagnosis are served such as board and cares, juvenile halls, and homeless shelters. The program will also outreach to churches and other community organizations where at-risk people frequent as well as to underserved populations, assembling a core team to best suit each specific populations’ needs. For example, a bi-lingual Peer Support Specialist will be part of the team which will provide services in the Hispanic communities. The project can also be customized to explore the richness of other specific cultures.

The RAC Project will address the need to increase access to underserved communities with a goal to increase quality of services including better outcomes (particularly the continued transformation of the infrastructure of mental health to include recovery and peer-based components as well as more effective services to support community integration). It will also promote interagency collaboration, increase access of services; and provide anti-stigma outreach and education.

The RAC Project builds bridges within the community, encouraging interagency collaboration, by involving local artists, art organizations, schools, and other nonprofits at the grassroots level. The arts are a point around which groups from many different organizations collaborate, which is an essential part of a civic community. The project can show how building these bridges create programs that promote essential aspects of mental health recovery: individual expression, positive community recognition (in a role other than “mental health client”), group participation, introduction to community roles and possibilities outside of mental health system, educational opportunities, vocational training, and paid employment.

EXHIBIT E

Innovation Funding Request

County: Riverside County

Date: 4/29/2009

	Innovation Work Plans		FY 09/10 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
	No.	Name		Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	1	Recovery Arts Core: A Peer-Based Project	$177,825		$54,514	$123,311	
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3							
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25							
26	Subtotal: Work Plans		$177,825	$0	$54,514	$123,311	$0
27	Plus County Administration		$26,674				
28	Plus Optional 10% Operating Reserve		$20,450				
29	Total MHSA Funds Required for Innovation		$224,949				

County Administration and Optional 10% Operating Reserve of $47,124 are county expenses required to provide mental health administration support for the program.

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Riverside County

Fiscal Year: 2009/10

Work Plan #: INN-01

Work Plan Name: Recovery Arts Core: A Peer-Based Project

New Work Plan ✓

Expansion ☐

Months of Operation: 09/09 - 06/10

MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures			174,000	$174,000
2. Operating Expenditures		10,000	31,000	$41,000
3. Non-recurring expenditures				$0
4. Training Consultant Contracts			8,000	$8,000
5. Work Plan Management			0	$0
6. Total Proposed Work Plan Expenditures	**$0**	**$10,000**	**$213,000**	**$223,000**
B. Revenues				
1. Existing Revenues				$0
a. Riv. Community Health Foundation for Occupational Therapist		10,000		$10,000
b. RivCo. Transportation Commission Match Funds for Fuel			32,175	$32,175
2. Additional Revenues				
a. In-Kind Support from Michelle Ebert Freire (Drama Professor)			3,000	$3,000
3. Total New Revenue	**$0**	**$0**	**$3,000**	**$3,000**
4. Total Revenues	**$0**	**$10,000**	**$35,175**	**$45,175**
C. Total Funding Requirements	**$0**	**$0**	**$177,825**	**$177,825**

Prepared by: Roize Basallo

Date: 4/29/2009

Telephone Number: (951) 358-4562

Personnel expenditures of $174,000 will cover expenses and benefits associated with a full-time Manager, full-time Peer Support Specialist/Coordinator, full-time Occupational Therapist, and part-time Peer Artists.

Operating expenditures of $41,000 will include rent, program supplies, phones, fuel (transportation), postage, printing, etc.

Training Consultant contract expenses of $8,000 include consulting fees for drama, art, and music professionals working with the program.

ATTACHMENT A

County of Riverside
Mental Health Board (MHB)
Executive Committee Review
June 9, 2009

for

Innovation – Recovery Arts Core Project
Public Hearing
Held on Wednesday, June 3, 2009

1. **Comment:** I see a lot of strengths in the program and it's nice to see it is moving forward. I like that it is (1) peer driven (2) uses the creativeness to heal, (3) uses the recovery model, and (4) the mobile unit will be very beneficial for the communities in Riverside because it is so large. I do have a couple of questions. In the Plan it does say that it will address all age groups – but when I went to Exhibit E, it says that the majority of the funding was for transition age groups and adults, so my question is: Will children and older adults be able to come for services and will funding go toward providing arts for those age groups?

   Response: With the state budget sheets, we have to allocate funds by age groups, and it didn't necessarily address that specifically in the plan. Based on what we know about the Art Works program, transitional age youth (TAY) and adults use those services more, so that is where we put the bulk of the funding. We don't know the full impact of what we are going to experience once we implement the plan.

   It is a difficult call, because this program will impact a lot of different people indirectly through education and outreach. We anticipate that the whole family (of all ages) will be impacted by the presentations and involvement and the integration into the community. We discussed this during the planning process, and children will be impacted positively by this program. However, they may not be impacted directly because they are not enrolled in the peer center, but through their family and community presentations and through stigma awareness and other factors.

   The older adults will not be excluded and they have already expressed an interest and we look forward to that participation.

2. **Comment**: I would just like to say that specifically one of the things that will be beneficial across the program and as it relates to prevention and early intervention, is that it would be necessary, and should be expanded, to include direct services to children and youth.

3. **Comment:** Will this give us an opportunity to go into the schools?

   Response: Schools have many rules and regulations about who comes on campus, so there may be school age children impacted but we don't think we would go directly in the schools.

   MHB RESPONSE to Comments 1, 2 and 3: The Mental Health Board recommends that the Department examines development of some type of art expression program specifically targeting children and youth with future Innovation funding proposals.

4. **Comment:** The plan also says it will go into the different areas and in the narrative it specifically says in the Desert Region, it will be in Palm Springs. Is that the only place?

   Response: Every site that we're going to conduct this service is not outlined in the proposal. If we can identify any underserved community, we can go there. It will be based on need, so it can be offered in any area.

5. **Comment:** So they were just examples, and it can be provided anywhere?

   Response: Yes, the key is that we're expanding it county wide where as before it was just centered in Riverside and local areas. That's why we're excited because we can we can go to other regions and communities based on need.

   MHB RESPONSE to Comments 4 and 5: The Mental Health Board recommends that the wording in Exhibit C, page 1, the last sentence under "**Increase access to underserved groups**" be expanded to say that 'services will be provided in all three regions which include, **but not be limited to**. . ." in order to more clearly reflect potential geographic areas to be served.

   The MHB also asked for clarification on how 'need' would be defined and determined because they are concerned that there will be too many requests from the community for service and that everyone who has a need will not be able to receive the service.

Response to MHB: After the plan is approved for implementation, one of the first responsibilities will be related to development of the curriculum, selection criteria, evaluation methodology, etc. At that time, the selection criteria will be more fully defined. This will be a pilot project and as with all programs with limited funding, the community needs are anticipated to exceed the resources available. However, the results of the project will be evaluated and if it is determined that the program is successful, expansion may be a consideration.

MHB RESPONSE: The MHB determined this was a reasonable course of action and recommended no change to the Innovation – Recovery Arts Core Project Plan at this time related to this issue.

6. **Comment:** Maybe people don't have specialized talents or maybe they are not artistic - what does this program hold for them? Maybe they are very black and white thinkers or maybe they are more technical kinds of thinkers. What are we offering them as far as trainings and those kinds of things? Do we have things that are going to be offered in the peer centers for them, which are also innovative, that are going to help them find jobs and help them to do things? Maybe the arts isn't for them, maybe they don't use that artistic side of the brain that other people do. There are black and white thinkers who don't think in the artistic fields.

   Response: I don't think there are any exclusionary criteria. In the peer centers they do have vocational support services. Part of what is built into the plan is instruction and I don't know if there would necessarily be an entry level requirement. But I think the staff of the program would be available to meet with them (the person) and provide instruction and assistance on whatever area of assistance they required. There are all ranges of skill levels, but no one would be excluded.

   Part of the proposal is peer artists telling their story and peers talking about their recovery. So as much as art is important, the act of expressing themselves and developing something that helps their self esteem is established at the very beginning. So the concept of peer recovery is established as the number one goal of the program.

7. **Comment:** I know what the program is all about. But they (other people) are asking me about those people that don't have the kind of talent to do arts kinds of things - what kind of vocational things are there for them? They are real concerned that they can't be expressive that way so are they going to be left behind. The big fear is that they are not going to get any help for what they want to do.

Response: I want to take a different slant. Recovery is about choice and part of what we are taking about is wanting to add more options. It doesn't necessarily mean that this program will be available, and of interest, to every person. We don't expect it to be – not every program is all encompassing. There are a number of supports that are offered at the peer centers, and people can choose to participate in them. So again, I don't want to assume that everybody is interested in it and from my perspective that is ok because it is a choice and it is expanding the kinds of options and the recovery paths they can utilize.

MHB RESPONSE to Comments 6 and 7: The MHB determined that as other program/support options are available to clients through the peer centers, no change to the Innovation – Recovery Arts Core Project Plan is recommended.

8. **Comment:** The plan says mobile proactive unit. Is it one unit that goes to a different place in the city every day or is it more units, is it six units? How many units are there? Is a unit out there every day all over the city or county?

   Response: It is a team that will be mobilized to different areas for a certain period of time.

   The MHB also asked for clarification on the definition of a mobile unit. Would it be a van, motor home or something else?

   Response: The peer centers have been provided with vans and JTP has also received transportation funds under Measure A grant, so transportation is available. As the service locations have not been determined and services will be provided at locations throughout the county, this will be part of the logistics assessed as the project is implemented.

   MHB RESPONSE to Comment 8: The MHB determined this was a reasonable course of action and recommended no change to the Innovation – Recovery Arts Core Project Plan.

9. **Comment:** How will we advertise - are we going to the schools, colleges, hospitals, mental hospitals, and what about outreach?

   Response: The services will be based out of the peer centers in each of the three regions. I anticipate there will be outreach to various underserved areas in the community but then there can be presentations and promotions through the peer centers and outreach will come from them.

10. **Comment:** And will they put flyers out at Bobby Bonds or La Sierra and places like that?

    Response: It wouldn't be unlike the art works program that already exists, where by virtue of being a participant in the Western Region or Mid-County Region services; you would be privy to the activities that were going on at the Art Works program. So this would make it available for all regions and certainly makes it possible for us to promote directly to our consumers from those sites about the types of activities that are going on. The peer centers will also work through organizations and service providers within the communities to promote participation.

    MHB RESPONSE to Comments 9 and 10: The MHB determined this was a reasonable course of action and recommended no change to the Innovation – Recovery Arts Core Project Plan.

11. **Comment:** You mention that you're going to do bi-lingual is that Spanish only are you going to Tagalog or any other languages?

    Response: In the proposal, it's Spanish. But that's not to say if there was a need it couldn't be expanded to other languages.

    MHB RESPONSE to Comment 11: The MHB determined this was a reasonable course of action and recommended no change to the Innovation – Recovery Arts Core Project Plan.

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MHB RESPONSE to Comments 12 through 25: Comment only – No recommended change to the Innovation – Recovery Arts Core Project Plan.

12. Comment: We really need to expand on this. We're talking about arts but the field that arts covers is not just art or acting, but writing or making crafts. This arts program, even though it's called arts, is going to be expanded to all levels and fields of self help and people getting back into helping themselves and how to express themselves again. This is a recovery program we've talked about - not just art.

Response: Part of having the Occupational Therapist (OT) intern on board is working with the Peer Support Specialists establishing that recovery is possible through things like 'In Our Own Voice', artistic expression or drama performance. The art activities are not necessarily going to be things like 'today we're going to draw this landscape and it's going to be perfect'. It is much like learning fundamentals, expressing yourself and things like 'what

color do you feel today', things like that. It's not so much just arts - it's more about creative expression and recovery principles. The proposal indicated that the core staff would be working with the people at the site and find out what their needs are: such as if we went into a bi-lingual community, there would be a bi-lingual Peer Support Specialist available. So we would make an effort to address all levels and all needs so that the program really speaks to them.

13. **Comment:** I think it's a great idea. I think the arts are essential to creating a humane way of looking at life and a way to express yourself in such a way that you don't feel isolated and it fights against stigma. It's kind of like if you are an artist you are kind of funky anyway. You can be an artist and do odd things and people just say "oh, she's an actor" and it takes away the stigma and helps people believe in themselves more.

14. **Comment:** I think that believing in yourself is a core recovery concept, with empowerment, and expression. I believe the art program, using peer artists and peer support specialists, can work through those important elements imperative to recovery. With the arts, it makes it fun.

15. **Comment:** I have seen this from personal experience with my son. The job he held before he got ill and used to be able to do, he can't do anymore. But with art, he has seen a greater appreciation of art in poetry. That's what I see as the biggest benefit - it gives them some longer functioning ability and a hope for the future with a different concept.

16. **Comment:** Art therapy is proven. It is not one these hypothetical things and it has been used in physical health for years and years. I think of all the therapies - if you can call it that - it is probably the one that is less intimidating. It really opens an avenue to express their thoughts and feelings. A lot of things people can't talk about or wade through in their emotions, but they can doodle and stuff. It will encompass many different areas and I give the department high marks for looking into this type of program.

17. **Comment:** As an employee and consumer – you don't have to have artistic ability to participate in this program. I have witnessed many who never were able to express how they felt, what was going on, that really deep part of them that they had no idea how to express and through some type of art - which encompasses a lot of different things - they have really come alive. So as far as working on that type of thing, there are other classes available for teaching other types of things. I am speaking personally that if not for the arts, I would literally have committed suicide. The arts program (not just this program but the arts in my life) have saved my life. The arts gave me an

avenue to express and get out my deepest feelings. From that standpoint, I can't express how important this is and as you said, it really works and whether you call it therapy or not, it works.

18. **Comment:** I think it is about expression and how you grow through expression through the art works. You see yourself in a different light and you see yourself as capable of doing things and through that expression you grow, in my opinion. I was, with a mental disability, going to RCC or UCR and personally my opinion is that it was intimidating because of my disability. When I'm with my peers and with Art Works and JTP, I feel 'yes, I can do this'. My peers understand and especially when someone who is teaching me also understands what I am going through – it's a great idea.

19. **Comment:** I was on the prevention and intervention team and we talked about this. We thought this was a good idea because it's going to reach the people like myself who had a hard time reaching out. This would be a great starting ground for someone with mental illness who has not gotten help and it will bring out many different talents. Now I feel I can do 'this' and can do 'that'. It will bring this to those people in the population who would not come out for treatment or a mental health program, like the Hispanics. They might go to an art program or take their kids to go see this and I think it's a really good idea myself.

20. **Comment:** Some of the outreach programs that are being talked about are going to the pregnant women/single mother home on Magnolia and to participate in going into the parks on Saturday. So is arts a possibility for them to pass their time and really find themselves? And what about sober living homes so we can have a program to outreach to them and bring them into our program.

21. **Comment:** When I was growing up we had almost 'rights of passage' like when I was in third grade, we had an art contest, and it was in a town of about 20 thousand. All our drawings and paintings were put on the windows downtown at Halloween time. In the 4th grade, we got to sing on the radio; in the 5th grade, I can't even remember what it was; and in the 6th grade you got to go to summer camp for a week. So there was something you were going to do for each grade as you progressed. I think the main thing I want to point out is when your picture was displayed on the window and you had used everything you could to do it – you might not have been the best artist - people recognized you and your parents came to see the picture and you shared in what everybody else was doing and were recognized. I think that is the most important thing with arts that we are looking at. They created, they participated, and they were recognized. Also at the May is Mental Health Month event, when we had our open house, the young lady that went

with me from Hemet at the NAMI table had an art tablet and she was sketching and they were the most beautiful drawings that I think I have ever seen. What an opportunity for her to participate in something we are putting on so that she can be recognized. She can't afford to go to Hemet Valley Art Association to take art lessons, but she certainly can participate through Jefferson or whoever the provider is going to be in Hemet. I just thing this is going to be a fabulous project.

Response: I don't think this proposal really states accurately what will actually come out of this program. There will be much more opportunity and many more outcomes than what is written. When we start implementing it there are so many other opportunities that will arise because it seems that every other week we're notified about an art exhibit or an opportunity to present art work or a contest and to me it's just a lot that can really come out of this if we're organized.

22. **Comment:** I wanted to find out if this is the city of the arts in the way the mayor says it is - that it is the renaissance of time and he really supports the arts. Has this project been presented to the mayor?

    Response: Probably not this project, but the Art Works has and I think the Art Works program was actually recognized by the city. But this proposal hasn't be implemented, so we haven't shared it yet and we won't until it's been approved.

23. **Comment:** I just want to make everyone aware that in addition to our main Mental Health Board, we also have Regional Boards, and our Desert Board is very progressive. Every year they have an annual art contest where they have drawings and paintings and have for a long time recognized that (in advance of the department) how important this is and we need to complement them in doing that and being progressive in what they are doing.

24. **Comment:** I am on the Desert Regional Mental Health Board and my favorite time of the year is May when we get to put on our May is Mental Health Month event which is our art contest or art show and now we're up to our 6th annual. We get a whole gammet of art from stick figures to really elaborate paintings and elaborate sculptures and I don't think there is anything more thrilling than to see the story these stick figures tell. So it doesn't matter your ability, it really doesn't, because some of the most powerful expressive artwork I have seen are those little stick figures. I commend the artists in the community and we seem to have a lot of artists. This is a great way to express your thoughts and stories and your trials and hurts and everything else, so I'm all for it.

25. **Comment:** I think strength is also to reach underserved populations like the Hispanic community and some of the different place where stigma is really high in other populations. The good thing about art is that it transcends cultural lines so not only will people be attracted to it with their family, but it is a better way of expressing a story, a play, or a visual medium.

ATTACHMENT A

Additional Clarification Requested from the MHB

26. **Comment:** This component appears to be under budgeted for the potential needs of those who will take advantage of it

    Response: As this project will be a pilot program, the funding requirements were assessed and discussed during the development process and determined to be sufficient to support the initial implementation.

27. **Comment**: What about outcomes for the project and will that information be collected?

    Response: The "Project Measurement" section in the Plan, Exhibit C, page 8, addressed how the project will be reviewed and assessed. Outcomes will be provided at the conclusion of the project for evaluation.

28. **Comment:** Will the state look at this as a new innovation program or just a continuation of the Art Works Project that was funded under CSS?

    Response: The Art Works and Recovery Arts Core project are two separate and distinct programs. The Recovery Arts Core project has yet to be approved or funded for implementation. The Arts Works was provided start up funds under CSS to establish a gallery and classes in Riverside and surrounding areas and is sustainable through outside grants and donations. The Recovery Arts Core project enables the concept of arts recovery to be delivered throughout the county in a mobile format and to a variety of communities through both existing peer centers and other community organizations.

29. **Comment:** If this has great measurements and outcomes, does it have to be evidenced-based in order to continue?

    Response: The results of the project will be evaluated and is not required to be an evidenced-based practice.

ATTACHMENT A

Feedback Form Comments

Of the 23 Feedback Forms submitted: 18 were "Very Satisfied", 3 were "Somewhat Satisfied", 1 was "Satisfied" and 1 did not indicate a Response

1. What do you feel are the strengths of the plan? Please identify the program and age group if applicable:

- Writing about our feelings on paper and sharing it with others. The short exercises that they have us do.
- We show the community about the service that the arts have to offer for them. It will help them in their recovery.
- Painting.
- I believe the strength of this plan is being out and connecting people to the right agency.
- I think it's a good idea because it will help to understanding us as individuals plus it helps others by telling our story and letting others know that everyone is the same.
- We need programs for children of all ages.
- Getting in touch with feelings in a deeper way.
- Art Works deals with adult and young adults and inspires them to create art and release tension inside themselves. The strengths are the creativity and inspiration it holds and gives.
- Provides peer driven outreach innovative ideas to express change. Meets people where they are. Creates opportunities for peers.
- The strengths of this plan incorporate peers teaching basic fundamentals of art, creativity, and inspiration.
- Help with arts – less stress.
- I think it sounds good. Very educational and interesting.

ATTACHMENT A

- I really believe that the Art Program is great. I really feel it helps peers get in touch with themselves. I believe that we should look at all different.

- To give those who want and need to express themselves the opportunity to share and display their artwork. It appears that "In Our Own Voice" can be done and this is a wonderful program.

- The strengths are: mobile unit(s), peer artists, drama, and OT (OT saved my sanity many times). There is the Fox Theatre opening soon and could there be a possibility of collaboration with Fox in RSA?

- To provide opportunities to create and hopefully appreciate the Art Works Program in the greater community. To peak interest and incentive towards providing interesting classes and activities.

- To broaden role and scope of peer-based services to enhance recovery education. This will be a very effective anti-stigma outreach activity, I believe.

- Positive approach to individual recovery.

- Recovery Model. Innovative. Reaching more consumers.

- The strengths are some good ones. I believe it should be for all ages.

- This is a great program that will benefit our community.

- Peer Driven. Creative, Mobile Unit, Recovery and Wellness Model.

- Appears to be a well thought, proven and will enhance the lives of consumers involved.

ATTACHMENT A

2. What Concerns do you have about the plan? Please identify the program and age group, if applicable.

- I'm concerned about us not having enough funding for the program. (See page 10, Response to Comment 26)
- I think this plan will help the youth program and older program to let the organization know that in mental health there is recovery.
- May it work? (See page 10, Response to Comment 27)
- May it get filled up? The project will run in 6 to 8 week cycles at each location and provide training to facilitators at those locations. This mobile 'train-the-trainer' concept allows each organization to incorporate and sustain arts recovery programs within their organization and continue to reach more people in the community after the initial training has been concluded.
- This program will only benefit everyone in the communities and families who would otherwise be at a loss as to where to go for help. I have no concerns, just optimistic.
- I do not have any real concerns about it because the age should be maybe 16 and up.
- We need adult programs for all adults.
- Need for me.
- The only concern I have is the funding or not enough funding it receives. Another concern is that young adults and adults might not have transportation. (See page 10, Response to Comment 26)
- Concerned that Art will be taken out of education.
- Only concern is to have the funds to start this program as well as creating jobs. (See page 10, Response to Comment 26)
- Arts Gallery.
- Types of art from different cultures.

ATTACHMENT A

- That there is sufficient outreach and publicity in all regions of the County to know about this opportunity. (See page 5, Response to Comments 9 and 10)

- Mobile Unit – insurance for drivers who travel to cities.

- That it is funded properly and that people would feel comfortable in being able to express themselves in a care-free environment. It is also a tremendous therapy for coping skills. Very beneficial.

- Make sure all populations of need are outreached to. (See page 5, Response to Comments 9 and 10)

- Outreach to non-compliant, indigent mentally ill. (See page 5, Response to Comments 9 and 10)

- My concern should be that it should be recreational.

- Exhibit C – 1st paragraph: Services provided in all three regions. The plan narrative says Western, Perris, Hemet, and Temecula in Mid-County Region and Palm Spring in the Desert. There may be additional cities with ethnic disparities that will benefit from the "Arts Work" Program. (See page 2, Response to Comments 4 and 5)

- Exhibit E – Only funding is for TAY and Adults. To be inclusive of all ages and address prevention and early intervention, direct services should be given to children and youth ages 0-15. They, too, would benefit from the "Arts Work" Program. (See page 2, Response to Comments 1, 2 and 3)

- This component appears to be under budgeted for the potential needs of those who will take advantage of it.

County of Riverside
Department of Mental Health
Mental Health Services Act

Prevention and Early Intervention Plan

July 15, 2009

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, 2008-09 and 2009-2010

County Name: Riverside County	Date: July 15, 2009

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

County Mental Health Director	Project Lead
Name: Jerry Wengerd, LCSW	Name: Janine Moore, LMFT
Telephone Number: 951-358-4500	Telephone Number: 951-358-3941
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E-mail: WENGERD@rcmhd.org	E-mail: JAMOORE@co.riverside.ca.us
Mailing Address: 4095 County Circle Drive Riverside, CA 92503	

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 _____ 7-14-09

County Mental Health Director Date

Executed at Riverside, California

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

Form No. 1

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VIII. Attachments:

Riverside County Department of Mental Health
Mental Health Services Act
Prevention and Early Intervention Plan

EXECUTIVE SUMMARY

This summary provides a brief description of the Prevention and Early Intervention plan submitted to the State by the Riverside County Department of Mental Health. Included below is background on prevention and early intervention, a description of the County's planning process, and a summary of the programs proposed for funding. For detail on programs, please refer to the plan posted on the Department of Mental Health website.

I. Background

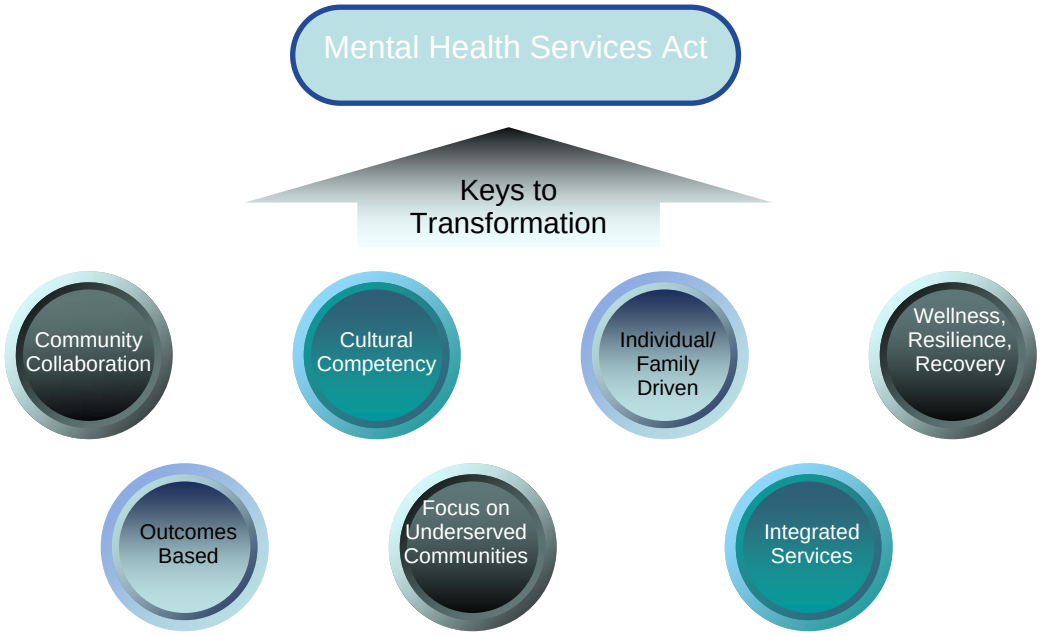
In November 2004, the Mental Health Services Act (MHSA), formerly known as Proposition 63, was approved by California voters. The MHSA imposes a 1% tax on personal income over $1 million and became effective January 01, 2005. As stated in the MHSA, "for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected, and often inadequate, frustrating the opportunity for recovery" and "Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government". The purpose and intent of the MHSA is to expand and transform the mental health service system throughout California "to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness".

The MHSA identifies five primary program components for funding which are:

- Community Services and Supports
- Workforce, Education, and Training
- Capital Facilities and Technology
- Prevention and Early Intervention
- Innovation

The intent of Prevention and Early Intervention (PEI) programs is to move to a "help first" system in order to engage individuals before the development of serious mental

illness or serious emotional disturbance or to alleviate the need for additional or extended mental health treatment by facilitating access to services and supports at the earliest signs of mental health problems. In order to achieve this goal PEI activities need to be provided in places where community members go for other supports and services and where mental health services are not traditionally given, such as schools, health providers, community centers, faith-based organizations, etc.
In conjunction with all components of the MHSA, PEI programs also align with the transformational concepts inherent in the MHSA as illustrated below.



II. Prevention and Early Intervention as defined by the MHSA

While prevention and early intervention can occur across the entire mental health intervention spectrum, the purpose of the PEI component is to design programs at the early end of the spectrum.

What is Prevention?

- ✓ Prevention in mental health involves building protective factors and skills, increasing support, and reducing risk factors or stressors.
- ✓ Prevention efforts occur prior to a diagnosis for mental illness.
- ✓ Generally there are no time limits on prevention programs.
- ✓ Prevention activities are classified according to those individuals receiving the services:
    - Universal: These interventions or activities target the general public or a whole population group that had not been identified as having a higher risk of developing mental health problems. An example of this would be training gatekeepers on the warning signs of suicide and how to intervene, such as the Question, Persuade, and Refer

(QPR) for Suicide Prevention model found in the Older Adult Project.

- Selective: These interventions or activities target individuals or a subgroup of individuals whose risk of developing mental health problems is higher than average based upon defined risk factors. An example of this would be providing an intervention for children with substantiated cases of abuse, such as the Seeking Safety program found in the Trauma Services Project.

What is Early Intervention?

- ✓ Addresses a condition early in its manifestation
- ✓ Is of relatively low intensity
- ✓ Is of relatively short duration (usually less than one year)
- ✓ Has the goal of supporting well-being in major life domains and avoiding the need for more extensive mental health services
- ✓ May include individual screening for confirmation of potential mental health needs

III. Building the PEI Framework

The State, through a comprehensive Stakeholder process, defined the following needs and populations as priorities for PEI activities:

PEI Key Community Mental Health Needs:

- **Disparities in Access to Mental Health Services** – PEI efforts will reduce disparities in access to early mental health interventions due to stigma, lack of knowledge about mental health services or lack of suitability of traditional mainstream services.
- **Psycho-Social Impact of Trauma on All Ages -** This refers to how the trauma is impacting the individual's level of functioning, emotionally and behaviorally.
- **At-Risk Children, Youth and Young Adult Population** – PEI efforts will increase prevention efforts and response to early signs of emotional and behavioral health problems among specific at-risk populations.
- **Stigma and Discrimination** – PEI will reduce stigma and discrimination affecting individuals with mental health illness and mental health problems.
- **Suicide Risk** – PEI will increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide.

PEI Priority Populations:

- **Underserved Cultural Populations** – Those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender (LGBT) communities, etc.).

- **Individual Experiencing Onset of Serious Psychiatric Illness** – Those identified as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service.
- **Children/Youth in Stressed Families** – Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of care giving adults (e.g., as a result of serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.
- **Trauma-Exposed** – Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.
- **Children/Youth at Risk for School Failure** – Due to unaddressed emotional and behavioral problems.
- **Children/Youth at Risk of or Experiencing Juvenile Justice Involvement** – Those with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately serviced through Community Supports and Services programs.

Per State guidelines each PEI program must incorporate at least one Community Mental Health Need and one Priority Population. PEI plans must address all age groups and a minimum of 51% of the Plan budget must be dedicated to individuals between the ages of 0 through 25 years old. PEI funds cannot be used for filling gaps in treatment and recovery services for individuals who have been diagnosed with a mental illness or serious emotional disturbance or their families.

IV. Riverside County Community Planning Process

Each of the MHSA components requires an extensive Community Planning Process (CPP). The CPP for the Prevention and Early Intervention component was conducted in order to select the Key Community Mental Health Needs and Priority Populations as outlined above, to be provided in Riverside County.

Contact was initiated with stakeholders and members of underserved communities utilizing a network of contacts, telephone, and electronic outreach. Meetings were held with community leaders, community based service providers, and consortiums throughout Riverside County ensuring contact with representatives from each of the three regions (Western, Mid-County, and Desert). The PEI team attended numerous existing community based stakeholder meetings as a part of the outreach campaign to begin the coordination and scheduling of focus groups and community forums.

Between July and October 2008, 108 focus groups and community forums were facilitated throughout the County with a total attendance of 1147 participants. A network of contacts that had been developed through telephone and electronic outreach was used to inform as many members of the community about the available focus groups and community forums. To ensure that stakeholders could fully participate in the community input process, specific Spanish speaking focus groups were facilitated and

Spanish translation was available at each community forum. Other specific focus groups were held for older adults, Deaf/Hard of Hearing, Native Americans, and LGBTQ individuals.

As a means to further solicit input from community stakeholders a community survey was developed and posted on the RCDMH website (www.mentalhealth.co.riverside.ca.us) in both English and Spanish. A total of 2354 surveys were completed and returned. The survey was designed to ascertain stakeholder input regarding priorities about key community mental health needs and priority populations in Riverside County.

PEI planning utilized the existing four age group MHSA planning committees (Children, TAY, Adult and Older Adult). Due to a great deal of interest in the PEI planning process, there were additional stakeholders who joined each of the committees so that the membership reflected all key stakeholders.

Through the planning process, it was determined that there was a need to develop three workgroups to address specific PEI needs. They were the Trauma Workgroup, the Reducing Disparities Workgroup and the Reducing Stigma and Discrimination Workgroup. There was specific outreach to stakeholders for participation, including members of unserved and underserved cultural communities, community providers with expertise as well as consumers and family members of consumers.

Each of the age group committees (Children, TAY, Adult and Older Adult) participated in a two day facilitated process to determine the priority needs and recommendations for the age group they represented. Each committee was tasked with ensuring that the voice of the community was heard in the recommendations that were developed. They began with a review of PEI related recommendations that were gathered as a part of the CSS planning process. Committees also received the analysis of the information gathered from the focus groups, community surveys and the three workgroups (Trauma, Reducing Disparities, and Reducing Stigma and Discrimination). Each committee and workgroup assigned representatives to attend the PEI Steering Committee to convey their respective committee and workgroup recommendations. The Steering Committee identified and prioritized the final PEI strategies.

V. Riverside County Prevention and Early Intervention Projects

As a result of the extensive Community Planning Process, the Riverside County Department of Mental Health Prevention and Early Intervention (PEI) Plan contains seven separate projects. The projects contain programs and strategies that address universal prevention, selective prevention, and early intervention. In addition, the projects identify programs and strategies for individuals across the age span.

EXECUTIVE SUMMARY

Below is a brief description of each project:

Project #1 – Mental Health Outreach, Awareness and Stigma Reduction

The goals of this PEI project are to increase community outreach and awareness regarding mental health information and resources and to develop and expand existing stigma reducing activities throughout Riverside County based upon the needs identified through the community planning process. This project will involve activities designed to outreach to unserved and underserved populations, increase awareness of mental health topics and to reduce stigma and discrimination. Individuals that will benefit from the activities in this project include youth, transition age youth, adults, older adults, parents, teachers, caregivers, community and faith based organizations, and the community at large. Activities will be wide ranging and will include maintaining and developing ongoing relationships with underserved cultural populations.

In addition to Department staff, a Reducing Stigma and Discrimination Committee has been developed to oversee, develop, and guide stigma and discrimination reducing activities. Activities to be funded under PEI provided throughout the County include:

- Media and mental health promotion and education materials will be prepared and provided for all community events and media efforts and outreach will occur to engage hard to reach populations.

- Parents and Teachers as Allies - This program, created by The National Alliance on Mentally Illness (NAMI), is designed to help families and school professionals identify the key warning signs of early-onset mental illnesses in children and adolescents in school.

- In Our Own Voice Program (IOOV) - This program, also developed by NAMI, is an interactive public education program in which two trained consumer speakers share their personal stories about living with mental illness and achieving recovery. Presenters of the program will be reflective of the audience, i.e. TAY and Older Adult consumers will provide the presentation to individuals within their age group or to providers of service representing those age groups.

- The “Dare to Be Aware” Conference - This is a full day conference for approximately 1000 youth in middle and high schools from across the County. The goals are to increase awareness and reduce stigma related to mental illness.

- Breaking The Silence: Teaching School Kids about Mental Illness - This program, which is another NAMI program, is an educational package that teaches students in upper elementary school, middle school, and high school about serious mental illness.

EXECUTIVE SUMMARY

- Toll Free, 24/7 “HELPLINE” – The “HELPLINE” will provide crisis and suicide prevention services including counseling and emergency assistance twenty four hours a day, seven days per week. Callers will be given, when appropriate, referrals to ongoing services both in Riverside County Department of Mental Health (RCDMH) and outside agencies as well as Riverside County 211.

- Network of Care – Network of Care is a user friendly website that is a highly interactive, single information place where consumers, community members, community-based organizations and providers can go to easily access a wide variety of important information. The Network of Care is designed so there is "No Wrong Door" for those who need services.

- Call To Care - This program provides outreach to, trains, and assists lay persons to initiate and maintain understanding, caring relationships with the persons of their religious communities, and to volunteer to use their lay counseling skills in their communities.

In order to provide targeted activities to underserved communities, the Department will continue to work with the Reducing Mental Health Disparities Committee developed during the PEI planning process. This committee is one of several efforts to build meaningful and sustainable relationships with the diverse populations throughout Riverside County. The committee will be responsible for overseeing the reduction of mental health disparities in the County of Riverside Department of Mental Health. Members will be from racially, ethnically and culturally unserved, underserved, and inappropriately served groups representative of the community.

- Outreach activities – Outreach and engagement staff will provide community outreach and engagement activities targeting those populations that are currently receiving little or no service to increase awareness and knowledge of mental health and mental health resources, such as PEI programs, and increase community readiness to address mental health issues and eliminate stigma associated with mental health issues. Staff will provide community education and referral and linkage.

- Ethnic and Cultural Community Leaders in a Collaborative Effort - RCDMH will continue relationships with community leaders from ethnic and cultural populations who were hired during the PEI planning process. These consultants will continue to work within local communities in order to identify key community leaders and to build a network of individuals from these communities to promote mental health information and the use of PEI services.

- Promotores de Salud (Community Health Workers) - The Promotores de Salud program will address that need within the large number of Hispanic communities in Riverside County. Promotores are health workers who work and are from the community they serve. They will provide health and mental health education and support to members of their communities.

EXECUTIVE SUMMARY

Project #2 – Parent Education and Support

This PEI project will work with children and families with a focus on providing services in non-traditional and natural community settings, e.g., family resource centers, faith based organizations, and child care centers. Each component of this project focuses on children and families through a variety of interventions and strategies. Specific and targeted outreach for the programs in this project will include grandparents raising grandchildren and fathers.

The programs are:

- Triple P – Positive Parenting Program is a multi-level system of parenting and family support strategies for families with children from birth to age 12. Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence.

- Parent Management Training (PMT) – PMT is a culturally adapted evidence-based approach targeting migrant Spanish-speaking families. PMT uses didactic instruction, modeling, role playing, and home practice to teach parenting skills in encouragement, monitoring, discipline, and problem solving.

- Strengthening Families Program (SFP) – SFP is a family skills training intervention designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children. This program brings together the family for each session.

- Parent-Child Interaction Therapy (PCIT) - PCIT is an intensive, short-term, evidence -based intervention that has been demonstrated to effectively help families with children between the ages of 2 and 8 who exhibit a number of chronic disruptive behaviors at home, in school, preschool or daycare (e.g., aggression, defiance, frequent temper tantrums, refusing to follow directions, talking-back, swearing).

Project #3 – Early Intervention for Families in Schools

This project focuses on working with children and families within schools. A program that is school specific was identified through the community planning process. The goal of the project is to provide a family based intervention in a setting that is de-stigmatizing to a lot of families, which is school.

The program is:

- Families and Schools Together (FAST) – The FAST program is an outreach and multi family group process in schools designed to build protective factors in children, empower parents to be the primary prevention agents for their children,

and to build supportive parent-to-parent groups. The overall goal of the FAST program is to intervene early to help at-risk youth succeed in the community, at home, and in school, thus avoiding problems such as school failure, violence, and other delinquent behaviors.

Project #4 – Transition Age Youth (TAY) Project

This project is designed to address specific outreach, stigma reduction, and suicide prevention activities for (TAY) at highest risk of self harm. Targeted outreach will occur to identify and provide services for LGBTQ TAY, TAY in the foster care system and those transitioning out of the foster care system, runaway TAY, and TAY transitioning onto college campuses.

The programs are:

- Depression Treatment Quality Improvement (DTQI) – DTQI is an evidence-based early intervention program used to treat depression, based on the concepts of Cognitive-Behavioral Therapy (CBT). This service will be provided in multiple locations in each service delivery region. It will be provided through organizations that serve youth and young adults in a setting where the youth feel comfortable e.g.: services targeting LGBTQ youth will be provided at an organization that serves LGBTQ youth and young adults.

- Peer-to-Peer Services – This service will be connected to DTQI. As an organization provides DTQI, their outreach and engagement efforts will be specific to the target population. Leveraging with existing agencies, this project will utilize youth speaker's bureaus to outreach and educate at-risk youth and the community-at-large of the unique issues each group of identified at-risk youth experience as they relate to mental health and interpersonal issues.

- Outreach and reunification services to runaway TAY – Runaway youth are at increased risk of becoming victims of crimes and trauma as well as becoming involved in the juvenile justice system. Targeted outreach and engagement to this population is necessary in order to provide needed services to return them to a home environment. Crisis intervention and counseling strategies will be used to facilitate re-unification of the youth with an identified family member. Follow up referrals will be provided to assist with stabilization of the living situation for the youth. RCDMH will collaborate with community providers in order to identify specific outreach strategies to reach runaway TAY. RCDMH will collaborate with community providers in order to identify specific outreach strategies to reach unserved and underserved populations, including LGBTQ youth.

- Digital Storytelling – TAY identified the need for media based engagement activities. There was acknowledgement that youth are media savvy and opportunities to participate in such activities will lead to engagement. Digital Storytelling provides a three day workshop for individuals during which they

identify a "story" about themselves that they would like to tell and produce a 3 to 5 minute digital video to tell their story. This activity gives the individual a unique way to communicate something about their life experiences, which could include trauma, loss, homelessness, etc. At the end of the workshop, the participants are then asked to invite whomever they would like to a viewing party.

- Active Minds – Active Minds is a national organization working to use the student voice to change the conversation about mental health on college campuses. RCDMH will work with local colleges and universities to develop and support chapters of this student run mental health awareness, education, and advocacy group on campuses. The goals are to increase student awareness of mental health issues, provide information and resources regarding mental health and mental illness, encourage students to seek help as soon as it is needed, and to serve as a liaison between students and the mental health community. The student run chapters will organize campus wide events to remove the stigma that surrounds mental health issues and create an environment for open conversations about mental health issues.

Project #5 – First Onset for Older Adults

This project focuses on the first onset of depression in the older adult population. Programs in this project include in home services as well as services that are portable. Collaboration will include partners that have experience and expertise with the older adult population in Riverside County. This includes, but is not limited to, the County Office on Aging and the Department of Public Social Services: Adult Protective Services. Targeted outreach will occur to identify and provide services for underserved cultural populations, specifically LGBTQ older adults. Although this project focuses on the first onset in older adults, older adults will also benefit from a variety of other PEI programs, including trauma related services, mental health awareness and stigma reducing activities, and parent education and support programs.

The programs are:

- QPR for Suicide Prevention - QPR stands for Question, Persuade, and Refer. People trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone for help. The QPR for Suicide Prevention model will be used to train gatekeepers who interact with seniors in order to look for depression and suicidal behavior.

- Cognitive-Behavioral Therapy for Late-Life Depression – This program focuses on early intervention services that reduce suicidal risk and depression. Cognitive Behavioral Therapy (CBT) for Late-Life Depression is an active, directive, time-limited, and structured problem-solving approach program. A highlight of this model is its portability which allows implementation in a variety of settings including places where older adults are likely to go, e.g.: senior centers and senior workforce centers.

- Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) - This is an intervention for people 60 years and older who have minor depression or dysthymia and are receiving home-based social services from community services agencies. The program is designed to reduce symptoms of depression and improve health-related quality of life.

- Caregiver Support Groups – RCDMH will partner with local community-based organizations and social service agencies to develop psychoeducation curriculum and supportive interventions and provide support groups for caregivers. Specific outreach, engagement, and linkage to the support groups will be to individuals and caregivers/family members of individuals receiving prevention and early intervention services, caregivers of seniors with mental illness, and caregivers of seniors with dementia.

Project #6 - Trauma-Exposed Services for All Ages

Through the community planning process the high need for services for trauma exposed individuals was a priority. This project includes programs that address the impact of trauma for youth, TAY, adults, and older adults.
The programs are:

- Cognitive Behavioral Intervention for Trauma in Schools (CBITS) – CBITS is a cognitive and behavioral therapy group intervention to reduce children's symptoms of Post Traumatic Stress Disorder (PTSD) and depression caused by exposure to violence.

- Safe Dates - This program is a dating violence prevention program for middle and high school students. It works as both a prevention and early intervention tool for teens who have already begun to date and those who have not yet started dating.

- Seeking Safety – This program is a present focused, coping skills program designed to simultaneously help people with a history of trauma and substance abuse. It has been conducted in group or individual format; for female, male or mixed gender groups; for people with both substance abuse and dependence issues; and, for people with PTSD and for those with a trauma history that do not meet criteria for PTSD.

- Trauma Recovery and Empowerment Model (TREM) – This intervention is a fully manualized group based early intervention designed to facilitate trauma recovery among men and women with histories of sexual, physical, and emotional abuse who have been economically and socially marginalized and for whom traditional recovery work has been unavailable or ineffective.

- Prolonged Exposure (PE) Therapy for Post Traumatic Stress Disorders – This early intervention is a cognitive-behavioral treatment program for adult men and women with PTSD who have experienced single or multiple/continuous traumas. It is a course of individual therapy designed to help individuals process traumatic events and reduce their PTSD symptoms along with depression, anger, and general anxiety.

Project #7 – Underserved Cultural Populations

Through the community planning process, input was solicited from key community leaders from unserved and underserved cultural populations. The key community leaders gathered feedback and information from the communities that they represent and provided specific PEI recommendations regarding needed services. The unserved and underserved populations in Riverside County will also benefit from the other PEI projects identified previously.

The programs are:

- Hispanic/Latino Culture –
    - Mamás y Bebés (Mothers and Babies): This program is an evidence-based mood management perinatal group intervention for women.

    - Cognitive-Behavioral Therapy (CBT) for Depression (with antidepressant medication): This program was developed for use with low-income Latina women. It uses an adapted format of CBT to address cultural issues associated with the Hispanic culture.

- African-American –
    - Effective Black Parenting Program (EBPP): The EBPP has been shown to be effective with parents of African American children, including teenage African American parents and their babies, and with African American parents of adolescent children. It includes: culturally specific parenting strategies; general parenting strategies; basic parenting skills taught in a culturally-sensitive manner using African American language expressions and African proverbs; and special program topics such as single parenting and preventing drug abuse.
    - Africentric Youth and Family Rites of Passage Program: This program was designed for African American male youth between ages 11 and 15. The goal of the program is empowerment of black adolescents through a nine-month rites of passage program. A major component of the program is the after school program that offers modules on knowledge and behaviors for living; module topics include manhood development, sexuality, and drugs. Another component of the program includes casework and counseling with linkage to needed services.

- Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) – The CBITS program is a cognitive and behavioral therapy group intervention for reducing children's symptoms of posttraumatic stress disorder (PTSD) and depression caused by exposure to violence that has been used successfully in inner city schools with multicultural populations.

- Native American –
  - Incredible Years – Native American adaptation (SPIRIT): Incredible Years is a parent training intervention which focuses on strengthening parenting competencies and fostering parents' involvement in children's school experiences to promote children's academic and social skills and reduce delinquent behaviors. SPIRIT is a culturally-tailored evidence-based practice that was adapted by Dr. Renda Dionne for the Riverside County Native American community.
  - Guiding Good Choices (GGC) – This is a prevention program that provides parents of children in grades 4 through 8 (9-14 years old) with the knowledge and skills needed to guide their children through early adolescence. It seeks to strengthen and clarify family expectations for behavior, enhance the conditions that promote bonding within the family, and teach skills that allow children to resist drug use successfully. Due to the historical trauma within Native American populations, substance abuse is inextricably linked with the development of depression and major mental illness, including Bi-Polar Disorder and Post Traumatic Stress Disorder. Therefore a program to address substance abuse prevention is essential in addressing the prevention of mental health problems.

- Asian American/Pacific Islander (AA/PI) –
  - Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF): A Curriculum for Immigrant Families – The target populations of the SITIF program are Asian American/ Pacific Islander immigrant parents and/or caregivers with inadequate parenting skills to effectively discipline and nurture their children. The primary strategies of the program are: community education/outreach workshops, a bicultural parenting class, and family support service linkage. The activities are delivered at locations that are natural congregation places for the immigrant families: school sites, community service delivery settings, community-based and culturally competent behavioral healthcare center.

VI. Prevention and Early Intervention Plan Funding Overview

The PEI plan, when submitted to the State, requests $28.2 million which includes the funds allocated for Riverside County for Fiscal Years 07/08, 08/09 and 09/10. In addition to program money, which totals $18 million, Riverside County is requesting $5.5 million to be kept in prudent reserve and $2 million budgeted for contingency funds both of which will be utilized to sustain the implemented programs over the next four years as the yearly allocation is predicted to drop significantly. This will allow the County

to continue programs in spite of this drop in State funding or to add program sites if the State allocation does not drop as expected in the next few years.

Programs included in the plan are estimated to begin in the County starting in the Fall of 2009 and implemented in phases in designated areas of the County through Spring of 2010. As State allocations are clarified, the Department may slow implementation of programs to ensure they can be sustained for at least four years. Programs can be expanded into other areas of the County as funds are available.

VII. Conclusion

The development of the Riverside County Prevention and Early Intervention Plan resulted from the extensive community planning process that was inclusive of consumers, family members, members of unserved and underserved cultural populations, community based and faith based organizations, and county agencies. The Riverside County Department of Mental Health and particularly the Prevention and Early Intervention (PEI) staff would like to acknowledge and thank the many community members, community stakeholders and County agencies that gave their time, energy and facilities to contribute to the Prevention and Early Intervention planning process. The valuable ideas collected have been used to facilitate the PEI planning process and would not have been possible without the contributions of attendees and organizers.

The complete PEI plan was posted for public comment for 30 days on the Department website. Two public hearings were held to solicit input from community members. Subsequent to those activities, the plan was submitted to the State Department of Mental Health and the Mental Health Oversight and Accountability Commission for review and approval.

COMMUNITY PROGRAM PLANNING PROCESS

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

County: Riverside County Date: July 15, 2009

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

Bill Brennemen, LCSW is the Mental Health Services Act (MHSA) Coordinator for the Riverside County Department of Mental Health (RCDMH). He led the Prevention and Early Intervention (PEI) team throughout the planning process. Janine Moore, LMFT is the MHSA PEI Coordinator and was assisted by Diana Brown, LMFT, Social Services Planner and Maria Jaquez, Peer Support Specialist.

Additional participation in the overall planning process included Donna Dahl, Assistant Director of Programs; the Research & Evaluation Unit; Myriam Aragon, Ethnic Services/Cultural Competency Manager; Renee Becker, Peer Policy and Planning Specialist for Children's Services; Alison Emery, Director of Consumer Affairs; Barbara Mitchell, Older Adult Manager; members of the MHSA Outreach Team; the Parent Support and Training Unit; and the Family Advocate Program. Administrative support was also provided by Sharon Lee, Secretary to Bill Brenneman; Cynthia Magill, Office Assistant III to the PEI Unit; and Cindy Hagan, Administrative Analyst.

Three expert consultants also assisted throughout the planning process. They were Lynne Marsenich, who assisted with the overall planning process; Dr. Renda Dionne, who assisted with outreach to the Native American community; and Benita Ramsey, who assisted with outreach to the African American and LGBTQ communities.

b. Coordination and management of the Community Program Planning Process (CPP)

Members of the PEI Planning Team formed the core of staff providing coordination and management for the community planning process. All aspects of the coordination and management of the CPP included extensive cooperation and involvement of Department staff, other County department staff, consultants, consumers, family members of consumers and community providers. Department staff, as well as three expert consultants, has specific experience in outreach and engagement with a focus on unserved and underserved cultural populations. The planning team utilized 35 trained focus group facilitators, comprised of Department staff, peer support specialists, community providers, consultants, and family members of consumers, to assist with focus group coordination and acquiring community input. Key stakeholders and community gatekeepers, including consumers and contractor/providers provided in-kind assistance in addition to those who assisted in facilitating focus groups. They helped

disseminate information, directed community members to appropriate community locations for participation in focus groups and community forums as well as themselves participating in focus groups and community forums. In addition, the key stakeholders and community gatekeepers participated in each of the four age group committees (Children, Transition Age Youth, Adult, and Older Adult) as well as three workgroups that were developed (Reducing Disparities, Reducing Stigma and Discrimination, and Trauma) throughout the progression of the planning process. All of the aforementioned individuals also assisted in the distribution of a community survey that was made available to community members as well as community providers and stakeholders to allow for the opportunity to give feedback on the PEI planning process.

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

During the 2005 MHSA, Community Supports and Services (CSS) community planning process, Riverside County conducted an extensive, broad-based, ethnically and culturally diverse community input process Countywide.

The PEI stakeholder process expanded upon the relationships built during the CSS community planning process in order to reach further into culturally diverse communities throughout Riverside County as well as to expand membership in the age group committees that were established as part of the CSS planning process.

The initial “plan to plan” process for PEI began with the development of orientation materials which included PEI specific guidelines including information regarding Priority Populations and Key Community Mental Health Needs (see Attachment A), a draft flow chart outlining the RCDMH PEI planning process (see Attachment B), and draft RCDMH guiding principles for the PEI plan (see Attachment C). Members of the PEI planning team then attended meetings with the MHSA Leadership Committee (see Attachment D), the main Mental Health Board (see Attachment E), and Regional Mental Health Boards (see Attachment F) in order to present the “plan to plan” and accept feedback and approval regarding the planning process and the above listed documents.

The PEI team initiated contact with stakeholders and members of underserved communities utilizing a network of contacts, telephone, and electronic outreach. Members of the PEI planning team met with many community leaders, community based service providers and consortiums throughout Riverside County ensuring contact with representatives from each of the three geographical regions (Western, Mid-County, and Desert). The team also attended numerous existing community based stakeholder meetings as a part of the outreach campaign to present and outline the PEI orientation materials in order to build upon existing relationships and to create new relationships and collaboration regarding the prevention and early intervention needs of the County. Attendance at the stakeholder meetings also led to the coordination and scheduling of focus groups and community forums.

COMMUNITY PROGRAM PLANNING PROCESS

In efforts to reach out across the County and across populations, informational meetings were held with: The Desert Consortium consisting of a large group of community based organizations, providers and advocates throughout the Desert region of the County; the advisory boards for each of the four DPSS facilitated Family Resource Centers which serve the three regions of the County (two are located in one of the regions); the Latino Commission of the Desert; KERU – Radio Bilingue (the local bilingual English and Spanish radio station in Blythe); Special Education Local Plan Area (SELPA) directors representing all areas of the County; the Safe and Drug Free School Coordinators throughout the County; The Group (a local community advocacy group for the African American population); the UNITY Advisory board (a group of local community organizations and advocates for youth); the Sun City Chamber of Commerce and Menifee City Council; Child Welfare Attendance representatives from each of the 23 school districts in Riverside County; and the Riverside County Tribal Alliance.

Between July and October 2008, 108 focus groups and community forums were facilitated throughout the County with a total attendance of 1147 participants (See Attachment G for the focus group and community forum schedule). The focus groups and community forums were advertised through a variety of media outlets including radio and newspaper and were also posted on the RCDMH website. The PEI team also used the network of contacts that had been developed through telephone and electronic outreach to inform as many members of the community about the available focus groups and community forums. To ensure that stakeholders could fully participate in the community input process, specific Spanish speaking focus groups were facilitated and Spanish translation was available at each community forum. There were also three focus groups conducted in American Sign Language.

As a means to further solicit input from community stakeholders a community survey was developed and posted on the RCDMH website (www.mentalhealth.co.riverside.ca.us) in both English and Spanish. See attached survey in English (Attachment H-1) and Spanish (Attachment H-2). A total of 2354 surveys were completed and returned. The survey was designed to gather stakeholder input regarding priorities about the State identified key community mental health needs and priority populations in Riverside County. MHSA outreach staff, other County department staff, and consultants, utilized the community survey to solicit feedback from stakeholders who were unable to attend either a focus group or community forum. This included primary health care providers; nursing staff; ethnic/cultural communities; individuals in natural community gathering places and community resource locations; Grandparents Raising Grandchildren Program; the Office on Aging CARE teams; RCDMH staff; the Desert Consortium; RCDMH consumers; Public Health Adolescent Family Services consumers; Office on Aging consumers and staff; the Golden Rainbow Senior Center; the Desert PRIDE Center; the Indio Senior Center; and distribution to community and faith based organizations, and through individual community gatekeepers. MHSA outreach staff and volunteers also attended a wide variety of health and awareness fairs and assisted community members in completing the survey which allowed for community members across ages to provide feedback. These

included the 2008 Dare to be Aware Youth Conference which is a conference designed to reduce mental health stigma among youth; the PRIDE Festival, an event for the LGBTQ community; Mecca Fiesta Campesina Latina (Mecca is a remote area in the Desert region of Riverside County); a food distribution event at the James A. Venable Community Center in Cabazon, a rural Desert community; the Corona Walk for Health, an event for Health promotion in the Western Region; the 4th Annual Family Partnership Summit, a conference for parents and service providers for children's mental health; and the Perris Valley Community Resource Fair, a fair for community members to learn about resources in Perris. The PEI team and the MHSA Outreach team were approached to provide resource information at the 1st Annual Blythe Education Fair. Blythe is a very remote area in the Desert Region. In working with the organizers of the event, 15 Spanish Speaking community gatekeepers were provided a training regarding PEI and ways to assist community members in completing the survey and a stipend was paid to each for their assistance in collecting approximately 700 surveys at the 3 day event.

Please see Attachments I-1 to I-9 for several samples of publicity flyers and press releases, including the Dare to be Aware Youth Conference flyer.

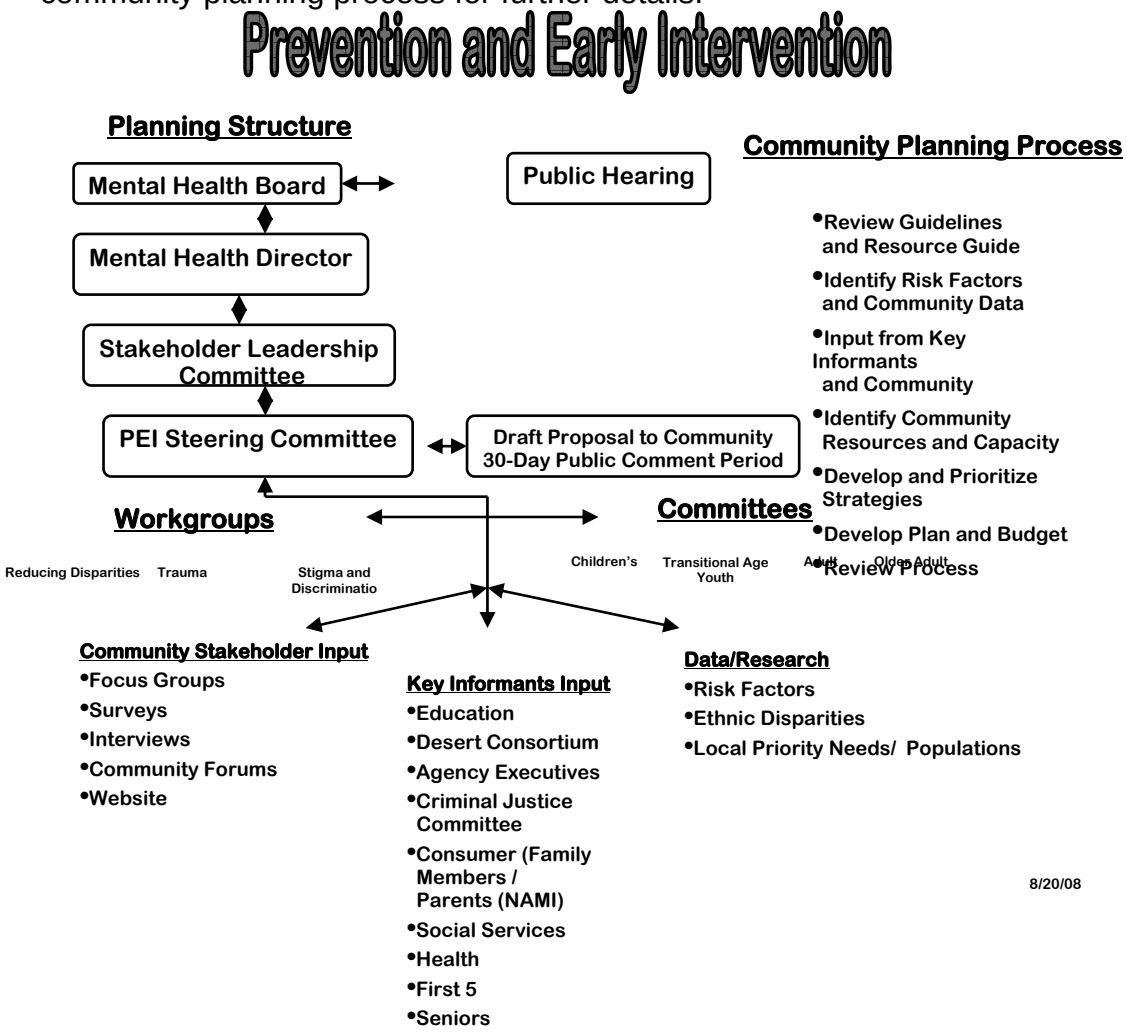
Riverside County Department of Mental Health Research and Evaluation Unit initiated an updating of demographic data so that the planning process would appropriately focus on unserved/underserved individuals and families, trauma-exposed individuals/communities, diverse regional challenges, children and youth at risk, stressed families/communities, and marginalized communities and/or individuals. The data was presented by Department researchers to each of the age group committees prior to the two-day facilitation process which is explained in greater detail below. The data presentations were designed to highlight the age group each individual committee represents.

PEI planning utilized the existing four age group MHSA planning committees (Children, Transition Age Youth, Adult and Older Adult). Committee membership was reviewed as a part of the PEI planning process to evaluate the need to add to the membership to reflect the stakeholders within the County. Due to a great deal of interest in the PEI planning process, there were additional stakeholders who joined each of the committees and it was then determined that the membership reflected representative stakeholders. See Attachments J-1 to J-4 for committee membership lists.

Following the lead from the community, RCDMH determined the need to develop three workgroups to address specific PEI needs. They were the Trauma Workgroup, the Reducing Disparities workgroup and the Reducing Stigma and Discrimination Workgroup. There was specific outreach to stakeholders for participation, including members of unserved and underserved cultural communities, community providers with expertise as well as consumers and family members of consumers. See Attachments K-1 to K-3 for workgroup membership lists.

COMMUNITY PROGRAM PLANNING PROCESS

All data was brought forward to the PEI Steering Committee for final review of recommendations and data. Based upon the feedback and recommendations throughout the community planning process, the PEI Steering Committee (comprised of two members from each of the age group committees and workgroups) made the final recommendations for PEI projects. See the flow chart below for an outline of the PEI community planning process for further details.



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

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

The PEI team ensured that representatives of unserved and underserved populations and family members of unserved and underserved populations had the opportunity to participate in the PEI community program planning process. Building upon the CSS planning process, efforts were made to reach further into the un/underserved communities of Riverside County. Focus groups and community forums were held to guarantee that the community voice was heard and relationships were formed.

COMMUNITY PROGRAM PLANNING PROCESS

Individuals representing these communities were involved in making decisions regarding locations, days, and times of focus groups and community forums in order to ensure access and the greatest likelihood of participation. In addition, transportation and childcare was provided as needed, as well as food and incentives. For example, focus groups were held in both Spanish and English at each of the four DPSS facilitated Family Resource Centers (FRCs). The FRCs are located in areas of the County with the specific intent of serving un/underserved populations.

Invitations to community members of unserved and underserved populations were in the form of fliers in both English and Spanish, and given to representatives of those communities for specific distribution in natural community settings, such as the Mecca Family and Farmworker's Service Center, Family Resource Centers throughout the County, schools, etc. There was also targeted outreach through newspaper including advertisements in La Prensa, the Spanish newspaper and radio ads, specifically through KERU – Radio Bilingue which is the only bilingual radio station in the Desert area.

Two consultants assisted with outreach to specific un/underserved communities. Dr. Renda Dionne assisted with outreach to the Native American community by arranging and co-facilitating focus groups. Benita Ramsey assisted with outreach to the African American community by arranging and facilitating focus groups. She also focused outreach to the LGBTQ community and facilitated the distribution of surveys at the Riverside PRIDE festival. Also, a Department employee assisted with outreach to the deaf and hard of hearing community by arranging and facilitating three focus groups specifically with the deaf and hard of hearing community including staff from the California School for the Deaf, Riverside.

As stated in the previous section outreach was made to recruit stakeholders from underserved communities to participate in the three workgroups (Reducing Disparities, Reducing Stigma and Discrimination, Trauma) and the four age group committees (Children, Transitional Age Youth, Adult, Older Adult).

The following graphs demonstrate: Graph 1 - the racial/ethnic demographics of Riverside County, Graph 2 – the racial/ethnic demographics of focus group and community forum attendees, Graph 3 – the racial/ethnic demographics of community survey respondents.

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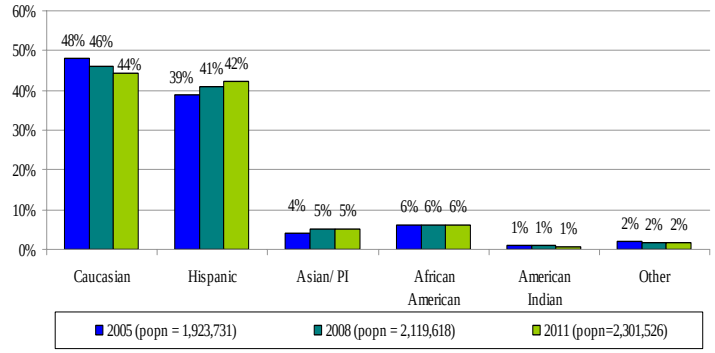
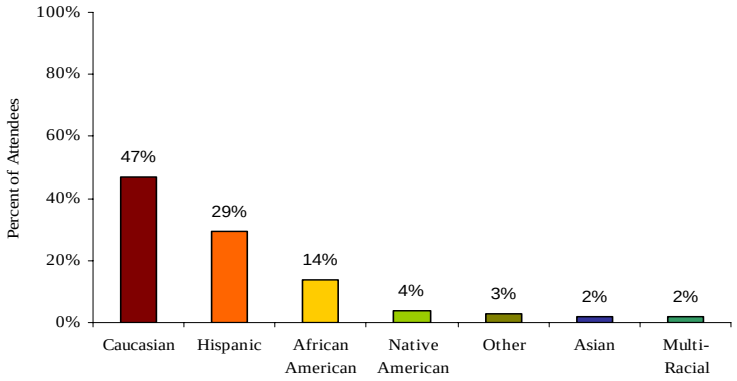
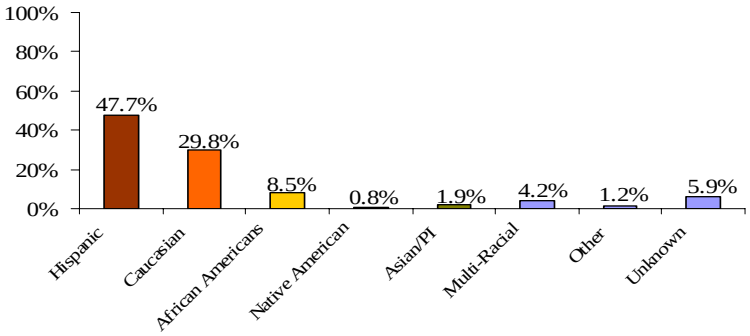
Graph 1
Population Projections by Race/Ethnicity



Graph 2
Focus Group Participants by Ethnicity



Graph 3
Ethnicity Community Survey Participants



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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.

Riverside County is the 4th largest county by population in California and is comprised of areas ranging from urban to rural. Members of the PEI planning team attended numerous existing community-based stakeholder meetings throughout the County as part of the outreach campaign to present and outline the PEI planning process, guidelines, and timeline with the goal of engaging community members in the planning process. One example of this activity was a meeting held with the Latino Commission in Mecca, which is a rural area of the County. In areas of the County where services have not been traditionally provided or accepted, MHSA outreach staff partnered with community and faith based agencies as well as other community leaders in order to foster relationships. These relationships and partnerships facilitated the scheduling of focus groups in those communities as well as allowed for the distribution of the community survey to community members.

Between July 2008 and October 2008 the PEI planning team members provided 108 focus groups and community forums throughout the 3 regions of Riverside County where 1147 community members participated. Focus groups were designed to foster an inclusive environment for individuals from diverse ethnic communities. Facilitators routinely asked participants for input regarding additional focus group suggestions to reach community members for inclusion in PEI planning activities. These efforts resulted in the scheduling of several additional focus groups. Incentives, such as refreshments and gift cards, were used to boost community participation. These proved to be highly effective outreach strategies. Focus groups and community forums were held in neutral settings where community members naturally congregated including community centers, family resource centers, and faith based organizations throughout the County and with the assistance of natural and/or local leaders from the community. The meetings were facilitated by a variety of people including consumers, parents, and Department staff, including bi-lingual staff, so that outreach to many populations was possible and accessible.

Specific outreach was made to engage youth and parents in providing input in PEI planning. This included focus groups with participation by probation youth, distribution of surveys to the youth who participated in the 8th annual Dare To Be Aware Youth Conference and also for completion of surveys at the PRIDE festival and the 1st annual Blythe Education Fair. In addition, transition age youth were invited to, and participated in, both the Children's and Transition Age Youth Committees. Additionally, several focus groups targeted parents of youth consumers. The Children's and Transition Age Youth Committees included several transition age youth as well as parents, parent partners, and community providers representing the needs of youth.

RCDMH Older Adult staff worked closely with the Riverside County Office on Aging staff to reach out to older adult consumers as well as service providers for older adults throughout the County. Additionally, RCDMH staff partnered with DPSS-APS,

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Community Health Agency-Public Health Nursing, and identified older adult providers in the community, i.e.: Senior Centers, Grandparents Raising Grandchildren groups, CARE Teams (Curtailing Abuse) and other agencies to outreach into the older adult community to educate about prevention and early intervention as well get feedback and recommendations about the PEI needs of older adults in Riverside County. This led to several focus groups being provided in senior centers and faith based organizations frequented by older adults. One specific older adult focus group focused on the needs of the LGBTQ community. The Older Adult Committee is comprised of older adults and community providers that represent the needs of the older adult communities throughout the county.

As stated earlier two consultants as well as a Department employee who is fluent in American Sign Language assisted with outreach to specific un/underserved communities.

Dr. Renda Dionne assisted with outreach to the Native American community by arranging and co-facilitating two focus groups with a cross representation of tribes from the County.

A focus group designed specifically for the African-American community was facilitated by a community leader and trusted individual within this population in partnership with another consultant in the PEI planning process, Benita Ramsey. The PEI team acted as a support for resources, refreshments, and incentives, as well as provided training for the facilitator to adequately retrieve the necessary PEI related information. The facilitator, a member of a local African American community advocacy coalition called The Group, reported the need for specific and unique outreach to the African American community due to the history of distrust in “the system” and the perception that the Department has inadequately addressed this community’s unique needs. The Ethnic Services/Cultural Competency Manager has established a relationship with The Group and will maintain collaboration and continue to develop the relationship between The Group and RCDMH.

Benita Ramsey also focused outreach to the LGBTQ community. She facilitated the distribution of surveys at the Riverside PRIDE festival and assisted in recruiting three LGBTQ youth to participate in the Trauma workgroup. Additional outreach assisted in the participation of an LGBTQ older adult in the planning process, specifically in focus groups and the Older Adult Committee.

The deaf and hard of hearing community was engaged through a Department staff member with expertise and relationships within this community. The staff member, who is fluent in American Sign Language, coordinated and facilitated three focus groups with this underserved population which included a community advocacy agency, The Center on Deafness of the Inland Empire (CODIE), as well as attended the Deaf Awareness Week event, sponsored by the California School for the Deaf, Riverside, in order to assist families and staff in completing the PEI community survey.

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The Asian American/Pacific Islander (API) community is largely underserved in Riverside County. Beginning in CSS, the RCDMH Cultural Competency/Ethnic Services Manager, Myriam Aragon, began to investigate the needs of this community and to build relationships with key stakeholders and organizations that work specifically with this population. During the PEI Community Planning Process, RCDMH worked closely with the Riverside Asian American Community Association (RAACA) and individual experts' interviews to obtain information on the mental health needs of the Riverside County API Community. RAACA assisted RCDMH in the development and implementation of an Asian American Survey in four languages identified as the most common: Thai, Lao, Vietnamese, and Chinese (standard and traditional). The survey was distributed at the Asian American Health Conference in 2008. There is recognition that there was low representation from the API population throughout the PEI CPP. RCDMH continues to build relationships with stakeholders from the API community and remains involved in the RAACA by attendance at their regularly scheduled collaborative. In addition, page 48 explains the Ethnic and Cultural Community Leaders in a Collaborative Effort program which includes information regarding ways in which ongoing efforts are planned to build relationships and outreach efforts to the API community.

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

One of the PEI team members is Maria Jaquez, Peer Support Specialist. Maria facilitated 17 focus groups with consumers to ensure consumer participation in the planning process. She outreached to consumers involved in County clinics as well as Jefferson Transitional Programs, which is a peer support and resource center. She also conducted a focus group with a depression/bi-polar support group and another at an apartment complex that houses consumers.

The PEI team met with the RCDMH Parent Support and Training Unit as well as the Family Advocate Program and the Director of Consumer Affairs in the planning process in order to identify specific outreach activities to ensure the participation of consumers and family members in the PEI planning process.

RCDMH Parent Support and Training and the Peer Support Specialists worked extensively with the PEI planning team to coordinate and facilitate focus groups with mental health consumers and their families. These focus groups were conducted in County Mental Health clinics, community-based organizations and local schools.

The Family Advocate Program worked with each of the four regional National Alliance on Mental Illness (NAMI) affiliates which led to the facilitation of a focus group at the monthly NAMI meetings, which includes both consumers and family members. In addition, two NAMI members were trained and facilitated focus groups for family members.

The RCDMH Director of Consumer Affairs worked closely with the many Peer Support Specialists within the Department to engage consumers in participating in focus groups and completing surveys. An outreach worker to the homeless also made specific efforts to assist homeless individuals in Riverside County in completing the community survey.

All participants in the community planning process were asked to complete a confidential demographic survey. Through responses to the survey it was determined that 32% of the participants in focus groups and community forums and 68% of respondents to surveys identified themselves as consumers and/or family members of consumers.

Membership within the workgroups and age group committees include consumers and their families and were a valuable resource for receiving community input about individuals with serious mental illness and/or serious emotional disturbance.

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

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

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

As stated earlier, specific outreach was made to, and separate focus groups were conducted with consumers of mental health services and their families. The Parent Support and Training Unit, the Family Advocate Program, and Peer Support Specialists throughout the Department worked diligently within Department programs and contract agencies to coordinate focus groups with consumers and their families. As a result, 32% of the participants in focus groups and community forums and 68% of respondents to surveys identified themselves as consumers and/or family members of consumers. Consumers and family members are included in the membership of the four age group committees, the three workgroups, and the PEI Steering Committee.

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

Focus groups and community surveys were made available to all Riverside County Department of Mental Health and Substance Abuse staff. Also, the PEI planning team enhanced relationships/collaborations with other County departments as well in order to facilitate focus groups with their staff. Focus groups were held with staff from Department of Public Social Services; Department of Public Health administration and their providers, including the Child Health and Disability Prevention Program and physicians; and the Office on Aging, including the Office on Aging Council. A forum was held with the participants of the RIGHT Partnership meeting, which included 66 social

service providers who provide services to foster youth throughout the County. In addition, the PEI planning team made efforts to outreach to many community based organizations in order to facilitate focus groups in their organizations and to distribute community surveys. One example of this is the MHSA Manager meeting with The Executive Group of Riverside which includes participants from many mental health and health care serving agencies.

Extensive outreach to the Desert Consortium (a compilation of providers, community advocates, school representatives including higher education, local government including the mayor of Palm Desert, healthcare and others – see attachment L for the list of participants – who represent individuals and their needs living in the Desert Region of Riverside County) assisted the PEI team in identifying the needs in the Desert Region of the County. The Alzheimer's Association of Rancho Mirage in the Desert region hosted a focus group with representatives from CalWorks, In-Home Supportive Services, the American Cancer Society, the Stroke Recovery Center, and others.

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

Building upon existing relationships, local school districts and Riverside County Office of Education played an important role in coordinating and providing space to conduct focus groups which allowed parent participation. In addition, teachers, school counselors, school psychologists, principals, and other staff participated in focus groups and/or completed community surveys which provided feedback regarding the needs of students in Riverside County. Multiple focus groups were held with Safe and Drug Free Schools Coordinators which included representatives from several school districts and prevention services. A PEI presentation and orientation was delivered at the SELPA Directors' meeting as well as at the Child Welfare and Attendance meeting, where school officials throughout the County were present. A forum was conducted with Riverside County Office of Education Headstart program with parents and staff from several school districts during the Parent Policy Council meeting at the start of the 2008-2009 school year. A presentation about PEI was made at the Child Welfare and Attendance Coordinators, which has representatives from each of the school districts, and the community survey was distributed.

Representatives from the County's educational system are standing members on the Children's Committee and the chair of the Transition Age Youth Committee is a representative from one of the local higher education programs.

- **Representatives of law enforcement**

Representatives from several law enforcement agencies of the County attended gatekeeper forums including the Public Defender's Office, California Youth Authority, District Attorney's Office, Riverside County Probation, Riverside County Sheriff's Department, and the Corona Police Department.

Key informant interviews were held with two Riverside County District Attorneys, the Riverside County Sheriff's Department School Resource Officer Liaison, and the Division Director and two Assistant Directors of Prevention Services with Riverside County Probation.

The Children's Committee, Transition Age Youth Committee, Trauma Workgroup and the PEI Steering Committee each have a minimum of one representative from law enforcement.

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

The Riverside County Mental Health Board was instrumental in the PEI planning process from the beginning. This included approval of the Riverside County PEI Guiding Principles, assisting in coordination of focus groups and participation in each of the age group committees and the Reducing Stigma/Discrimination Workgroup.

Members of NAMI who were trained in the PEI guidelines and focus group facilitation coordinated and facilitated focus groups with the local NAMI chapters. Additionally, staff from Jefferson Transitional Programs, a contracted peer run center, also assisted in coordinating focus groups with consumers. Representatives from NAMI were represented in the age group committees and Jefferson Transitional Programs staff participated in the Children's, Transition Age Youth, and Adult committees.

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

Members of the PEI team became educated regarding the PEI guidelines through information available from the State Department of Mental Health (DMH) and the Oversight and Accountability Commission. The team participated in the monthly conference calls as well as attended numerous trainings offered by the California Institute of Mental Health, State DMH and the California Mental Health Directors Association.

The initial "plan to plan" process for PEI began with the development of orientation materials which included PEI specific guidelines including information regarding the State identified Priority Populations and Key Community Mental Health Needs, a draft flow chart outlining the RCDMH PEI planning process, and draft RCDMH guiding principles for the PEI plan. The PEI team provided education and training to the Mental Health Board, the MHSA Leadership Committee, and each of the age group committees as well as public and private providers through multiple existing meetings and community collaboratives. The content of these presentations helped to improve awareness of the PEI guidelines as well as differentiating PEI services from existing mental health services (e.g., Community Supports and Services). Emphasis was also made to encourage community members to participate in upcoming focus groups and

community forums. The orientation materials and links to the State DMH and OAC websites were provided on the RCDMH website.

In order to establish a team of focus group facilitators, the PEI team built upon the Community Supports and Services and Workforce Education and Training community planning process by reaching out to those individuals who facilitated focus groups under those plans as well as additional persons who had a unique ability to assist with the PEI planning process. In order to ensure better representation of underserved communities during the PEI planning process, the Department drew on the expertise and connections of its employees who are also members of or have close contact with those communities. These included staff with connections to parent groups, consumers, the deaf and hard of hearing community, migrant populations, the Spanish-speaking community, law enforcement, and schools. In addition, outreach was made to the contracted consultants of the LGBTQ and Native American communities to assist in facilitating focus groups with the populations that they represent. Two trainings were held by the PEI team for facilitators of focus groups and 35 facilitators were trained in total. A PowerPoint presentation was constructed by the Department's Research & Evaluation Unit in conjunction with an expert consultant (see attachment M for the PowerPoint presentation). The presentation gave a brief overview of the MHSA components and transformational concepts, definitions of prevention and early intervention, priority populations and key community mental health needs. The training included a review of this presentation along with presenter notes to assist facilitators in presenting the PowerPoint at each focus group and community forum. The consultant also presented the training to provide valuable guidance & expertise regarding the facilitation of focus groups e.g.: things to avoid, things to help get the group sharing, etc. Facilitators received materials for the focus groups as well as refreshments and incentives for participants.

During this time, three workgroups (Reducing Disparities, Reducing Stigma and Discrimination, Trauma) also met for several facilitated meetings in order to develop PEI recommendations to address these needs.

Riverside County Department of Mental Health Research and Evaluation Unit also initiated an updating of demographic data so that the planning process would appropriately focus on unserved and underserved individuals and family members, trauma-exposed individuals/communities, diverse regional challenges, children and youth at risk, stressed families/communities, and marginalized communities and/or individuals. A "data download" meeting was held with each of the four age group committees separately, and this data, along with focus group and community survey data, as well as continued orientation/discussion about MHSA PEI guidelines was presented to each committee. A make-up "data download" meeting was also held to ensure that participants in each of the age group committees received the information needed prior to participation in the next steps of the planning process.

Subsequently, each age group committee met for a two-day facilitated process in November 2008. The facilitator, Deputy Director of Training & Organization

Development for the Riverside County Center of Government Excellence, guided the committees through the data sources and the committees developed prioritized PEI recommendations for the age group they represented.

The final step was completed through the PEI Steering Committee and meetings were held in January and February 2009. The participants of the Committee had each participated in one of the age group committees and/or the three workgroups. The Steering Committee received a review of PEI guidelines and community data prior to moving into decision making. The data sources included strategies elicited from focus groups and community surveys, recommendations from each of the four age group committees, recommendations from each of the three workgroups, as well as community data compiled by the RCDMH Research & Evaluation Unit.

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.

Riverside County learned from the experiences of the CSS community planning process. The lessons learned informed the PEI community planning process and provided an infrastructure that better enabled the County to include underserved communities more so than the CSS process did. One of the lessons learned was the need to have ongoing relationships, interactions, and engagement with the unserved and underserved populations within the County. During CSS, efforts were made to include underserved communities in the process; however, attempts were not as successful as planned. As a result of the CSS process, an Ethnic Services/Cultural Competency Manager was hired to oversee an outreach program. One objective of the Manager and the staff of the outreach program is to ensure the cultural and linguistic needs of the underserved communities in Riverside County are met. The outreach program played a large role in the relationship building and coordination required to include underserved populations in focus groups, community survey completion, and age group committees, workgroups, and PEI Steering Committee membership. Through coordination with the Ethnic Services/Cultural Competency Manager and the staff of the outreach program, better engagement with, and increased participation by, members of unserved and underserved communities was successful during the PEI process.

Additional enhancements to the Department through the CSS process were the development of the MHSA Leadership Committee and the Transition Age Youth and Adult Committees. These groups, along with the existing Children's and Older Adult Committees also provided a structure to the PEI process where key community leaders, stakeholders and constituents were readily available to participate in the PEI community planning process and provide their expertise regarding the prevention and early intervention needs of Riverside County.

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An important lesson learned from CSS regarding planning for PEI was the inclusion of the Department's Research and Evaluation Unit in the plan-to-plan phase. While gathering data from the community during CSS, a clear link between the kind of information gathered and the data analysis required was not made early in the process which created some pitfalls. During the PEI community planning process, the Research team was involved from the beginning and provided invaluable insight into data collection. Also, the Research team developed the introductory PowerPoint presentation shown to each focus group and community forum. The Research team analyzed the input from the focus groups, community forums, and community surveys and provided the results of the data analysis to each of the age group committees which guided their recommendations. The involvement of the Research team throughout the process assisted in a more fluid and comprehensive understanding of the data analysis. The information was given to the community in a way that increased the community's understanding of mental health risk factors and the role that MHSA PEI will play to address them in Riverside County.

An additional benefit in the PEI process was the State-developed resource guide provided with the PEI guidelines, which assisted in the decision making process.

The Riverside County community members and stakeholders that were involved in the CSS community planning process voiced concern over the availability of information and their knowledge of the final RCDMH CSS Plan. The Department recognizes the need to increase feedback provided to the community and the desire of the community to get direct access to the outcome, or draft, of the RCDMH PEI Plan in order to see the end product that they were involved in creating. In this effort, the PEI team was careful and deliberate in gathering mailing addresses or electronic email contact information for anyone who participated in the process. The final draft of the PEI Plan will be sent directly to these participants as well as an invitation to the public hearings. In addition, the Executive Summary will be presented to the Stakeholder Leadership Committee and at each of the two public hearings.

Per the State PEI guidelines, one of the objectives of PEI is to increase capacity for mental health PEI programs and provide those programs in places where mental health services are not traditionally provided. Throughout the planning process, the PEI team made concerted efforts to reach out to small community based organizations to assist with the planning process and to build relationships toward implementation. A natural progression is to encourage these organizations to participate in the Request for Proposal (RFP) process. In order to de-mystify the process of contracting with the County, PEI organized RFP trainings to educate smaller organizations on County requirements for responses to an RFP. The trainings allowed small organizations to gain an understanding of the process of responding to an RFP as well as identifying the minimum requirements in order to respond. The overall goal of the trainings is to build community capacity for PEI programs. Three RFP trainings were held, one in each of the three service delivery regions of the County.

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b. Measures of success that outreach efforts produced an inclusive and effective community program planning process with participation by individuals who are part of the PEI priority populations, including Transition Age Youth.

The PEI team made great efforts to reach out to providers, consumers, family members, and the community at large to have as much representation as possible throughout the planning process. As stated earlier, 1147 people participated in a total of 108 focus groups and community forums that were provided throughout all areas of Riverside County. This included specific outreach to areas in the Desert region of the County that included rural areas in which a significant immigrant farm worker population live. In addition, 2354 people responded by completing and returning the community survey also from across the County.

All participants in the community planning process were asked to complete a confidential demographic survey which included information re: age, gender, ethnicity, language, region, participant involvement and agency affiliation, if any, whether participation was as a part of a focus group or community forum or if the individual was completing the community survey. The demographic survey was available in English and Spanish. Through the compilation of the demographic information the PEI team was able to assess the success of outreach efforts. Of the 1147 participants in focus groups and community forums, 935 completed and returned the demographic survey. Attachments N-1 & N-2 provide an overview of the demographic characteristics of those 935 participants who attended focus groups and forums and completed the demographic survey as well as the 2208 individuals who completed the demographic information on the community survey.

As a result of concerted outreach efforts, Transition Age Youth represented 25% of the respondents to the community survey. TAY participation was also specifically targeted at a community forum where teens, primarily those involved in the juvenile justice system participated. Another focus group was with juveniles residing in a probation residential placement – Van Horn Youth Center. TAY represented 7% of focus group and community forum participation. Additionally, TAY participated in both the Transition Age Youth Committee as well as the Reducing Stigma and Discrimination and Trauma Workgroups.

As reported earlier, 32% of the participants in focus groups and community forums and 68% of respondents to surveys identified themselves as consumers and/or family members of consumers. Consumers and family members are included in the membership of the four age group committees, the three workgroups, and the PEI Steering Committee.

Riverside County convened three workgroups (Reducing Disparities, Reducing Stigma and Discrimination, and Trauma) and four age group committees (Children, Transitional Age Youth, Adult, and Older Adult). Membership in each of these groups included persons who were identified within the priority populations for PEI. Through existing relationships within the Department and with other County departments as well as

contact from newly developing relationships, invitations for focus groups, workgroups, and age group committees were sent out via email, telephone, and hard copy to ensure that a broad representation of Riverside County's population was included and present within these different groupings.

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

a. The date of the public hearing:

The public hearings addressed both the draft Prevention and Early Intervention Plan and the draft Training, Technical Assistance, and Capacity Building Plan.

Public hearings were conducted on July 1 and July 6, 2009. Due to the size of Riverside County, hearings were conducted in two regions to allow for and encourage attendance.

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 Riverside County Draft Prevention and Early Intervention Plan and the Draft Training, Technical Assistance, and Capacity Building Plan were posted on the RCDMH website at http://mentalhealth.co.riverside.ca.us/opencms/ for the 30-day public review and comment period from May 29 through June 30, 2009. The website also provided links to the PEI executive summary as well as, feedback forms and flyers for the public hearings in English and Spanish for both draft plans. (See attachments P-1 & P-2 for the public hearing flyers and attachments Q-1 to Q-4 for the feedback forms.)

Copies of the draft PEI plan and the draft Training, Technical Assistance, and Capacity Building plan were made available to all stakeholders through a variety of methods:

- An email notice was sent on May 29, 2009 with a link to the website to approximately 1350 stakeholders who participated in a focus group/community forum or who completed a community survey, including consumers and family members, who provided an email address. The email notice included information on how to obtain a hard copy of the plan upon request.
- Each of the draft plans were placed in each of the 36 branches of the County library, posted in the lobby of each RCDMH clinic, and mailed to contractors, including peer centers, for posting.
- Bound copies were given to the Mental Health Board and RCDMH management.
- An email notice with the link for the plan was sent to the membership of each of the age group committees and workgroups.
- All RCDMH staff were sent an email with the link to the plans.
- PEI staff maintained copies of the plans that were distributed to stakeholders upon request.

The County Information and Technology Department tracked that the draft PEI plan was downloaded from the County Mental Health website 372 times and the Training, Technical Assistance, and Capacity Building plan was downloaded 78 times during the period that the plans were posted.

In order to encourage attendance and participation at the public hearings flyers in English and Spanish with information about the dates, times, and locations of the hearings were emailed to the approximately 1350 stakeholders listed above and the flyer was handed out at the local NAMI meetings.

In addition, the information regarding the public hearings was posted in four English language newspapers and one Spanish language newspaper that are circulated through all areas of the County.

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

The Prevention and Early Intervention Draft Plan received 27 comments at both public hearings as well as 35 feedback comment forms. The Training, Technical Assistance, and Capacity Building Draft Plan received 8 comments at both public hearings as well as 10 feedback comment forms. Three substantive changes to the plan resulted.

The Mental Health Outreach, Awareness, and Stigma Reduction Project includes the Call to Care program. A comment was received which provided greater detail about the interventions of the program and a request was made to incorporate this information into the plan. In addition, the need to fund this program Countywide was brought forward. Upon review, the Mental Health Board Executive Committee, agreed with the requests. The program description in the plan was modified to more accurately reflect the interventions and purpose. The budget was revised to include funding Countywide. Please see page 45 for the program description.

The Early Intervention for Families Project and the Local Evaluation of a PEI Project identified initial target communities for implementation. Several comments were made regarding need in additional locations, primarily in the Desert Region. Target communities were identified by local school districts and a concern was brought forward that a school district in the Desert with a wide range of socio-economic status did not accurately reflect the needs of a small portion of the district. Based upon this feedback, additional research by RCDMH was conducted specifically focusing on four elementary schools in a high-risk area. Upon completion of this research and review with the Mental Health Board Executive Committee, it was deemed appropriate and necessary to add these local school communities to the initial target area for implementation. Please see tables on pages 73 & 74.

The final substantive change approved by the Mental Health Board Executive Committee was made to the Training, Technical Assistance, and Capacity Building Draft Plan. Several comments regarding the use of schools for implementation and partnership with PEI programs brought forward the concern that adequate training and

use of Student Assistance Programs was not clearly identified. A fourth component was added to the plan describing the goal of RCDMH to provide Student Assistance Program training to school personnel as well as mental health training to community-based organizations, substance abuse providers, and additional community gatekeepers. Please see the change to the plan on page 165.

Additionally, there were significant comments to the Prevention and Early Intervention plan and the Training, Technical Assistance, and Capacity Building plan made by consumers and stakeholders which will be taken into consideration during the ongoing planning, implementation, and evaluation process. Several comments resulted in clarifying statements to accurately reflect the Department's position within the plan. The details of these comments are listed in Attachments R-1 and R-2 which includes all comments made and the Mental Health Board Executive Committee's response to those comments.

There were many positive comments brought forward by the community highlighting their overall support of the plan. Examples include:

- Used evidence-based programs/practices.
- Addresses a wide variety of cultures.
- Community involvement in program development.
- Address all major groups.
- I'm pleased that it strives to be inclusive, particularly of the Lesbian, Gay, Bisexual and Transgender communities.
- Covers many needs of broad segments of the populations.
- The strength in the plan clearly lies in its attention to provide training to law enforcement. Thank you.

d. The estimated number of participants:

Two public hearings were offered: One in the Desert Region and one for both the Western and Mid-County Regions.

July 1, 2009 (Western & Mid-County Regions): 41 participants

July 6, 2009 (Desert Region): 29 participants

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

PEI PROJECT SUMMARY

County: Riverside PEI Project Name: Mental Health Outreach, Awareness, and Stigma Reduction Date: July 15, 2009

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	☒	☒	☒	☒

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	☒	☒		

PEI PROJECT SUMMARY

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

The Prevention and Early Intervention community planning process in Riverside County included 108 focus groups with 1147 participants as well as the completion and return of 2354 community surveys. Throughout the input process, stakeholders identified a high need for:

a) Activities to reduce stigma and discrimination related to identifying mental health needs and in accessing mental health services
b) Culturally competent, community based outreach and engagement resources to all age groups
c) Activities designed to increase awareness regarding mental health.

Effective outreach and engagement activities will naturally lead to an increase in mental health awareness and stigma reduction. Feedback included the idea that specific outreach, engagement, and information regarding resources as well as specific stigma reducing strategies would be necessary in order to engage participation in any PEI activity.

The Mental Health Services Oversight and Accountability Commission Stigma and Discrimination Advisory Committee White Paper (2007) states, "the shame and blame of society's discomfort with the differentness of mental illness lands squarely on those most vulnerable – those struggling to have meaningful lives while coping with the symptoms and effects of mental illness." Throughout the community planning process for both Community Supports and Services and Prevention and Early Intervention, stakeholders, including consumers and family members of consumers, made similar statements and identified a high need for activities designed to reduce stigma and discrimination. Additionally, focus groups and survey responses clearly stated the need to educate community members, including youth, parents, teachers, caregivers and the community at large about mental health related topics. Research has been clear about the effects of stigma and discrimination on a person's ability and/or willingness to access services. The President's New Freedom Commission recognized the serious impact of stigma and identified its reduction as a priority in transforming mental health care in the nation. The President's New Freedom Commission on Mental Health: *Achieving the Promise: Transforming Mental Health Care in America (2003)* report states, "stigma frequently surrounds mental illnesses, prompting many people to hide their symptoms and avoid treatment….Some people may not recognize or correctly identify their symptoms of mental illness; when they do recognize them, they may be reluctant to seek care because of stigma…..stigma and discrimination can be lessened through education; when people have a personal understanding of the facts, they will be less likely to stigmatize mental illnesses and are more likely to seek help for mental health problems."

The UC Davis Center for Reducing Health Disparities (2008) conducted focus groups throughout the State soliciting input on specific strategies to engage the underserved in prevention and early intervention activities. In that process, "Focus group findings suggest that new, concerted, and ongoing efforts to engage communities in the development and dissemination of new programs, to promote social inclusion, and to build sustainable relationships with underserved communities are critically needed." The RCDMH focus group and community survey input as well as meetings with key informants in the community planning process in Riverside County reflected similar ideas.

PEI PROJECT SUMMARY

Focus group feedback strongly recommended outreach, mental health awareness and stigma reducing activities as a goal for PEI funding:

- "Provide outreach in communities where people live- go door to door have outreach workers in grocery stores and other gathering places."
- "Better outreach to the Spanish- speaking community through the schools, church and media about available services and programs."
- "Partner with faith-based organizations for outreach."
- "Forums to educate the deaf community about mental health programs, greater outreach into the deaf community."
- "Educate general public on signs and symptoms of depression, anxiety, trauma with seniors."
- "Pamphlets and information needs to be in universal language also in Spanish and or other appropriate language."
- "Education to teachers, Kindergarten through college."
- "Have people talk about mental health issues and/or their own mental health issues."
- "Early education programs like Breaking The Silence."
- "Directory (hotline 24-7) live mental health professionals."

Respondents to the community surveys were asked to identify their ideas about how to help PEI priority populations. There was a high frequency of responses related to outreach, mental health awareness and stigma reduction. Some of the responses were:

- "Outreach work in streets: interviews, educational materials, referrals."
- "Culturally sensitive outreach and education, training of public sector staff to be sensitive to needs of all who might benefit from services…"
- "Safe 800 numbers."
- "Be culturally aware – people respond better to those they are familiar with."
- "Education for pastors and lay ministers."
- "More campaigns for stigma."
- "More community awareness of recovery using peer success stories."
- "Many people see M.H. issues as a stigma. Training or education on M.H. issues/illness to let everyone know it's okay to ask for help."

As a result of the feedback received from the focus groups, community forums, and surveys, and in light of the Statewide Suicide and Discrimination projects, a Reducing Stigma and Discrimination Workgroup was formed. This Workgroup provided a unique opportunity for consumers, family members, community leaders, media experts, and public and private agencies to come together to explore stigma and discrimination issues in the County Mental Health system and the community at large. The diverse forum allowed participants to benefit from each others' expertise and wisdom to strategically develop recommendations that would reduce mental health stigma and discrimination. The goal of the Reducing Stigma and Discrimination Workgroup (RSDW) was to identify strategies to reduce mental health stigma

and discrimination and to provide feedback to ensure that County Mental Health anti-stigma efforts are integrated into the PEI planning process.

Additionally, the Reducing Disparities Workgroup (RDW) was formed and the membership reflected the diversity of the community of Riverside County and included community leaders, community based and faith based organizations, public agencies, consumers and family members, and members of unserved and underserved ethnic and cultural populations. The goals of the Workgroup were to provide feedback to ensure that County Mental Health efforts to reduce mental health disparities are integrated into the PEI plan and to prioritize PEI related activities for specific unserved and underserved populations. Members of the Workgroup met with key community leaders as well as community members of specific underserved populations and worked with those leaders and community members to develop PEI recommendations. The Workgroup participants had an opportunity to meet, conduct focus groups, and conduct interviews with key leaders in the community. Through this process, specific recommendations were developed for the unserved and underserved ethnic and cultural populations. In addition to recommendations for specific unserved and underserved cultural populations, the workgroup also developed general recommendations for reducing disparities in accessing PEI services. Those recommendations focus on specific mental health awareness and stigma reduction activities which include:

- "Provide education and training to community-based organizations, faith-based organizations, partner public agencies, advocacy agencies, and the community at large on mental health prevention and early intervention."
- "Fund and promote sharing of resources with existing agencies in the community."
- "Build community collaboratives and partnerships."

The Reducing Stigma and Discrimination Workgroup and the Reducing Disparities Workgroup reports (see Attachments O-2 & O-3) were provided to each of the four age group committees (Children, Transition Age Youth, Adult, and Older Adult) as a source of stakeholder input to be considered as recommendations were developed by each of the committees. Subsequently each committee developed recommendations for reducing stigma and discrimination at the local level. Those recommendations were brought forth to the PEI Steering Committee and the members then recommended the development of specific PEI mental health outreach, awareness, and stigma reducing activities.

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

a) 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 program planning process.

The goals of this PEI project are to develop and expand existing stigma reducing activities, expand outreach and engagement activities, and increase community awareness regarding mental health throughout Riverside County based upon the needs identified through the community planning process. The community planning process that included focus groups,

community forums and community surveys called for outreach and engagement, mental health awareness and stigma reducing activities that targeted unserved and underserved communities. This included education for community members, faith based organizations, teachers, parents, caregivers, and many others. The UC Davis Center for Reducing Health Disparities report titled, Engaging the Underserved: Personal Accounts of Communities on Mental Health Needs for Prevention and Early Intervention (2008) identifies several recommendations, two of which were also identified throughout the Riverside County community planning process. They are to "build ongoing, sustainable relationships with community members, organizations, and advocates and involve them in meaningful ways in PEI planning and mental health programs" and "establish and maintain collaborative and trusting relationships with community partners to improve delivery of mental health care". Activities will be wide ranging and will include maintaining and developing ongoing relationships with underserved cultural populations including the Hispanic, African American, Asian American, Native American, Deaf/Hard of Hearing and LGBTQ communities. The identified programs clearly address the State identified Key Community Mental Health Needs of Disparities in Access to Mental Health Services, Psycho-Social Impact of Trauma, At-Risk Children, Youth and Young Adult Populations, and Stigma and Discrimination. They also focus on the PEI Priority Populations of Underserved Cultural Populations, Trauma Exposed Individuals, Individuals Experiencing Onset of Serious Psychiatric Illness, Children/Youth in Stressed Families, Children/Youth at Risk of School Failure, and Children/Youth at Risk of or Experiencing Juvenile Justice Involvement. The programs in this project will include and benefit youth, transition age youth, adults, and older adults. Activities will be wide ranging and will include maintaining and developing ongoing relationships with underserved cultural populations.

In addition to Department staff, a Reducing Stigma and Discrimination Committee has been developed to oversee, develop, and guide stigma and discrimination reducing activities. Members of the committee include consumers, family members, transition age youth, adults, older adults, community leaders, members of unserved and underserved cultural populations, and community-based and faith-based organizations.

Activities to be funded under PEI provided throughout the County include:

- **Parents and Teachers as Allies** – This program, created by the National Alliance on Mentally Illness (NAMI), is designed to help families and school professionals identify the key warning signs of early-onset mental illnesses in children and adolescents in school. It focuses on the specific, age-related symptoms of mental illnesses in young people. An educator, a facilitator, a parent of a child with mental illness, and a Transition Age Youth consumer provide the two hour presentation at school sites. Educators often state the need for information regarding the signs of mental health issues in the children they are teaching; however, this education is not part of their formal education and training. For those who receive the program, it has been shown to be effective in reducing the stigma related to the mental health needs of children. Specific outreach will be made to schools that were identified through the community planning process as having students and families with multiple risk factors for developing mental health problems, specifically underserved ethnic and cultural

populations living in poverty. This program will be implemented in partnership with school districts in areas of the County identified through the community planning process.

- **In Our Own Voice Program (IOOV)** – This program, also developed by NAMI, is an interactive public education program in which two trained consumer speakers share their personal stories about living with mental illness and achieving recovery. Presentations will be given to consumer groups, students, faith based community members, interested civic groups, providers, politicians, law enforcement, and the public at large. Special efforts will be taken to reach the different age groups and targeted outreach will be made to underserved ethnic and cultural populations by offering the presentations in natural community settings, such as churches, family resource centers, and libraries. Presenters of the program will be reflective of the audience, i.e. TAY and Older Adult consumers will provide the presentation to individuals within their age group or to providers of service representing those age groups.

- **The "Dare To Be Aware" Conference** (youth anti-stigma conference) – This is a full day conference for approximately 1000 youth in middle and high schools from across the County. The goals are to increase awareness and reduce stigma related to mental illness. The day begins with a keynote speaker who is a Transition Age Youth who has struggled with many issues, including a mental health diagnosis. The day continues with the youth selecting three workshops that they can attend. The topics covered are varied and include presentations on unhealthy relationships; depression awareness; self mutilation/self injury; substance abuse; a presentation by LGBT youth about their life experiences; and a presentation by a mother who lost her daughter to suicide. Prior to the conference, a committee of youth leaders will be established as an advisory committee which drives decisions about the conference, including the theme and the conference workshops. A youth art contest will be held based upon the theme of the conference and the winning drawing will be used on the conference brochures, t-shirts and posters. Outreach will made to the media to cover the event as a means to promote stigma reduction. The Riverside Community College media department will partner with the conference organizers to put together a news segment explaining the stigma reducing goals of the conference. The taped news segment will be used to dialogue with local schools, media and internet resources about developing stigma reducing messages that can be disseminated through those outlets.

- **Breaking The Silence: Teaching School Kids About Mental Illness** – This NAMI program is an educational package that teaches students in upper elementary school, middle school, and high school about serious mental illness. The program humanizes serious mental illness through the use of stories. Students learn that mental illnesses are real illnesses that can be treated, and are not character flaws. The goal of the message is to separate the individual from the illness. Another primary goal of the program is to teach youth about stigma and how to overcome it. The lesson plans are easily implemented within the classroom setting. This component will be implemented

within schools throughout the County identified through the community planning process as having students with the highest risk of developing mental health challenges. In addition to program implementation in schools for the students, specific outreach will be made to teacher education programs in order to provide presentations to future teachers about how to implement Breaking The Silence in the classroom.

- **Toll Free, 24/7 "HELPLINE"** – The "HELPLINE" will be funded due to the enormity of the input from the community stakeholders expressing the need for increased access to a crisis hotline. The "HELPLINE" will provide crisis and suicide prevention services including counseling and emergency assistance twenty four hours a day, seven days per week. The "HELPLINE" will be staffed with bilingual (Spanish) individuals who are trained in telephone response to mental health crisis situations. Translation services will be available for callers of languages other than English and Spanish, and TDD will be available for deaf and hard of hearing callers. The use of a hotline will reduce disparities in access by providing crisis counseling and referrals anonymously and in the language of the caller. In addition to the immediate response to the caller, the caller will be given, when appropriate, referrals to ongoing services both in RCDMH and outside agencies as well as Riverside County 211.

- **Network of Care** – Network of Care is a web based, highly interactive, single information place where consumers, community members, community-based organizations, and providers can go to easily access a wide variety of important information. The resources include a comprehensive service directory, links to pertinent web sites from across the Nation, an easy to use library, and many other options. This user friendly website includes translated materials with access phone numbers and provides information in 14 languages. Regardless of where the individual begins their search for assistance with mental health issues, the Network of Care helps them find what they need - it helps ensure that there is "No Wrong Door" for those who need services. PEI funds will support the maintenance of the Network of Care website which will include information about PEI related activities. (The cost for these activities can be found in the PEI Administrative Budget.)

- **Call To Care** - This is a training program for the non-professional caregiver. The program has an interactive format which helps the participants practice the skills being taught. It is centered first on the needs of the person seeking support or help, and secondly on increasing self-awareness of the caregivers. At the same time, it strives to point out and clarify the skills, knowledge and boundaries that the caregiver needs in order to be effective. The program teaches core qualities of a caregiver: good communication skills, cultural issues, mental health issues, loss and grief, care of self, suicide risk, stigma and discrimination, psycho-social impact of trauma, and dealing with at risk populations, particularly with the older adult population. Partners will work with faith-based organizations for outreach. A great proportion of community members of unserved and underserved cultural populations belong, at some level, to a spiritual community, and as such, that population is an excellent

base from which to operate. This service will help identify community members that may need mental health services that normally would not seek help.

- **Media and Mental Health Promotion and Education Materials** will be prepared and provided for all community events and media efforts and outreach will occur to engage hard to reach populations. The purpose of this program is to identify ongoing additional local needs to increase awareness related to mental health resources and stigma related activities for implementation throughout Riverside County. These may include such activities as media outreach including public service announcements, the development of informational materials, outreach to radio programs for discussion of mental health related topics, consumer developed performances, and participation in community events such as health fairs. Separate activities will be identified targeting individuals based upon age, e.g. older adults, in order to provide the most appropriate information.

In order to provide targeted activities to underserved communities, the Department will continue to work with the Reducing Mental Health Disparities Committee developed during the PEI planning process. This committee is one of several efforts to build meaningful and sustainable relationships with the diverse populations throughout Riverside County. The committee will be responsible for overseeing the reduction of mental health disparities in the County of Riverside Department of Mental Health. Members will be from racial, ethnic and cultural unserved, underserved, and inappropriately served groups representative of the community.

- **Outreach activities** – Three RCDMH outreach and engagement staff will provide community outreach and engagement activities targeting those populations that are currently receiving little or no service to increase awareness and knowledge of mental health and mental health resources, such as PEI programs, and increase community readiness to address mental health issues and eliminate stigma associated with mental health issues. Staff will provide three key activities:

    - ✓ Community Education – This includes culturally competent, targeted community education on mental health topics and resources. Staff will attend community health fairs with specific focus to those in culturally unserved and underserved communities and participate in a monthly bilingual radio program addressing mental health topics. Staff will collaborate and partner with community leaders, schools and churches to identify local events that will be attended by unserved and underserved cultural populations and to develop culturally specific outreach activities. Although targeted events in ethnic communities will occur, general community events are also opportunities to reach a diversity of people with information and resources.
    - ✓ Selective Education – Staff will liaison with Promotores and Ethnic and Cultural Community Leaders in a Collaborative Effort (see below), as well as key community leaders in order to provide accurate and culturally appropriate information and resources to individuals and families in need of PEI and other services.

- ✓ Referral and Linkage – Staff will work to improve communication and referral linkages across a multitude of settings, including, schools, courts, churches, senior centers, social service agencies, and public health clinics. These activities include working with individuals and families to address any barriers in accessing needed PEI and other services. Staff will assist with the coordination of other ethnic specific activities as identified by the Ethnic and Cultural Community Leaders and the Promotores de Salud.

Staff will participate in the Reducing Mental Health Disparities Workgroup in order to build and maintain ongoing and sustainable relationships with key community leaders.

- **Ethnic and Cultural Community Leaders in a Collaborative Effort** - Throughout the community planning process, stakeholders indicated the need for mental health awareness education specifically tailored for unserved and underserved cultural populations. Input from the community focused on ensuring that individuals providing the mental health awareness information reflect the culture of the communities receiving the information. In this component, RCDMH will continue relationships with Ethnic and Cultural Community Leaders from ethnic and cultural populations within local communities in order to identify key community leaders and to build a network of individuals from these communities to promote mental health information and the use of PEI services. The Ethnic and Cultural Community Leaders represent the following populations: African American; Native American; Asian American/Pacific Islander; Deaf/Hard of Hearing; and LGBTQ. The Promotores de Salud program listed below will address similar needs in the Hispanic population. The Ethnic and Cultural Community Leaders will assist RCDMH in coordinating an advisory group for the population they represent that will be inclusive of key community leaders, community based providers and faith based organizations. Each advisory group will work to develop culturally and linguistically appropriate mental health education and awareness materials which will provide information on mental health, mental illness, and available mental health services. They will also assist the Department in developing culturally appropriate mechanisms to provide mental health related information to the community. In order to achieve this, RCDMH will work with the Ethnic and Cultural Community Leaders to provide mental health educational groups for key leaders within the community. The community leaders will then reach out into their local communities and provide culturally and linguistically appropriate mental health informational meetings for community members. These activities will ensure that there is increased knowledge within communities about mental health related information and services as well as reduced stigma related to mental health needs. Because the Ethnic and Cultural Community Leaders come from the community they serve they can address barriers due to linguistic and cultural differences, stigma, and mistrust of the system.

- **Promotores de Salud (Community Health Workers)** – As stated earlier, the community planning process revealed that stakeholders indicated the need for community based education and outreach efforts within local communities. The Promotores de Salud program will address that need within the large number of

Hispanic communities in Riverside County. Promotores are health workers who work and are from the community they serve. They will provide health and mental health education and support to members of their communities. The Promotores have long standing relationships with people in the communities that they serve and, as a result, individuals from those communities are more likely to trust not only the individual but the information they provide. Promotores reduce the stigma associated with mental health related information and services. Additionally, Promotores provide services within the community, which significantly reduces barriers to access such as transportation and limited resources. Promotores will provide outreach to individuals and families within their communities where individuals feel comfortable and may typically gather.

b) Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

The goals of this PEI project are to develop and expand existing stigma reducing activities, expand outreach and engagement activities, and increase community awareness regarding mental health throughout the County. In achieving these goals, and in order to effectively implement the identified programs, this project allows for multiple partnership opportunities that include peer-led organizations, local NAMI programs, elementary, middle and high schools, and community-based and faith-based organizations that have the trust of and a wealth of history providing services to members of their communities. Additionally, partnerships will be formed with key community leaders within traditionally underserved communities who know their community and have contacts throughout their area to increase access to referrals and resource information for the population targeted. The memberships for Reducing Stigma and Discrimination Committee and the Reducing Mental Health Disparities Committee allows for partnership with consumers, family members, transition age youth, adults, older adults, community leaders, and members of unserved and underserved cultural populations. Project activities will be provided in ways and settings that increase access for community members including natural community settings such as home, churches, childcare centers, primary care offices, family resources centers, libraries and any other locations identified by the providers as a gathering place for the community, which lends to additional partnerships.

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

National research demonstrates that individuals from ethnic minorities living in poverty have an increased risk of developing mental health needs. This is most often in relation to those individuals having access to significantly fewer resources and increased exposure to community violence. RCDMH divides the County into three regions which are Western, Mid-County, and Desert. Communities within each of the three regions of the County were identified as high need and will be the initial target demographic for programs throughout

the County PEI plan. The analysis of the data, provided by the RCDMH Research and Evaluation Unit, including age, poverty and ethnicity, resulted in the identification of priority communities within each service delivery region. The priority communities in Western Region are: Rubidoux, CasaBlanca, Eastside, Arlanza, and Moreno Valley. The priority communities in Mid-County Region are: Lake Elsinore, San Jacinto, Perris, Winchester, Romoland and San Jacinto. The priority communities in Desert Region are: portions of the Coachella Valley, Mecca, East Side Banning, Indio, North Palm Springs, Desert Hot Springs, Cathedral City, and Blythe. Local data also indicates that the highest numbers of underserved individuals within the County are Hispanic. The identified communities are primarily Hispanic, but also include individuals of other underserved populations. Target populations include children, TAY, adults, and older adults of unserved or underserved cultural populations.

d) Highlights of new or expanded programs.

Parents and Teachers as Allies; Breaking The Silence: Teaching School Kids About Mental Illness; Media and Mental Health Promotion and Education Materials; Ethnic and Cultural Community Leaders in a Collaborative Effort; and the Promotores de Salud (Community Health Workers) programs are new activities for RCDMH. The other programs identified in this project are an expansion of services.

Parents and Teachers as Allies:

- Helps school professionals effectively support students with mental illness and their families.
- The program is provided by individuals with a lived experience of mental illness.

In Our Own Voice Program (IOOV):

- Uses the consumer voice to educate the public.
- The program is interactive with the audience.

The Dare To Be Aware Conference:

- Unique opportunity for middle and high schools students to attend a conference focused on mental health education to reduce stigma.
- Youth leaders make primary decisions.

Breaking The Silence: Teaching School Kids About Mental Illness:

- Incorporated into classroom curriculum.
- Programming is available for upper middle school, junior high and high school.

Toll Free, 24/7 “HELPLINE”:

- Toll free number increases access.
- Provides crisis support as well as referrals to callers.

Network of Care:

- Provides up to date, accurate information on mental health topics and referrals.
- Information is available in 14 languages.

PEI PROJECT SUMMARY

Call To Care:

- Education on mental health/emotional topics to lay persons connected to faith based organizations.
- Provides attendees with the skills to support members of their communities with needed emotional support.

Media and Mental Health Promotion and Education Materials:

- Allows for ongoing assessment of needs.
- Provides the opportunity for ongoing development of age appropriate stigma reducing activities.

Outreach activities:

- Establish collaborations and partnerships with natural support systems within communities.
- Information will be provided in natural community settings and at events in which community members are likely to gather.

Ethnic and Cultural Community Leaders in a Collaborative Effort:

- Builds relationships with key community leaders from traditionally unserved and underserved communities.
- Development of culturally and linguistically appropriate mental health educational materials.
- Ability to provide culturally and linguistically appropriate education and information to unserved and underserved communities.

Promotores de Salud (Community Health Workers):

- Promotores have established ongoing relationships with individuals and providers within their communities.
- Promotores reduce stigma related to awareness of mental health and access to mental health resources.

e) Key milestones and anticipated timeline for each milestone.

- PEI plan approval by State DMH – Summer 2009
- Competitive Procurement Process – September ’09 – November ‘09
- Recruitment and hiring of appropriate staff – December ’09
- Training staff in evidence-based model (including cultural and linguistic needs of population) – January ’10
- Program implementation – February - June 2010

PEI PROJECT SUMMARY

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Parents and Teacher as Allies	Individuals: 1080 Families:	Individuals: Families:	10
In Our Own Voice Program (IOOV)	Individuals: 2160 Families:	Individuals: Families:	10
The Dare To Be Aware Conference	Individuals: 1000 Families:	Individuals: Families:	10
Breaking The Silence: Teaching School Kids About Mental Illness	Individuals: 1300 Families:	Individuals: Families:	10
"HELPLINE"	Individuals: 6000 Families:	Individuals: Families:	10
Network Of Care	Individuals: 23,000 Families:	Individuals: Families:	10
Call To Care	Individuals: 60 Families:	Individuals: Families:	10
Media and Mental Health Promotion and Education Materials	Individuals: 1000 Families:	Individuals: Families:	10
Outreach Activities	Individuals: 2500 Families: 1500	Individuals: Families:	10
Ethnic and Cultural Community Leaders in a Collaborative Effort	Individuals: 5300 Families:	Individuals: Families:	10
Promotores de Salud	Individuals: 18,000 Families: 2000	Individuals: Families:	10
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 59,960 Families**: **3500**	**Individuals: Families**:	10

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

One of the goals of the Mental Health Outreach, Awareness and Stigma Reduction PEI Project is to provide linkage for community members to needed services in order to reduce the barriers that individuals face in recognizing mental health symptoms, both internally and externally, to allow them to access needed services and to assist others in need, which may include family members, students, and other community members. This may include prevention and early intervention services and other CSS program services as well as linkage to primary care, vocational services and other basic need services such as food, clothing and shelter. This project will strengthen and rely upon ongoing referral mechanisms to link individuals who may need mental health assessment and treatment to County Mental Health or other appropriate community providers. This project also has a goal of increasing the use of other needed community resources and the project partners will also work with those receiving the programs in accessing needed services, such as employment, housing, substance abuse, and domestic violence services.

The project partners will ensure that an organized system of referrals is developed between community based organizations and County programs. The referral system will ensure that individuals served through the identified programs within this project are able to access services based upon their individual needs. The partners will be aware of up to date and accurate referral information.

An extensive resource guide of community support services, community mental health services, domestic violence services, etc. including information of those providers that have linguistic capacity is being developed under the Workforce, Education, and Training component of MHSA. All outreach staff will be provided with this resource guide and the information will be included on the Network of Care website and the RCDMH website.

6. Collaboration and System Enhancements

This PEI project provides multiple opportunities for collaboration and system enhancement. RCDMH will be able to collaborate with community based organizations that both employ and have volunteer individuals with first hand knowledge and experiences related to mental health stigma and discrimination. In addition, there will be opportunities for collaboration with individuals and organizations trusted within their communities to provide outreach and engagement services to those communities that have been traditionally underserved. By working with members of traditionally underserved communities, outreach activities will allow for sustained relationship building in communities throughout the County. Additionally, the Reducing Stigma and Discrimination Committee and the Reducing Disparities Committee will ensure ongoing collaboration with consumers, family members, transition age youth, adults, older adults, community leaders, members of unserved and underserved cultural populations, and community-based and faith-based organizations.

Through the implementation of the programs many opportunities will be available to collaborate with schools, health care providers, faith based organizations, and other

community service organizations to provide the programs within those settings and will include work in natural community settings such as homes, churches, libraries, etc. Providers of the programs will also closely collaborate with the Ethnic and Cultural Community Leaders in a Collaborative Effort and the Promotores de Salud thus ensuring that programs reach the traditionally unserved and underserved communities.

The outreach, mental health awareness, and stigma reducing activities will enhance the present system by increasing appropriate referrals and access to culturally and linguistically appropriate PEI and other needed services for community members. Additionally, by providing stigma reducing activities to health care providers and community service providers any stigmatizing attitudes will be reduced which will allow for increased access to services.

All providers will be expected to leverage supports and provide in-kind resources. The infrastructure of the established community based organizations that will be the program providers allows for leveraging of provider time, space, utilities, volunteers, experience, and the trust and relationships of the providers within their known communities.

7. Intended Outcomes

The following outcomes apply to all programs within the Mental Health Outreach, Awareness, and Stigma Reduction PEI project:

Person-Level outcomes

- Increased knowledge of community mental health resources
- Increased access to mental health early intervention services
- Increased knowledge of social, emotional, and behavioral issues across the age span
- Increased knowledge of risk and protective factors

System-Level outcomes

- Increased number of individuals and families from underserved cultural populations who receive PEI services
- Increased collaboration with community and faith based organizations
- Reduction of stigma and discrimination, particularly among unserved and underserved cultural populations
- Increased referral for appropriate services for those in need

Specific measures for outcomes will be developed in conjunction with the contracted providers in order to ensure collection of appropriate data and cultural and linguistic appropriateness.

8. Coordination with Other MHSA Components

Through implementation of the components of this project it is anticipated that individuals and families will be identified as meeting criteria for mental health services. For those that can be served through CSS Full Services Partnerships, PEI or other CSS services, referrals will be made and they will be assisted with needed linkage.

In addition, individuals and families who may not meet criteria for referral to a CSS program will be provided a referral and assisted with linking with other RCDMH or community based services that will meet their needs. As stated earlier, a resource guide will be developed and kept up to date which will ensure the most appropriate referrals for individuals and families.

Through the Workforce, Education, and Training component of the MHSA, Riverside County has hired a University Liaison position in order to establish relationships with high schools, community colleges, and universities. The Liaison will assist service providers in connecting with schools to implement the school based programs.

9. Additional Comments (optional)

N/A

PEI PROJECT SUMMARY
PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: RIVERSIDE Date: 06/30/09
PEI Project Name: 1 - MENTAL HEALTH OUTREACH, AWARENESS and STIGMA REDUCTION
Provider Name (if known): TBD
Intended Provider Category: MENTAL HEALTH TREATMENT/SERVICE PROVIDER

Proposed Total Number of Individuals to be served:	FY 08-09	N/A	FY 09-10	84,760
Total Number of Individuals currently being served:	FY 08-09	N/A	FY 09-10	N/A
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	N/A	FY 09-10	N/A
Months of Operation:	FY 08-09	N/A	FY 09-10	9

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages:			
3.0 FTE Clinical Therapist II	$0	$189,641	$189,641
1.0 FTE Volunteer Services Coordinator	$0	$43,528	$43,528
b. Benefits and Taxes	$0	$99,650	$99,650
c. Total Personnel Expenditures	$0	$332,819	$332,819
2. Operating Expenditures			
a. Facility Cost	$0	$31,911	$31,911
b. Other Operating Expenses	$0	$237,904	$237,904
c. Non-Reoccuring Cost	$0	$25,000	$25,000
d. Total Operating Expenses	$0	$294,815	$294,815
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Providers to be Determined.	$0	$1,032,996	$1,032,996
a. Total Subcontracts	$0	$1,032,996	$1,032,996
4. Total Proposed PEI Project Budget	$0	$1,660,630	$1,660,630
B. Revenues (list/itemize by fund source)			
	$0	$0	$0
1. Total Revenue	**$0**	**$0**	**$0**
C. Total Funding Requested for PEI Project	$0	$1,660,630	$1,660,630
D. Total In-Kind Contributions	$0	$0	$0

PEI PROJECT SUMMARY
PEI Revenue and Expenditure Budget Worksheet

County Name: RIVERSIDE Date: 06/30/09

PEI Project Name: 1 - MENTAL HEALTH OUTREACH, AWARENESS and STIGMA REDUCTION

Proposed Expenses and Revenues Narrative
A. Expenditure
1. Personnel
Estimated annual salaries and benefits of 4.0 new program FTEs to provide Community Outreach and Engagement Activities to reduce stigma and increase awareness and knowledge of mental health illness and recovery resources. Staff will target various populations throughout Riverside County that are currently receiving little or no services.
2. Operating Expenditures
a. Facility Cost: Estimated annual cost of program rent, utilities, and building maintenance. b. Other Operating Expenses: Communication, transportation, office supplies and liability, malpractice and property insurance. c. Non-Reoccurring Cost: Estimated cost of Promotores de Salud Training and program development.
3. Subcontracts/Professional Services
The Mental Health Outreach, Awareness, and Stigma Reduction Program will include contracted programs that will help the community identify early warning signs of mental illnesses and provide knowledge of mental illness through consumer speakers who will share their experience of living with mental health illnesses. Outreach will be provided through the use of consultants who will target Native Americans, African Americans, Asian Americans, Hispanic, LGBTQ and Deaf/Hard of Hearing populations. County wide services will also include access to a resource website and 24/7 helpline, as well as the Dare to Be Aware Youth Conference. Estimated annual cost covers all costs for contracted services including training, training materials, client materials, food, and a portion of the program's operating expenses.
4. Total Proposed PEI Project Budget
B. Revenues
N/A

PEI PROJECT SUMMARY

County: Riverside PEI Project Name: Parent Education and Support
Date: July 15, 2009

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	☐	☐	☐	☐

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	☐	☐		

PEI PROJECT SUMMARY

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

Stakeholder Input

The Riverside County community planning process included 108 focus groups and community forums with 1147 participants as well as 2354 completed and returned community surveys. In addition, four age group committees (Children, Transition Age Youth (TAY), Adult and Older Adult), three workgroups (Trauma, Reducing Disparities, and Reducing Stigma and Discrimination), and the PEI Steering Committee met to develop recommendations for PEI services based upon the input from the community. The stakeholder and community planning process, from initial orientation to Prevention and Early Intervention (PEI) through the PEI Steering Committee, reflected consensus from the members of the County in recommending parenting education and support interventions and services. The PEI team made concerted efforts to recruit participants throughout the community planning process and they included consumers, family members, local school personnel, representatives/providers from agencies who serve youth, and the community-at-large. There was also a consistent message in each of the four age group committees that the earlier prevention and early intervention services are available and accessible to children and families, the greater the positive impact and increased resiliency in children. Feedback included:

Focus Group

- "Parent classes before and after children and youth are troubled."
- "Program for parents on how to interact with their children when kids are small."
- "ID kids (K-5th) earlier through presence at schools, observe in the classroom, educate parents, get kids attention sooner."
- "Educate parents about mental health and developmental issues."
- "Mobile services to go where people are."

Community Surveys

- "Parenting classes."
- "Support and education for teen parents."
- "Parent training and/or workshops."
- "Use of a standardized screening tool that could be used by a variety of health professionals that come in contact with potential clients and clients found to have problem could be triaged by mental health."
- "Early screening and counseling services at the elementary level would make such a difference."

PEI PROJECT SUMMARY

The Children's Committee recommendations developed as a result of community input included:

- "School based PEI services – This is where children most often go and it is less stigmatizing for parents/families."
- "Leveraging – Do not re-invent the wheel, use existing models to screen and provide PEI services."
- "Situate services where families already go – to have greater access. One of the PEI guidelines is that we have a responsibility to reduce access disparities."
- "Education:
  a. Evidence Based parenting.
  b. Educating non-traditional mental health providers to identify mental health needs and have places to refer them."

Data Analysis

According to a recent report from the Institute of Medicine, "Mental health problems often can be prevented if children get the help they need early on from parents and schools," (U.S. News & World report, 2/13/09, 'How to Protect Your Child's Mental Health', Nancy Shute). The Centers for Disease Control refer to childhood abuse, neglect and exposure to other traumatic stressors as adverse childhood experiences (ACE). The short and long-term outcomes of these adverse experiences in childhood can lead to a variety of health and social problems. The study also shows a correlation between the number of adverse childhood experiences and an increase in alcoholism and alcohol abuse, depression, risk for intimate partner violence, sexually transmitted diseases, and suicide attempts. Risk factors in the community and at home including poverty, child maltreatment, high crime neighborhoods, domestic violence, and parental mental health/substance abuse issues can negatively impact the social and emotional development of youth.

Riverside County's profile of risk factors indicates that many children may be vulnerable to negative impacts on development.

- ✓ In Riverside County, 40% of children age 17 and under live at or below 200% of the poverty line.
- ✓ Child maltreatment in Riverside County is substantial. In 2007, the Department of Social Services received 48,391 child abuse/neglect referrals with 9,393 that were substantiated. Children under the age of five had slightly fewer referrals than the other age groups, but had more substantiations that the other age groups. Hispanic children had the highest proportion of referrals (48%).
- ✓ The County has more children in foster care per capita (10 per 1,000) than the state foster care rate (7 per 1,000).

- ✓ Neighborhood safety is a contributing factor impacting the mental health of children. Violent crime rates in Riverside County (814 per 100,000) are 37% higher than the state rate. Moreover, the County has high domestic violence levels and was ranked among the 10 counties with the highest number of reported domestic violence according to the CPOC (Chief Probation Officer of California) annual survey of 2006-2007.
- ✓ Women responsible for the care of children represented 16% of the 16,156 women receiving mental health services and 33% of the 9,617 entering substance abuse services through RCDMH in 2006-2007.

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

a) 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 program planning process.

The Parent Education and Support Project will serve children and their families beginning in preschool through elementary school both in schools and non-traditional and natural community settings e.g.: family resource centers, child care centers, and community-based and faith-based organizations. One of the themes consistently brought forward throughout the community planning process was parent education and interventions for parents and their children together. Specific and targeted outreach for the following programs will include grandparents raising grandchildren and fathers. These two groups have been identified throughout the PEI community planning process as a priority and essential to reaching unserved and underserved cultural populations within the County. A key factor that led to program selection was the evidence of strong community support for programs that would enhance the capacity of communities to provide prevention and early intervention activities, building on their current strengths and ability to provide these services in natural settings. This project will address the State identified Key Community Mental Health Needs of Disparities in Access to Mental Health Services, At-Risk Children, Youth, and Young Adult Population, and Stigma and Discrimination and the Priority Populations of Children/Youth in Stressed Families and Children/Youth at Risk for School Failure. Program implementation will also provide additional activities as needed, such as consultation, screening, and training on mental health issues. This project includes the following components:

- ➢ **Triple P** – Positive Parenting Program is a multi-level system of parenting and family support strategies for families with children from birth to age 12. Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing parental knowledge, skills, and confidence.
  - Selected Triple P provides specific guidance on how to address common child developmental issues (e.g.: toilet training) and minor child behavior problems (e.g.: bedtime problems). Included are parenting tip sheets and videotapes that demonstrate specific parenting strategies. This program is delivered mainly through one or two brief face-to-face 20 minute consultations and will be

provided in a multitude of locations including physician offices and childcare centers.

- Primary Care Triple P targets children with mild to moderate behavior difficulties (e.g.: tantrums, fighting with siblings) and includes active skills training that combines guidance with rehearsal and self-evaluation to teach parents how to manage these behaviors. This program is delivered through brief and flexible consultation, typically in the form of four 20-minute sessions and will also be provided in a multitude of settings.
- Standard Triple P and Group Triple P is an intensive strategy for parents of children with more severe behavior difficulties (e.g.: aggressive or oppositional behavior) and is designed to teach positive parenting skills and their application to a range of target behaviors, settings, and children. This program is delivered in 10 individual or 8 group sessions totaling about 10 hours.

- **Parent Management Training** (**PMT)** – PMT uses didactic instruction, modeling, role playing, and home practice to teach parenting skills in encouragement, monitoring, discipline, and problem solving. The PEI Steering Committee identified the Spanish-speaking migrant community of the County as a high priority for parenting programs specifically tailored to their needs and culture. A cultural modification of the PMT program, developed by Charles Martinez, has been shown effective with this population. The program a 12-week group intervention with 2 ½ hour sessions (including 1 hour for a meal and social interaction time for families to build social support networks). “Some researchers suggest that community or culturally specific adaptations of empirically based intervention programs not only may increase the likelihood that families and individuals will participate and complete programs, but also may improve outcomes for those participating children and families (Martinez, C. & Eddy J.M., 2005). Martinez and Eddy also note that Latino youth appear to be at greater risk for school dropout, incarceration, and poor physical and mental health. However, Latinos have been found to be less likely to use social services, including mental health services, than members of other groups.

- **Strengthening Families Program (SFP)** – SFP is a family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children 3-16 years old. SFP is comprised of three life-skills courses delivered in 14 weekly, 2 hour sessions. The parenting skills sessions are designed to help parents learn to increase desired behaviors in children by using attention and rewards, clear communication, effective discipline, substance use education, problem solving, and limit setting. The children’s life skills sessions are designed to help children learn effective communication, understand their feelings, improve social and problem-solving skills, resist peer pressure, understand the consequences of substance use, and comply with parental rules. In the family life skills sessions, families engage in structured family activities, practice therapeutic child play, conduct family meetings, learn communication skills, practice effective discipline, reinforce positive behaviors in each other, and plan family activities

together. Each session includes a dinner for the entire family. Additional children in the family who are outside of the age range to receive the children's life skills sessions will also be included in the family life skills sessions. Childcare will be provided on site. SFP has been modified for African American families, Asian/Pacific Islanders, Hispanic, and American Indian families, rural families, and families with early teens. Feedback from the community planning process included a need for services to be in non-stigmatizing locations. Faith-based organizations were noted as a natural environment that would help families feel more comfortable and afford easier access to services. SFP is portable and will be implemented in natural community settings.

- **Parent-Child Interaction Therapy (PCIT)** - PCIT is an intensive, short-term, evidence -based early intervention that has been demonstrated over the past three decades to effectively help families with children between the ages of 2 and 8 who exhibit a number of chronic disruptive behaviors at home, in school, preschool or daycare (e.g., aggression, defiance, frequent temper tantrums, refusing to follow directions, talking-back, swearing). PCIT has been shown effective for improving child behaviors and reducing child maltreatment rates. PCIT uses a one-way mirror and remote sound equipment to prompt and coach parents in real time as they interact with their child. The goals of the program are to work with parents and children together in one hour sessions for 15-20 weekly visits to improve the quality of the parent/child relationship, to develop consistently positive and supportive communication (the Relationship Enhancement Component of the program), and to teach parents skills that enable them to manage their children's behavioral problems (the Behavioral Component). Referral sources will include school personnel and primary care offices who will utilize the Deveaurex Early Childhood Assessment (DECA) to identify children with emerging mental health, developmental and behavioral problems. The point of access for this age range is often via the primary care physician. A Registered Nurse (RN) trained to deliver PCIT will act as a liaison between the program and the pediatric referrals. The medical expertise the RN has can enhance the communication and relationship between referral source and service delivery systems. Implementation of PCIT will include the use of recreational vehicles that will be customized with PCIT capacity as well as a room for individual or group services. These mobile units allow for flexibility to travel among multiple locations within a service delivery region and increases service access for these communities.

b) Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

PEI PROJECT SUMMARY

The goals of this PEI project are to provide parent education and support activities to reduce the risks of the development of mental health problems and/or to reduce the need for more intensive mental health services in children and to increase access, particularly with groups who historically have not had access to mental health services. In achieving these goals, and in order to effectively implement the identified programs, this project allows for multiple partnership opportunities that include community-based and faith-based organizations and schools who have the trust of and a wealth of history providing services to members of their communities. The implementation partners for this PEI project are numerous due to the importance of partnering with community providers to provide the services in natural community settings. Partners will include local school districts as well as California School for the Deaf Riverside, which is one of two Schools for the Deaf in the State as well as community based agencies that work closely with families, such as the YMCA, YWCA, and Boys and Girls Clubs. In addition, partnerships with the Latino Commission, the Latino Network, and other ethnic specific organizations and coalitions will assist with implementation to the significant number of Hispanic community members who will benefit from the programs identified in this project. In addition, partnerships with Public Health, the Department of Public Social Services, and the Probation Department will occur in order to facilitate referrals and community connections. Project activities will be provided in ways and settings to increase access for community members including natural community settings such as in homes, churches, childcare centers, primary care offices, family resources centers, libraries and any other locations identified by the providers as a gathering place for the community, which leads to additional partnerships.

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

As stated in the data analysis portion of this project, data related to population by poverty, ethnicity, crime, Child Protective Services substantiations, community and domestic violence was analyzed to identify areas in the County where individuals are at increased risk of developing mental health issues. RCDMH divides the County into three regions which are Western, Mid-County, and Desert. The analysis of the data, provided by the RCDMH Research and Evaluation Unit, resulted in the identification of high need, priority communities within each service delivery region that will be the initial target demographic. In the Western region, the target communities are located in poor, densely populated areas of Rubidoux, East Side, Arlanza, and Moreno Valley. In the Mid-County region, the target communities are located in older, low income areas of Lake Elsinore, San Jacinto, and Perris. In the Desert region, large, low income areas with a significant Hispanic/Latino migrant population in areas including portions of the Coachella Valley, Desert Hot Springs, and Eastside Banning. Service providers will be asked to identify specific underserved cultural populations to be served and specific outreach activities that will be utilized.

PEI PROJECT SUMMARY

d) Highlights of new or expanded programs.

Each of the identified programs is new to Riverside County Department of Mental Health with the exception of PCIT. The PCIT component will be an expansion of existing services within the Department.

Triple P
- Multiple levels allow for intervention for many families early in the manifestation of problems
- Mothers of families who received Triple P reported significantly greater satisfaction with parenting and significantly lower stress anxiety

Parent Management Training
- Culturally adapted specifically for mono-lingual Spanish speakers
- Works to change maladaptive parent-child interactions
- Increases social network for families

Strengthening Families
- Family Intervention
- Can be used in a variety of settings
- Can be culturally adapted to meet the needs of the target community

Parent-Child Interaction Therapy
- Coaches parents on how to change interactions with their children in real time
- Culturally-tailored and available in Spanish
- Improves the quality of the parent-child relationship

e) Key milestones and anticipated timeline for each milestone.

- PEI plan approval by State DMH – Summer 2009
- Competitive Procurement Process – September ’09 – November ‘09
- Work with contractors to identify specific schools within identified school districts – December ‘09
- Recruitment and hiring of appropriate staff – December ’09
- Training staff in evidence-based model (including cultural and linguistic needs of population) – January ’10
- Program implementation – February - June 2010

PEI PROJECT SUMMARY

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Triple P (Positive Parenting Program)	Individuals: 3000 Families:	Individuals: 720 Families:	10
Parent Management Training	Individuals: 288 Families:	Individuals: Families:	10
Strengthening Families	Individuals: Families:	Individuals: Families: 90	10
Parent Child Interaction Therapy (PCIT)	Individuals: Families:	Individuals: Families: 175	10
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 3288 Families**:	**Individuals: 720 Families**: **265**	10

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

This Prevention and Early Intervention project will target children and their families who present with risk factors for the development of mental illness as well as children who are displaying symptomology associated with mood, anxiety, and conduct disorders when they are early in their manifestation. Screening tools will be utilized to determine criteria and appropriate fit to programs. When screening/assessment suggests a child's needs are better served through other interventions, referrals will be made both within and outside of the County mental health system. As appropriate, siblings and other family members will be referred to services, which may include CSS programs and/or community programs/providers. In addition, children and families will be linked to additional resources as needed, which may include healthcare enrollment opportunities, food, clothing, housing, substance abuse, and domestic violence services.

6. Collaboration and System Enhancements

This PEI project provides multiple opportunities for collaboration and system enhancement. RCDMH will partner with community and faith based organizations and local schools which have extensive knowledge and experience in working with children and families. Key collaborations for implementation of programs within this project will include churches, community based organizations that serve youth and families, Public Health, medical offices, childcare settings, schools, the Department of Public Social Services, and the Probation Department.

System enhancement will occur as each of the programs effectively reach into communities. Through effective screening and referral of children in need to the PEI programs identified within this project, children and families will have the opportunity to receive services early in the manifestation of symptoms.

All providers will be expected to leverage supports and provide in-kind resources. The infrastructure of the established community based organizations that will be the program providers allows for leveraging of provider time, space, utilities, volunteers, experience, and the trust and relationships of the providers within their known communities.

7. Intended Outcomes

Person-Level outcome

- Decreased child behavior problems
- Parental reports of a more positive parent-child relationship
- Increased parental competence
- Decreased parental stress

System-Level outcome

- Enhanced capacity of organizations to provide prevention and early intervention services
- Increased number of individuals and families who receive prevention and early intervention services
- Greater collaboration and coordination between agencies increasing efficiencies and sustainability of programming

Each of the evidence based practices identified in this project also includes specified outcome measures that will be used. In addition, specific measures will be developed in conjunction with providers in order to ensure collection of appropriate data and cultural and linguistic appropriateness.

8. Coordination with Other MHSA Components

Through implementation of the components of this project, it is anticipated that individuals and families will be identified as meeting criteria for additional mental health

services. For those that can be served through the CSS Full Services Partnerships, PEI or other CSS services, referrals will be made and they will be assisted with needed linkage. In addition, individuals and families who may not meet criteria for a referral to a CSS program will be provided a referral and assisted with linking with other RCDMH or community based services that will meet their needs. In addition, any individuals or families that comes to the attention of a CSS provider who may benefit and be appropriate for a prevention and early intervention program such as the parent education and support project, will have the ability to refer for services.

Through the Workforce, Education, and Training component of the MHSA, Riverside County has hired a University Liaison position in order to establish relationships with high schools, community colleges, and universities. The Liaison will assist service providers in connecting with schools to implement the school based programs.

9. Additional Comments (optional)

In accordance with the guidelines of the MHSA PEI component, Riverside County will be implementing many evidenced based practices. In order to adequately establish and sustain these programs a solid infrastructure is required. From the community planning process feedback, the need for infrastructure to provide thorough and supportive training, maintenance of skills for providers, and accountability across settings to ensure fidelity to the practices came through as necessary activities.

It is important that evidence based programs are model adherent, that the core concepts and theoretical background are carried out in service delivery, and that guidelines for outcome (pre- and post- test) measures are accurately maintained. RCDMH will utilize clinical staff members to ensure that training in evidence-based practices is provided to all service providers. The Department will also assist the service providers in implementation of those evidenced based programs. The clinical staff will hold monthly team meetings with all practitioners of a particular model in order to maintain fidelity, provide clinical consultation, and practice skills required for implementation. The staff member will also assist with infrastructure stability at each site by guiding practitioners to maintain all needed materials and environment set-up. This will allow for greater adherence to the often stringent requirements of evidence-based practices as well as provide assistance to smaller organizations when staff turn-over impacts service delivery. Consistent training and coordination of needs will be available to all PEI programs within the County system as well as any partner agency delivering PEI programs.

PEI PROJECT SUMMARY
PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: RIVERSIDE Date: 06/30/09
PEI Project Name: 2 - PARENT EDUCATION & SUPPORT
Provider Name (if known): TBD
Intended Provider Category: MENTAL HEALTH TREATMENT/SERVICE PROVIDER

Proposed Total Number of Individuals to be served:	FY 08-09	N/A	FY 09-10	5,068
Total Number of Individuals currently being served:	FY 08-09	N/A	FY 09-10	N/A
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	N/A	FY 09-10	N/A
Months of Operation:	FY 08-09	N/A	FY 09-10	9

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages:			
12.00 FTE Clinical Therapist II	$0	$832,888	$832,888
1.00 FTE M.H. Peer Specialist	$0	$38,967	$38,967
1.00 FTE M.H. Service Supervisor	$0	$89,514	$89,514
1.00 FTE Office Assistant II	$0	$29,154	$29,154
1.00 FTE Office Assistant III	$0	$41,085	$41,085
1.00 FTE Registered Nurse IV	$0	$87,707	$87,707
1.00 FTE Sr. Clinical Psychologist	$0	$80,519	$80,519
b. Benefits and Taxes	$0	$546,900	$546,900
c. Total Personnel Expenditures	$0	$1,746,732	$1,746,732
2. Operating Expenditures			
a. Facility Cost	$0	$167,478	$167,478
b. Other Operating Expenses	$0	$338,613	$338,613
c. Non-Reoccuring Cost	$0	$633,615	$633,615
d. Total Operating Expenses	$0	$1,139,706	$1,139,706
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Providers to be Determined.	$0	$1,699,917	$1,699,917
a. Total Subcontracts	$0	$1,699,917	$1,699,917
4. Total Proposed PEI Project Budget	$0	$4,586,355	$4,586,355
B. Revenues (list/itemize by fund source)			
MediCal FFP	$0	$504,990	$504,990
Total Revenue	**$0**	**$504,990**	**$504,990**
C. Total Funding Requested for PEI Project	$0	$4,081,365	$4,081,365
D. Total In-Kind Contributions	$0	$0	$0

PEI PROJECT SUMMARY
PEI Revenue and Expenditure Budget Worksheet

County Name: RIVERSIDE Date: 06/30/09

PEI Project Name: 2 - PARENT EDUCATION & SUPPORT

Proposed Expenses and Revenues Narrative
A. Expenditure
1. Personnel
Estimated annual salaries and benefits of 18.0 new program FTEs required to support one County based Parent-Child Interaction Therapy (PCIT) program in support of 6 school based PCIT therapy rooms and 3 mobile units with PCIT capability which will be utilized through out the County.
2. Operating Expenditures
a. Facility Cost: Estimated annual cost of program rent, utilities, and building maintenance. b. Other Operating Expenses: Communication, transportation, office supplies and liability, malpractice and property insurance. c. Non-Reoccuring Cost: Estimated cost of Triple P (Positive Parenting Program), Parent Management, and Strengthening Families Training, as well as 6 School Based PCIT room conversion and required equipment and 3 mobile PCIT units to be used throughout Riverside County. Additional expenses include cost to equip new 18.0 FTE PEI staff and program development.
3. Subcontracts/Professional Services
The Parent Education and Support Program will include contracted services that will provide parent management training for both the home and school setting. Estimated annual cost covers all costs for contracted services including training, training materials, client materials, food, and a portion of the program's operating expenses. Specific and targeted outreach will include grandparents raising grandchildren and fathers. Staff will address the State identified Key Community Mental Health Needs of Disparities in Access to Mental Health services, At-Risk Children, Youth and Young Adult Population, and Stigma and Children/Youth at Risk for School Failure.
4. Total Proposed PEI Project Budget
B. Revenues
New program generated Medi-Cal revenue.

PEI PROJECT SUMMARY

County: Riverside County PEI Project Name: Early Intervention for Families in Schools Date: July 15, 2009

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	☐	☐	☐	☐

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	☐	☐		

PEI PROJECT SUMMARY

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

Stakeholder Input:

The RCDMH PEI community planning process was extensive and far reaching throughout Riverside County. The result was 108 focus groups and community forums with 1147 participants as well as 2354 completed and returned community surveys. In addition, four age group committees (Children, Transition Age Youth, Adult, and Older Adult) and three workgroups (Trauma, Reducing Disparities, and Reducing Stigma & Discrimination) met to provide recommendations for PEI services based upon the community input. There was strong collaboration with many of the school districts in each of the three service delivery regions. Among the stakeholders and community participants, school personnel and the children and families who attend local schools had a substantial presence in the planning process. A great deal of community and stakeholder feedback focused on providing early intervention services for children and their families at schools. Feedback included:

Focus Groups

- "Program for parents on how to interact with their children."
- "In elementary schools – a dedicated person to work with those students/families who are displaying 1st at-risk behaviors."
- "Identify kids (K-5th) earlier through presence at schools, observe in the classroom, educate parents, get kids attention sooner."
- "Train school staff on mental health issues."
- "Partner with other programs and schools."
- "Parent partners located at schools."
- "Outreach at school with mental health information."

Community Surveys

Responses to the community survey showed that the Priority Population of Children/Youth at Risk for School Failure was the second most frequent response chosen as a high need or very high need population for PEI services. 71.7% of responses identified this need, second only to Children/Youth in Stressed Families. Recommendations from surveys included:

- "School based programs that are designed to teach children how to cope with different situations."
- "More support to schools to provide therapeutic services."
- "Schools need to be trained for early screening of mental health issues."
- "School based mental health programs."
- "Parenting classes."
- "Parent training and/or workshops."

PEI PROJECT SUMMARY

The Children's Committee recommendations developed as a result of community input included:

- "School based PEI services – This is where children most often go and it is less stigmatizing for parents/families."
- "Leveraging – Do not re-invent the wheel, use existing models to screen and provide PEI services."
- "Education:
    c. Evidence Based parenting.
    d. Educating non-traditional mental health providers to identify mental health needs and have places to refer them."

Data Analysis:

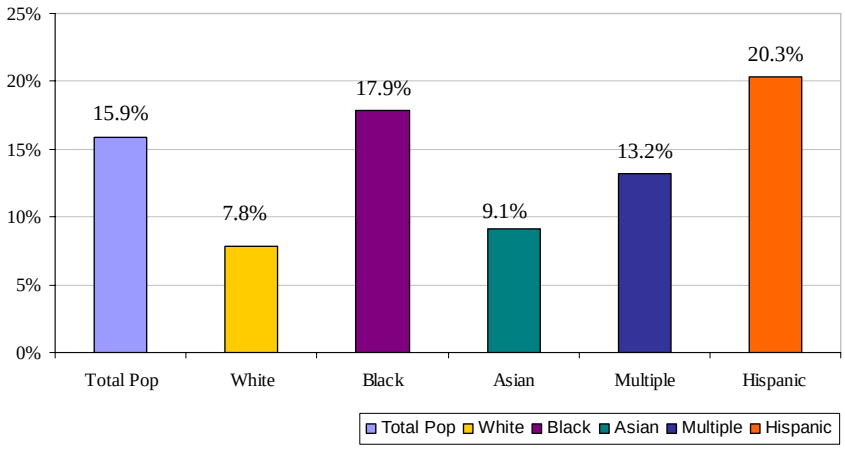
The education system offers more extensive exposure than any other public system into the population of children and youth. This includes youth at high risk for negative outcomes associated with early emotional/behavioral issues and mental illness. High school drop out rates in Riverside County increased from the 2005-2006 school year to the 2006-2007 school year. The highest drop out rate was among students who are English language learners and the economically disadvantaged. The drop out rate is highest for 9th graders indicating the importance of providing prevention and early intervention services to youth and their families while students are in primary school. Riverside County stakeholders and community members voiced great concern over these statistics and look to prevention and early intervention services as a resource to address these problems. Untreated mental health disorders lead to higher rates of juvenile incarcerations, school dropout, family dysfunction, drug abuse, and unemployment (American Academy of Pediatrics: Committee on School Health, 2004). School-based programs offer the promise of improving access to diagnosis and treatment for the mental health problems of children and adolescents (American Academy of Pediatrics: Committee on School Health, 2004).

Research indicates that the two factors of poverty and ethnicity have the most significant impact on the risk for the development of a mental illness. The UC Davis Center for Reducing Health Disparities (2008) notes, "racial and ethnic minority groups are at increased risk for mental health problems given exposure to discrimination and racism as well as elevated levels of poverty and social and geographic isolation." The risk factors for children associated with an underserved cultural population living in poverty include: child maltreatment; high crime neighborhoods; domestic violence; parental mental health/substance abuse issues; lack of resources; and higher rates of foster care placement.

The graph below shows the percentage of youth who live in poverty in Riverside County and the ethnic disparities are clear. Historically unserved, underserved, and inappropriately served cultural populations have higher percentages of youth living in poverty than does the White population.

PEI PROJECT SUMMARY

Total Population Under 18 years of Age Living Below Poverty Level by Ethnicity



The Centers for Disease Control refer to childhood abuse, neglect and exposure to other traumatic stressors as adverse childhood experiences (ACE). The short and long-term outcomes of these adverse experiences in childhood can lead to a variety of health and social problems. Evaluation of data regarding risk factors, as listed above, led to the identification of communities (specifically the school districts, and in some cases specific elementary schools, within those communities) at highest risk of developing mental health problems and will be the initial target communities for this PEI project. Additional outreach will be in place as implementation occurs. As evidenced in the charts below, the targeted school districts have a significant number of minority populations, English language learners, and low school performance.

Target School Districts	CVUSD	BUSD	RUSD	MVUSD	SJUSD	PESD	LEUSD	JUSD	AUSD	PSUSD*	DSUSD**	County
Elementary Enrollment	8,940	2,304	18,989	16,264	4,407	4,861	9,980	9,176	9,486	2,128	2,426	N/A
Ethnicity												
Hispanic	98%	65.51%	58.77%	66.98%	67.17%	85.79%	55.83%	81.12%	71.22%	87.58%	93-98%	42.20%
African-American	.36%	10.58%	9.03%	18.58%	8.9%	8.88%	5.3%	2.93%	8.41%	5.07%	<1%	5.78%
Asian	.08%	6.11%	3.13%	2.37%	1.29%	.73%	2.29%	1.03%	1.53%	.67%	<1%	5.30%
White	1.54%	17.8%	29.07%	12.07%	22.64%	4.61%	36.58%	14.92%	18.8%	6.68%	<1-3.2%	42.96%

*PSUSD-Data includes only three elementary schools located in Desert Hot Springs that are a part of the Palm Springs Unified School District since Desert Hot Springs was identified as a high need area.

**DSUSD– Data includes four elementary schools located in Indio area that are a part of Desert Sands Unified School District identified as a high need area.

Target School Districts-
CVUSD– Coachella Valley School District
BUSD– Banning Unified School District
RUSD– Riverside Unified School District
MVUSD– Moreno Valley Unified School District
SJUSD– San Jacinto Unified School District
PESD– Perris Elementary School District
LEUSD– Lake Elsinore Unified School District
JUSD– Jurupa Unified School District
AUSD– Alvord Unified School District
PSUSD–Palm Springs Unified School District
DSUSD--Desert Sands Unified School District

PEI PROJECT SUMMARY

Low performing schools are an indicator of communities that are disproportionately challenged with risk factors. Target school districts are disproportionately socio-economically disadvantaged as evidenced by high rates of free and reduced price school lunches. School's Annual Performance Index (API) state rankings are low (state ranking ranges 1 to a high of 10). Suspensions from targeted elementary schools are high and commonly involve physical injury to another person. The number of child abuse and neglect referrals for 2007 are numerous in each school district. These community risk factors are listed in the table below for the identified school districts. Focusing on these high risk target communities, with substantial low income populations, will help build resilient traits in the most vulnerable children and decrease the likelihood of the development of mental illness.

Risk Factors	Target School Districts										
	CVUSD	BUSD	RUSD	MVUSD	SJUSD	PUSD	LEUSD	JUSD	AUSD	PSUSD*	DSUSD**
Poverty: Free/Reduced Lunch	90%	76%	53%	64%	61%	83%	43%	61%	51%	80%	80-87%
English Language Learner [1]	55%	30%	26%	39%	33%	50%	25%	44%	53%	40%	76%
API Rank [2]	1	4	6	4	3	2	6	4	4	1	1-5
Suspensions [3]	430	57	1664	6,730	471	40	329	534	479	202	148
% of Suspension for violence	66%	29%	65%	27%	75%	78%	61%	57%	52%	64%	45%
Child Abuse/Neglect	580	391	1,390	1,898	526	1,042	940	817	791	592	785

*PSUSD– Data includes only three elementary schools located in Desert Hot Springs that are a part of the Palm Springs Unified School District since Desert Hot Springs was identified as a high need area.

**DSUSD— Data includes four elementary schools located in Indio area that are a part of Desert Sands Unified School District identified as high need area.

[1] English Learners is calculated based on 1-6th grade. Source: California Dept. of Education Data Quest

[2] API rank is based on Elementary Grades ranking including Kindergarten. Source: California Dept. of Education Data Quest.

[3] Suspension is based on Elementary schools including Kindergarten. Source: California Dept. Of Education Data Quest.

Target School Districts-
CVUSD– Coachella Valley School District
BUSD– Banning Unified School District
RUSD– Riverside Unified School District
MVUSD– Moreno Valley Unified School District
SJUSD– San Jacinto Unified School District
PESD– Perris Elementary School District
LEUSD– Lake Elsinore Unified School District
JUSD– Jurupa Unified School District
AUSD– Alvord Unified School District
PSUSD–Palm Springs Unified School District
DSUSD--Desert Sands Unified School District

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

a.) 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 program planning process.

Recommendations from feedback received throughout the community planning process regarding prevention and early intervention services for children included: school-based services, collaboration among agencies, parenting, services for the whole family, and skill-building for youth. The program selection for this project includes each of these concepts. The State identified Key Community Mental Health Needs addressed in this project are Disparities in Access to Mental Health Services and At-Risk Children, Youth and Young Adults. The targeted Priority Populations are Children/Youth in Stressed

Families and Children/Youth at Risk for School Failure. Program implementation will also provide additional activities as needed, such as consultation, screening, and training on mental health issues. The program identified for this PEI project is:

- **Families and Schools Together (FAST)** – The overall goal of the FAST program is to intervene early to help at-risk youth succeed in the community, at home, and in school, thus avoiding problems such as school failure, violence, and other delinquent behaviors. The program is an outreach and multi family group process designed to build protective factors in children, empower parents to be the primary prevention agents for their children, and to build supportive parent-to-parent groups. Referrals into the program most frequently come from teachers, who identify a child with at-risk behaviors for serious future academic and social problems. The program is implemented by a trained team consisting of a parent partner, a school professional, and two community partners with expertise related to the specific target community. This expertise may be specifically related to substance abuse or mental health. The team is required to reflect the culture of the families participating in the program. Families gather with 8 to 12 other families for ten weekly meetings held at the school. Meetings include planned opening and closing routines, a family meal, structured family activities and communications, parent mutual support time, and parent-child play therapy. Families participate in a graduation ceremony at the end of 10 weeks and participate in monthly follow up meetings, run by the families, for up to two years. This program has been shown effective in outreaching to and engaging hard to reach families. There is a Spanish language edition that will be implemented as well.

  Providing services in schools will reduce stigma and enable youth who traditionally would not receive services to receive the service. RCDMH will partner with community providers as a means to have trained team members who are reflective of the families in the communities being served, both culturally and linguistically.

b.) Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

In line with the stakeholder and community recommendations for school-based services and collaboration with multiple agencies, RCDMH will partner with local school districts and community-based organizations for implementation in targeted communities. This program utilizes a school professional and provides the service on a school campus. The additional FAST team members will best serve families they work with because they will reflect the ethnic/cultural population of the families in the program and they are members of the communities they in which they work. Community-based organizations often

have a unique understanding of the local needs of children and families and have the capacity to fulfill the program needs of this project. RCDMH will partner with local family resource centers, community based organizations, and agencies that serve children and their families in order to implement this multi-disciplinary team program.

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

As stated in the data analysis portion of this project, data related to population by poverty, ethnicity, English language learners, low school performance, suspensions, and Child Protective Services substantiations was analyzed to identify areas in the County where individuals are at increased risk of developing mental health issues. RCDMH divides the County into three regions which are Western, Mid-County, and Desert. The analysis of the data, provided by the RCDMH Research and Evaluation Unit, resulted in the identification of high need, priority communities within each service delivery region that will be the initial target demographic. In the Western region, the target communities are located in poor, densely populated areas of Rubidoux, East Side, Arlanza, and Moreno Valley. In the Mid-County region, the target communities are located in older, low income areas of Lake Elsinore, San Jacinto, and Perris. In the Desert region, large, low income areas with a significant Hispanic/Latino migrant population in areas including portions of the Coachella Valley, Desert Hot Springs, and Eastside Banning. The targeted communities correspond geographically to the attendance boundaries of several elementary schools in each district. Expansion of service to elementary schools in additional school districts will be evaluated based upon risk factors as implementation progresses. Service providers will be asked to identify specific underserved cultural populations to be served and specific outreach activities that will be utilized.

d.) Highlights of new or expanded programs.

The FAST program is new to RCDMH.

<u>Families and Schools Together (FAST) -</u>

- Utilizes a multi-disciplinary team approach; reduces stigma associated with mental health services
- Provides positive experiential learning activities for the family

e.) Key milestones and anticipated timeline for each milestone.

- PEI plan approval by State DMH – Summer 2009
- Competitive Procurement Process – September ’09 – November ‘09
- Work with contractors to identify specific schools within identified school districts – December ‘09

- Recruitment and hiring of appropriate staff – December ’09
- Training staff in evidence-based model (including cultural and linguistic needs of population) – January ’10
- Program implementation – February - June 2010

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Families and Schools Together (FAST)	Individuals: Families:	Individuals: Families: 504	10
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** **Families**:	**Individuals:** **Families**: 504	10

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

This Prevention and Early Intervention project will target children and their families who present with risk factors for the development of mental illness as well as children who are displaying symptomology associated with mood, anxiety, and conduct disorders when they are early in their manifestation. Screening tools will be utilized to determine criteria and appropriate fit to the program. When screening/assessment suggests a child’s needs are better served through other interventions, referrals will be made both within and outside of the County Mental Health system. As appropriate, siblings and other family members will be referred to services as needed, which may include CSS programs and/or community programs/providers. In addition, children and families will be linked to additional resources as needed, which may include healthcare enrollment opportunities, food, clothing, housing, substance abuse, and domestic violence services.

6. Collaboration and System Enhancements

Collaboration is the foundation of this PEI project. The program features a partnership with community based organizations and local school districts. RCDMH has an established relationship with the local school districts through collaborative efforts to provide mental health services in the past. This project, however, will aim to utilize school staff in a more active way to provide prevention and early intervention services to children and families. The team members consist of school professionals, parents, a mental health and a substance abuse counselor. This multi-disciplinary team approach enhances the effectiveness of services. An additional benefit is the ability to utilize parents who have graduated from the FAST program in outreach efforts to engage new families for program participation. The utilization of parents in this capacity increases access for many families who may not have otherwise been contacted, and reduces stigma and discrimination associated with receiving the early intervention service. Additional outreach for this program will be the Promotores de Salud and Ethnic and Cultural Community Leaders in a Collaborative Effort described in the Mental Health Outreach, Awareness and Stigma Reduction Project. They will build relationships with key community leaders and will identify children and families as they educate about mental health and will link families to this program as appropriate. Also, the program providers may connect with the Promotores and Ethnic and Cultural Community Leaders in a Collaborative Effort for assistance in reaching hard to engage families.

Services will be offered at school sites and the referral base will come largely, if not exclusively, from the school districts identified during the community planning process with the highest need (mental health risks). Leveraging opportunities are available by use of school facilities for both evening groups with parents as well as providing designated space for mental health services to be provided during the school day.

7. Intended Outcomes

Person-Level Outcome

- Reduced family conflict and stress
- Improved academic performance of FAST kids
- Improved child self esteem, social skills

System-Level Outcome

- Increases teacher support and climate of learning
- Connection of parents and children to their schools

The evidence based practice identified in this project also includes specified outcome measures that will be used. In addition, specific measures will be developed in conjunction with providers in order to ensure collection of appropriate data and cultural and linguistic appropriateness.

8. Coordination with Other MHSA Components

Through implementation of the FAST program, it is anticipated that individuals and families will be identified as meeting criteria for additional mental health services. For those that can be served through the CSS Full Services Partnerships, PEI or other CSS services, referrals will be made and they will be assisted with needed linkage. In addition, individuals and families who may not meet criteria for a referral to a CSS program will be provided a referral and assisted with linking with other RCDMH or community based services that will meet their needs. In addition, any individuals or families that come to the attention of a CSS provider who may benefit and be appropriate for a prevention and early intervention program such as the FAST program will have the ability to refer for services.

Through the Workforce, Education, and Training component of the MHSA, Riverside County has hired a University Liaison position in order to establish relationships with high schools, community colleges, and universities. The Liaison will assist service providers in connecting with schools to implement the FAST program.

9. Additional Comments (optional)

In accordance with the guidelines of the MHSA PEI component, Riverside County will be implementing many evidenced based practices. In order to adequately establish and sustain these programs a solid infrastructure is required. From the community planning process feedback, the need for infrastructure to provide thorough and supportive training, maintenance of skills for providers, and accountability across settings to ensure fidelity to the practices came through as necessary activities.

It is important that evidence based programs are model adherent, that the core concepts and theoretical background are carried out in service delivery, and that guidelines for outcome (pre- and post- test) measures are accurately maintained. RCDMH will utilize clinical staff members to ensure that training in evidence-based practices is provided to all service providers. The Department will also assist the service providers in implementation of those evidenced based programs. The clinical staff will hold monthly team meetings with all practitioners of a particular model in order to maintain fidelity, provide clinical consultation, and practice skills required for implementation. The staff member will also assist with infrastructure stability at each site by guiding practitioners to maintain all needed materials and environment set-up. This will allow for greater adherence to the often stringent requirements of evidence-based practices as well as provide assistance to smaller organizations when staff turn-over impacts service delivery. Consistent training and coordination of needs will be available to all PEI programs within the County system as well as any partner agency delivering PEI programs.

PEI PROJECT SUMMARY
PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: RIVERSIDE Date: 06/30/09
PEI Project Name: 3 - EARLY INTERVENTION FOR FAMILIES
Provider Name (if known): TBD
Intended Provider Category: PRE K-12 SCHOOL

Proposed Total Number of Individuals to be served:	FY 08-09	N/A	FY 09-10	2,016
Total Number of Individuals currently being served:	FY 08-09	N/A	FY 09-10	N/A
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	N/A	FY 09-10	N/A
Months of Operation:	FY 08-09	N/A	FY 09-10	9

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages:			
	$0	$0	$0
b. Benefits and Taxes	$0	$0	$0
c. Total Personnel Expenditures	$0	$0	$0
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	$0	$0	$0
c. Non-Reoccuring Cost	$0	$3,815	$3,815
d. Total Operating Expenses	$0	$3,815	$3,815
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Providers to be Determined.	$0	$649,949	$649,949
a. Total Subcontracts	$0	$649,949	$649,949
4. Total Proposed PEI Project Budget	$0	$653,764	$653,764
B. Revenues (list/itemize by fund source)			
	$0	$0	$0
Total Revenue	**$0**	**$0**	**$0**
C. Total Funding Requested for PEI Project	$0	$653,764	$653,764
D. Total In-Kind Contributions	$0	$0	$0

PEI PROJECT SUMMARY
PEI Revenue and Expenditure Budget Worksheet

County Name: RIVERSIDE Date: 06/30/09

PEI Project Name: 3 - EARLY INTERVENTION FOR FAMILIES

Proposed Expenses and Revenues Narrative
A. Expenditure
1. Personnel
N/A
2. Operating Expenditures
c. Non-Reoccurring Cost: Estimated cost of program development.
3. Subcontracts/Professional Services
The Early Intervention for Families Program will include contracted services. RCDMH will partner with local school districts, community based organizations, local family resource centers, and agencies that serve children and their families in order to implement a multi-disciplinary team program. This program will provide, through group settings, training to help build family relationships and emphasize the importance of parent involvement as well as multifamily group interaction. Estimated annual cost includes contracted services including training, training materials, client materials, food, and a portion of the program's operating expenses.
4. Total Proposed PEI Project Budget
B. Revenues
N/A

PEI PROJECT SUMMARY

County: Riverside PEI Project Name: Transition Age Youth Project Date: July 15, 2009

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	☐	☒	☐	☐

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	☐	☐		

PEI PROJECT SUMMARY

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

Stakeholder Input

The Riverside County community planning process included 108 focus groups and community forums, four age group committees (Children, Transition Age Youth (TAY), Adult, and Older Adult), three workgroups (Trauma, Reducing Disparities, and Reducing Stigma & Discrimination), and the PEI Steering Committee which included members from each of the committees/workgroups listed. In addition, 2,354 community surveys were completed and returned. One product of the CSS planning was the development of the Transitional Age Youth Committee. The Committee brings together interested parties who work with the TAY population in Riverside County. The committee continues to meet on a regular basis and played a critical role in the community planning process for Prevention and Early Intervention. See attachment J-2 for membership list for the Transition Age Youth Committee. As the planning process progressed through to the PEI Steering Committee, TAY representatives advocated for the recommendations made by the TAY committee. This resulted in the selection of this project. Throughout the community planning process the recommendations from community members and stakeholders alike expressed desire for prevention and early intervention activities for youth and young adults ages 16-25. Comments included:

Focus Groups

- "Suicide awareness training in High School."
- "Enhance suicide prevention programs."
- "Peer counseling to include groups provided by teens for teens at school, recreation centers, YMCA, focus on feelings and school or personal problems."
- "Educating teenagers and young adults about abuse: mental and physical."

Community Surveys

- "I think that suicide groups would need the most help."
- "Supporting groups for those in gay communities possibly suspecting that they may have a mental illness but are afraid of stigma."
- "Suicide prevention class with teenagers the same age."
- "More outreach, more information, more personal contact."
- "School presentation, outreach, early prevention and awareness."
- "Broadcast services to LGBT community for professional assistance open offices for counseling and classes. Have seminars to educate families and communities about understanding and supporting LGBT."

PEI PROJECT SUMMARY

The Transition Age Youth Committee recommendations developed as a result of community input included:

- Community awareness, outreach, and education for TAY and their support network about early signs of mental health needs to those youth who are unlikely to seek help from traditional mental health services.
- Services provided by peers/youth to educate about mental health issues and services and reduce stigma about mental health.

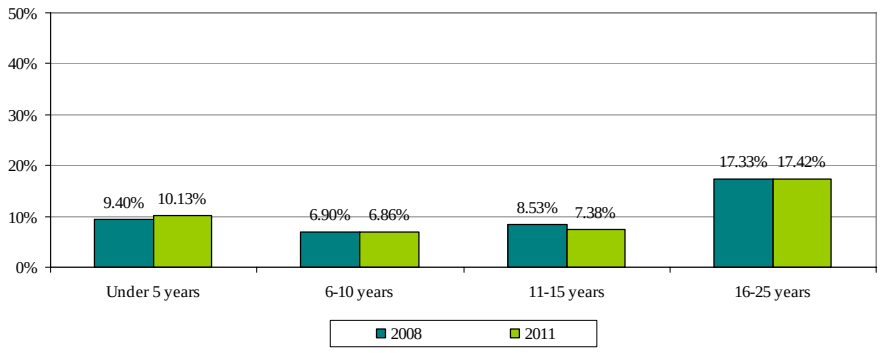
The Reducing Disparities Workgroup was developed during the PEI community planning process to provide recommendations for underserved cultural populations including the LGBTQ community. This Workgroup provided specific recommendations for the LGBTQ population:

- Implementation of a targeted prevention and early intervention program directed to lesbian, gay, bisexual, transgender and questioning (LGBTQ) children, youth, and their families in a community based setting.
- Implementation of a culturally competent peer based community mental health outreach worker program designed to provide a targeted outreach and engagement campaign in the LGBTQ community in natural community settings.
- Develop specific support to LGBTQ people through LGBTQ organizations.

Data Analysis

Transition Age Youth (TAY), defined as youth between the ages of 16-25, made-up 17.33% of the total population in Riverside County for the year 2008. As the graph below indicates, the TAY population will increase by the year 2011.

Percent of the Children, Youth and Young Adults in the Total Population of Riverside County



The PEI community planning process identified the TAY population as a priority for prevention and early intervention services. Four categories of data were used to determine the priority populations and the type of interventions needed.

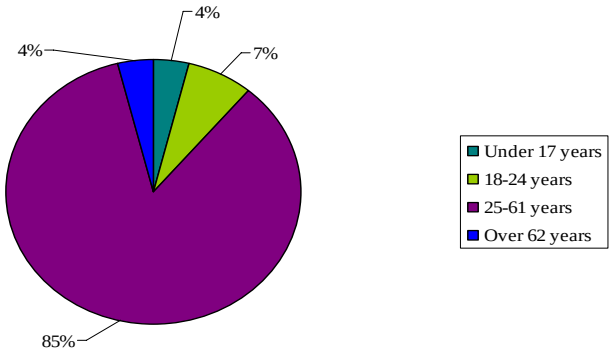
1) Runaway/homelessness rates

2) Foster system statistics including youth transitioning out of the foster care system
3) Teen self-reports of depressive mood
4) Youth suicide ideation, attempts and rates

The Office of Juvenile Justice and Delinquency Prevention in the US Department of Justice estimates the number of homeless youth. Their most recent study, published in 2002, reported there are an estimated 1,682,900 homeless and runaway youth throughout the Country. This number is equally divided among males and females, and the majority of them are between the ages of 15 and 17 (Molino, 2007). According to the National Alliance to End Homelessness, five to seven percent of American youth become homeless in any given year. (NAEH, 2007) http://www.nationalhomeless.org/publications/facts/youth.html

The County Department of Public Social Services (DPSS), in collaboration with the Homeless Coalition for Riverside County, conducted a homeless count and survey on January 24, 2007. A person was considered homeless, if he/she resided in places not meant for human habitation, such as cars, parks, sidewalks and abandoned buildings, in an emergency shelter and in transitional housing for homeless persons.

Homeless Population by Age (N=4,508) counted on January 24, 2007



In the graph above, the TAY population is identified across three categories due to the format of data collection. However, the majority of the TAY population (16-25 years) results from this survey can be seen in the category 18-24. This category lists 7% of the homeless surveyed as between these ages. However, we can estimate that percentage to be higher with the overlap into the under 17 years and 25-61 years categories.

Causes of homelessness among youth fall into three inter-related categories: family problems, economic problems, and residential instability. Many homeless youth leave

home after years of physical and sexual abuse, strained relationships, addiction of a family member, and parental neglect. Disruptive family conditions are the principal reason that young people leave home. In one study, more than half of the youth interviewed during shelter stays reported that their parents either told them to leave or knew they were leaving and did not care (U.S. Department of Health and Human Services (a), 1995). In another study, 46% of runaway and homeless youth had been physically abused and 17% were forced into unwanted sexual activity by a family or household member (U.S. Department of Health and Human Services (c), 1997). In the face of these difficult experiences the risk for the development of mental health problems and/or suicidal ideation is very high. The need for prevention and early intervention services to address these high risk youth is evident.

A history of foster care correlates with becoming homeless at an earlier age and remaining homeless for a longer period of time (Roman and Wolfe, 1995). The rates for foster care in Riverside County are higher than the state of California rates and have been increasing over the last five years while the rates in California have declined. On January 1, 2008, 5,458 children were in foster care in Riverside County. Almost 50% of the children in foster care were between the ages of 6-15 and 13.2% (719) youth age 16-17 were close to transitioning out of the foster care system. Children in foster care can reside in a variety of placements. Many of the 5,458 children in foster care resided in foster homes or Foster Family Agency homes (41.6% total). Compared to the total population of ethnic groups, children of African American and Hispanic ethnicity are disproportionately represented in the foster care population; with 17.3% African American and 51.7% Hispanic children in foster care. Children and youth involved in the child welfare system have been shown to have an even greater prevalence of mental health disorders, which often go untreated. Research also indicates as many as 70 percent of all foster care children in California will develop mental health problems (From Promise to Practice: Mental Health Models that Work for Children and Youth, a Toolkit). As youth transition out of the foster care system they are often without adequate resources. In addition, the history of abusive or neglectful family dynamics that led them to foster care put them at higher risk of developing mental health problems as they reach adulthood. The UC Davis Center for Reducing Disparities (2008) met with community members throughout the State regarding prevention and early intervention. A foster youth commented, “whatever the issue, unfortunately, it’s that (foster youth community) they don’t receive the necessary treatment or the attention which allows the problems to snowball and become real hurdles…things that if had they been treated earlier, the symptoms could have been prevented,” (Engaging The Underserved: Personal Accounts Of Communities On Mental Health Needs For Prevention And Early Intervention Strategies, 2008).

National statistics from several sources about the LGBTQ youth population reveals some alarming information and risk factors for this group. Extrapolations for Riverside County draw a picture of great concern and need for prevention and early intervention services.

- One study suggests that 20 percent of gay teens were kicked out of their homes when they revealed their sexuality to their parents.

- 74% of transgender youth reported being sexually harassed at school and 90% of transgender youth reported feeling unsafe at school because of their gender expression.
- LGBT students are significantly more likely than heterosexual youth to:
    - Report a suicide attempt (32% vs. 7% of other students)
    - Have been bullied (42% vs. 21%) or threatened or injured with a weapon at school
    - Report current alcohol use (60% vs. 45%) and binge drinking (44% vs. 26%)
- In a survey of 402 transgender people, 78% reported having been verbally harassed and 48% reported having been victims of assault, including assault with a weapon, sexual assault, and rape.
- Several large population-based public health studies revealed:
    - Higher rates of major depression, generalized anxiety disorder and substance abuse or dependence in lesbian as gay youth.
    - Higher rates of recurrent major depression among gay men.
    - Higher rates of anxiety, mood, and substance use disorders, and suicidal thoughts among people ages 15 to 54 with same-sex partners.
    - Higher use of mental health services in men and women reporting same-sex partners

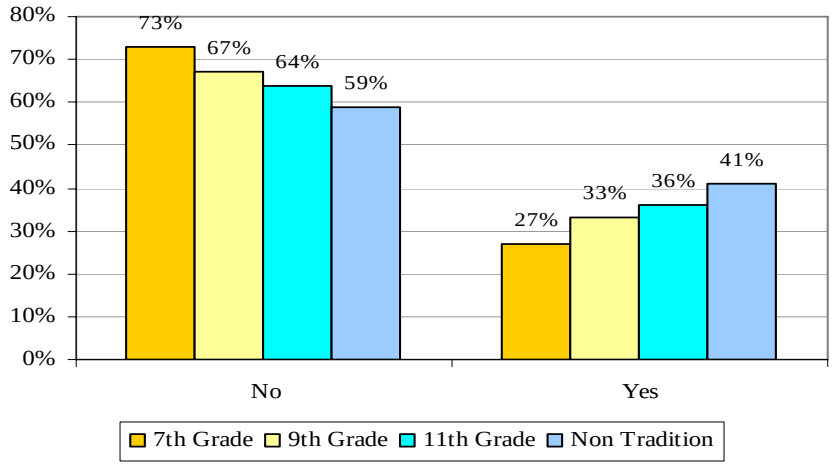
The unique needs and challenges (risk factors) of LGBTQ transitional age youth, if unaddressed, can progress into the development of mood disorders, suicide risk, and other mental health and relationship issues that can result in life long difficulties.

The California Healthy Kids Survey is a mandated survey administered to students in grades 7, 9, 11 and non-traditional school settings. Non-traditional students can be in grades 7-12 and in various types of alternative schools including; court, community, continuation, or independent study. The data illustrated is for Riverside County and is a compilation of 47,398 surveys from 23 districts completed from 2005-2007. A single depression question was asked for all youth completing the survey.

PEI PROJECT SUMMARY

Frequency of Sad and Hopeless Feelings, Past 12 Months

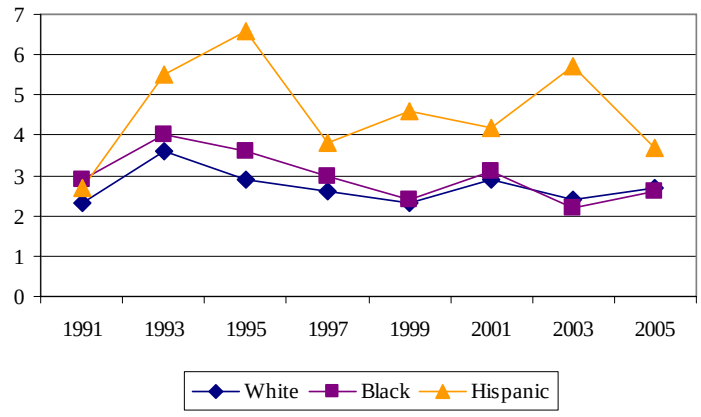
Question HS A.90/MS A.79: "During the past 12 months did you ever feel so sad and hopeless almost every day for two or more weeks that you stopped doing some usual activities?"



The graph demonstrates the increase in depressive symptoms as youth progress through each academic year. In addition, it is noteworthy that nearly half (41%) of all students at non-traditional schools report feeling sad and hopeless to a degree that it affects their daily activities. Further analysis of the data reveals that female students report these feelings at a higher frequency than male students. In non-traditional school settings, 53% of female students report depressive symptoms.

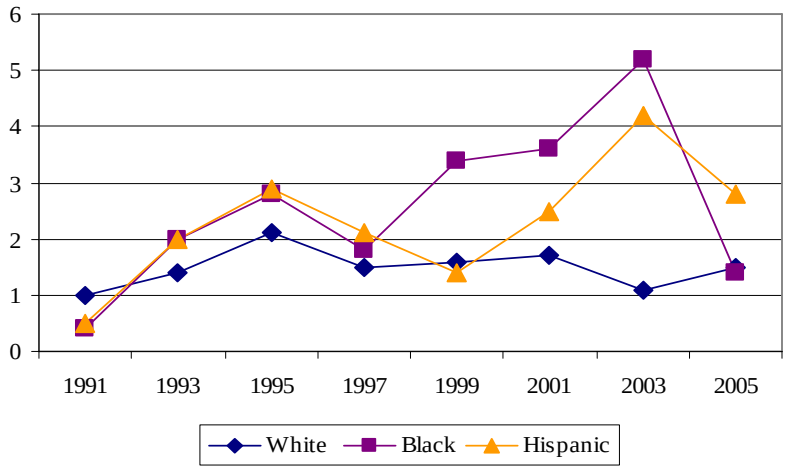
From 1991-2005 in Riverside County, Hispanic females in grades 9-12, had the highest percentage of suicidal ideation, attempts and injurious attempts. While African American females had similar rates to the White population. In contrast, male students overall had similar rates between Afircan American, Hispanic, and White, although the Afican American male shows a sharp rise in attempts from 1999-2003.

Rates of Suicidal Ideation, Attempts, and Injurious Attempts Among Female Students Grades 9-12 (per 100,000)



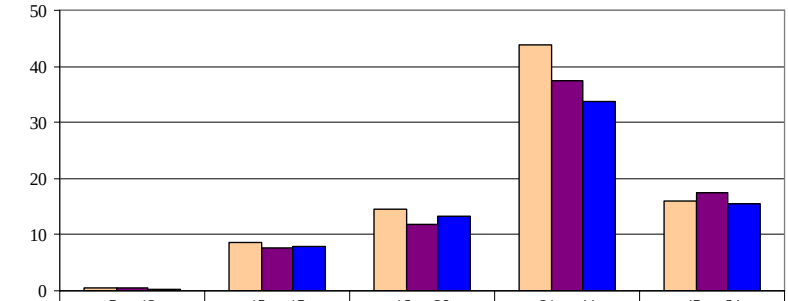
PEI PROJECT SUMMARY

Suicidal Ideation, Attempts, and Injurious Attempts Among Male Students Grades 9-12 (per 100,000)



Among youth and young adults between 16 to 25 years of age, suicide is the third leading cause of death (California Strategic Plan on Suicide Prevention). For Riverside County, the suicide rate categorized by age is shown in the graph below:

2003-2005 Suicide Rates in Riverside County by Age[4]
(per 100,000)



	5 to 12	13 to 15	16 to 20	21 to 44	45 to 64
2003	0.4	8.6	14.7	43.9	15.9
2004	0.4	7.7	11.8	37.5	17.5
2005	0.4	7.9	13.3	33.8	15.5

This project is intended to serve Transition Age Youth (TAY) which is inclusive of college students. There is a lack of resources on college and university campuses. The University of California system has seen rises in student suicide attempts and completions. A large survey in 2000 found that over 9% of students had seriously considered suicide. Only 20% of those students were receiving mental health services – 80% of those students who were thinking of suicide received no mental health services at all (University of California, 2006). Racial and ethnic minorities, gay and lesbian, and graduate students are at particularly high risk because of the multiple challenges they face (MHSOAC Student Mental Health Initiative). The students at highest risk for completing suicide were identified as graduate students; LGBTQ students; international students; and racially and ethnically underrepresented students.

PEI PROJECT SUMMARY

Outreach and awareness about depression and suicide at schools from high schools through the university level is a key element in connecting to at-risk youth.

This project will include targeted outreach and engagement to LGBTQ youth, youth who are in or have been in the foster care system, students in non-traditional school settings, and runaway or homeless youth through the use of the peer-to-peer services as outlined below.

With all of this data in mind, including focus groups, community surveys and recommendations from the TAY Committee, the PEI Steering Committee recognized the need for a targeted project to address the prevention and early intervention needs of the Transition Age Youth in Riverside County. In accordance with PEI guidelines and Riverside County's guiding principles, activities will be situated in de-stigmatizing locations to increase the likelihood of TAY accessing those activities. This will include settings where youth go who are at highest risk of developing mental health problems.

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

a.) 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 program planning process.

Data from focus groups, community forums, community surveys, the four age group committees, and the three workgroups, including community data gathered by the RCDMH Research Unit, were funneled to the PEI Steering Committee where representatives from the age group committees and workgroups prioritized and selected priority populations based upon those at highest risk of developing mental illness. The identified Key Community Mental Health Needs that are addressed in this project are Disparities in Access to Mental Health Services, At-Risk Children, Youth and Young Adult Populations, Stigma and Discrimination, and Suicide Risk. The Priority Populations for TAY are Children/Youth in Stressed Families and Children/Youth at Risk of School Failure. Program implementation will also provide additional activities as needed, such as consultation, screening, and training on mental health issues. This project includes the following components:

- **Depression Treatment Quality Improvement (DTQI)** – DTQI is an evidence-based early intervention program used to treat depression. It is based on the concepts of Cognitive-Behavioral Therapy (CBT). There is considerable evidence that CBT, alone or in combination with medication, is effective in the acute treatment of major depression in youth. A CBT program contains three phases: conceptualization, skills and application training, and relapse prevention. CBT is often provided on a weekly basis and can be offered in individual sessions or a group format serving as many as 8 youth at one time for 12-20 sessions. This program, in line with the concepts of CBT, is low intensity and short in duration. Some family psychoeducation regarding depression and family or parent sessions is recommended. This service will be provided in multiple locations in each service delivery region. It will be provided

through organizations that serve youth and young adults in settings where the youth feel comfortable i.e.: services targeting LGBTQ youth will be provided at an organization that serves LGBTQ youth and young adults. The target population will be TAY who are experiencing depression early in its manifestation.

- **Peer-to-Peer Services** – This service will be connected to DTQI. As an organization provides DTQI, their outreach and engagement efforts will be specific to target populations including homeless, foster, and LGBTQ youth. Leveraging with existing agencies, this project will utilize youth speaker's bureaus to outreach and educate at-risk youth and the community-at-large of the unique issues each group of identified at-risk youth experience as they relate to mental health and interpersonal issues. Youth will work through a stipend program to outreach to local school districts, Gay/Straight Alliances, social service agencies, colleges, universities, transition age youth and their families, and the community-at-large with the purpose of educating the public about mental health, depression and suicide issues. The speaker's bureau is intended to educate, reduce stigma about mental illness, and build resiliency and coping skills in TAY at highest risk.

- **Outreach and reunification services to runaway TAY** - Runaway youth are at increased risk of becoming victims of crimes and trauma as well as becoming involved in the juvenile justice system. Targeted outreach and engagement to this population is necessary in order to provide needed services to return them to a home environment. Crisis intervention and counseling strategies will be used to facilitate re-unification of the youth with an identified family member. Follow up referrals will be provided to assist with stabilization of the living situation for the youth. RCDMH will collaborate with community providers in order to identify specific outreach strategies to reach runaway TAY. RCDMH will collaborate with community providers in order to identify specific outreach strategies to reach unserved and underserved populations, including LGBTQ youth.

- **Digital Storytelling** – TAY, through focus groups, community surveys and the TAY Committee, identified the need for media based engagement activities. There was acknowledgement that youth are media savvy and opportunities to participate in such activities will lead to engagement. Digital Storytelling provides a three day workshop for individuals during which they identify a "story" about themselves that they would like to tell and produce a 3 to 5 minute digital video to tell their story. This activity gives the individual a unique way to communicate something about their life experiences, which could include trauma, loss, homelessness, etc. At the end of the workshop, the participants are then asked to invite whomever they would like to a viewing party. This will be used to de-stigmatize mental health needs, outreach to TAY of Riverside County, and engage TAY in PEI or other services as warranted. The workshops will be offered in all three regions of the County in the identified target

communities. Staff will collaborate with local community-based and faith-based organizations, as well as schools to host the workshops.

- **Active Minds** – Active Minds is a national organization working to use the student voice to change the conversation about mental health on college campuses. RCDMH will work with local colleges and universities to develop and support chapters of this student run mental health awareness, education, and advocacy group on campuses. The goals are to increase student awareness of mental health issues, provide information and resources regarding mental health and mental illness, encourage students to seek help as soon as it is needed, and to serve as a liaison between students and the mental health community. The student run chapters will organize campus wide events to remove the stigma that surrounds mental health issues and create an environment for open conversations about mental health issues.

b.) Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

Riverside County will partner with community-based agencies that have relationships and connections with the identified at-risk youth and young adults. Community based organizations that assist runaway and homeless youth and young adults offer the opportunity for leveraging services, e.g.: Operation Safehouse. In addition, there are agencies, who work with foster youth and the young adults transitioning out of the foster care system, e.g.: Department of Social Services Independent Living Program. The County has a growing number of agencies and centers whose work, outreach, interventions, and resources specifically target the LGBTQ community and youth and young adults in particular, for example the Rainbow Pride Youth Alliance and Gay Associated Youth. Also, agencies that target youth for a multitude of services could also provide an opportunity for this type of intervention, e.g.: Youth Opportunity Centers. Local school districts, colleges and universities also have a natural link to transition age youth. This project is aimed at leveraging with these agencies in order to provide early intervention programs and peer-to-peer services situated in locations that are de-stigmatizing, safe, and increase access for targeted underserved cultural populations.

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

National research indicates there is increased risk of mental illness for minority individuals who live in poverty. This is closely related to a lack of available resources and increased risk of exposure to community violence. Based upon County poverty and ethnicity data, and, as stated in the data analysis portion of this project, data related to population by homelessness, foster care statistics, LGBTQ statistics, student self-report

of depression, suicide rates for TAY, and the expertise of committee members and consultants was analyzed to identify areas in the County where TAY are at increased risk of developing mental illness. RCDMH divides the County into three regions which are Western, Mid-County, and Desert. The analysis of the data, provided by the RCDMH Research and Evaluation Unit, resulted in the identification of high need, priority communities within each service delivery region that will be the initial target demographic. In the Western region, the target communities are located in poor, densely populated areas of Rubidoux, East Side, Arlanza, and Moreno Valley. In the Mid-County region, the target communities are located in older, low income areas of Lake Elsinore, San Jacinto, and Perris. In the Desert region, large, low income areas with a significant Hispanic/Latino migrant population in the areas including portions of the Coachella Valley, Desert Hot Springs, and Eastside Banning. Service providers will be asked to identify specific underserved cultural populations to be served and specific outreach activities that will be utilized.

d.) Highlights of new or expanded programs.

Depression Treatment Quality Improvement (DTQI), a Cognitive Behavioral Therapy that addresses depression in adolescents, is currently offered through CSS in several of the RCDMH children's clinics. The use of this program for PEI activities is an expansion into community based settings to address the needs of TAY dealing with depression early in its manifestation. The PEI funded DTQI services will be in addition to, not a replacement of, the existing CSS DTQI services. All other services are new services for RCDMH.

Depression Treatment Quality Improvement (DTQI)

- Cognitive-Behavioral intervention designed to meet the needs of adolescents and young adults
- Flexible formatting allows for delivery in individual and group model
- Shows positive outcomes for the reduction of depression and suicidal ideation

Peer-to-Peer Services

- Decreases stigma
- Increases access to mental health services
- Builds resiliency in youth

Outreach to runaway youth

- Provides outreach to a very vulnerable population to reduce the risk of trauma exposure
- Connects youth with needed services including reunification with family

Active Minds

- Active Minds chapters are student run on community college and university campuses
- Activities will allow incoming students the opportunity for supportive services

Digital Storytelling
- A unique media based opportunity for TAY to tell their story
- Reduces stigma in sharing about life experiences
- Increases engagement in PEI activities

e.) Key milestones and anticipated timeline for each milestone.

- PEI plan approval by State DMH – Summer 2009
- Competitive Procurement Process – September '09 – November '09
- Recruitment and hiring of appropriate staff – December '09
- Training staff in evidence-based model (including cultural and linguistic needs of population) – January '10
- Program implementation – February - June 2010

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Depression Treatment Quality Improvement (DTQI)	Individuals: Families:	Individuals: 270 Families:	10
Peer-to-Peer Services	Individuals: 10,000 Families: 1000	Individuals: Families:	10
Outreach to runaway youth	Individuals: 800 Families: 200	Individuals: 200 Families: 50	10
Digital Storytelling	Individuals: 90 Families:	Individuals: Families:	10
Active Minds	Individuals: 100 Families:	Individuals: Families:	10
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 10,990 Families**: **1,200**	**Individuals: 470 Families**: **50**	10

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

The TAY Suicide Prevention project will be provided in partnership with organizations in Riverside County who serve transition age youth. In addition to the identified PEI services provided in this project, those partnering agencies offer additional supportive

activities for TAY. Some examples are runaway youth will have access to safe places like Operation Safehouse, foster youth become acquainted with the services provided by DPSS Transitional Living Program, and LGBTQ TAY gain awareness of and access to LGBTQ youth centers, such as the Rainbow Pride Youth Alliance. This project will increase the support network of the young person and will enhance or increase resilient traits and reduce the impact or development of mental illness. Service providers and peer-to-peer services will link the community to resources such as the Helpline which is a crisis line and can provide additional community resources. An additional link for the LGBTQ population is The Trevor Project, which is a web based support and referral resource specifically designed for LGBTQ individuals. Peer-to-Peer services will link youth to this resource as needed. As a part of this resource, youth will be given the nationally accredited 800 suicide prevention line run by the Trevor Project. As outreach activities educate, recruit, and encourage TAY community members to participate in activities, young people with more serious mental health issues may surface and this will be an opportunity to link and refer them to other mental health services as needed either through the County Department of Mental Health MHSA CSS programs or other community providers. TAY will also benefit from other projects in the PEI plan including the Mental Health Outreach, Awareness, and Stigma Reduction; the Parent Education and Support project; the Trauma-Exposed project; and the Underserved Cultural Population project. In addition, linkage and referral to other types of services in the community are also expected including healthcare enrollment opportunities, recreation, education, and vocation to name just a few.

6. Collaboration and System Enhancements

This PEI project provides multiple opportunities for collaboration and system enhancement. RCDMH will partner with community-based organizations who serve transition age youth, specifically runaway/homeless youth, youth in and transitioning out of foster care, and LGBTQ TAY. Key collaborations for implementation of programs will also include the Department of Public Social Services, Public Health, local high schools, and local colleges and universities.

System enhancement will occur as each of the programs effectively reach into communities. Through effective outreach, engagement, stigma reducing activities, and depression services TAY will have the opportunity to receive services early in the manifestation of symptoms.

All providers will be expected to leverage supports and provide in-kind resources. The infrastructure of the established community based organizations who will be the program providers allows for leveraging of provider time, space, utilities, volunteers, experience, and the trust and relationships of the providers within their known communities.

7. Intended Outcomes

Person-Level outcome

- Reduced depression and re-occurrence of depression for LGBTQ TAY
- Increased willingness to utilize mental health resources as needed
- Development of coping strategies in family and social relationships

System-Level outcome

- Enhanced collaboration with agencies serving transition age youth
- Reduction in access disparities for mental health services
- Earlier recognition and identification of depression and other mental health issues in youth
- Reduction of stigma associated with mental health services

DTQI is an evidence based practice that includes specified outcome measures that will be used. In addition, specific measures will be developed in conjunction with providers in order to ensure collection of appropriate data and cultural and linguistic appropriateness.

8. Coordination with Other MHSA Components

Through implementation of the components of this project, it is anticipated that TAY and families will be identified as meeting criteria for additional mental health services. For those that can be served through the CSS Full Services Partnerships, PEI or other CSS services, referrals will be made and they will be assisted with needed linkage. In addition, individuals and families who may not meet criteria for a referral to a CSS program will be provided a referral and assisted with linking with other RCDMH or community based services that will meet their needs.

Through the Workforce, Education, and Training component of the MHSA, Riverside County has hired a University Liaison position in order to establish relationships with high schools, community colleges, and universities. The Liaison will assist service providers to connect with schools for implementation of appropriate programs.

9. Additional Comments (optional)

In accordance with the guidelines of the MHSA PEI component, Riverside County will be implementing many evidenced based practices. In order to adequately establish and sustain these programs a solid infrastructure is required. From the community planning process feedback, the need for infrastructure to provide thorough and supportive training, maintenance of skills for providers, and accountability across settings to ensure fidelity to the practices came through as necessary activities.

It is important that evidence based programs are model adherent, that the core concepts and theoretical background are carried out in service delivery, and that guidelines for outcome (pre- and post- test) measures are accurately maintained.

PEI PROJECT SUMMARY

RCDMH will utilize clinical staff members to ensure that training in evidence-based practices is provided to all service providers. The Department will also assist the service providers in implementation of those evidenced based programs. The clinical staff will hold monthly team meetings with all practitioners of a particular model in order to maintain fidelity, provide clinical consultation, and practice skills required for implementation. The staff member will also assist with infrastructure stability at each site by guiding practitioners to maintain all needed materials and environment set-up. This will allow for greater adherence to the often stringent requirements of evidence-based practices as well as provide assistance to smaller organizations when staff turn-over impacts service delivery. Consistent training and coordination of needs will be available to all PEI programs within the County system as well as any partner agency delivering PEI programs.

PEI PROJECT SUMMARY
PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: RIVERSIDE Date: 06/30/09
PEI Project Name: 4 - TRANSITIONAL AGE YOUTH (TAY) PROJECT
Provider Name (if known): TBD
Intended Provider Category: YOUTH CENTER

Proposed Total Number of Individuals to be served:	FY 08-09	N/A	FY 09-10	19,070
Total Number of Individuals currently being served:	FY 08-09	N/A	FY 09-10	N/A
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	N/A	FY 09-10	N/A
Months of Operation:	FY 08-09	N/A	FY 09-10	9

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages:			
	$0	$0	$0
b. Benefits and Taxes	$0	$0	$0
c. Total Personnel Expenditures	$0	$0	$0
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	$0	$0	$0
c. Non-Reoccuring Cost	$0	$71,827	$71,827
d. Total Operating Expenses	$0	$71,827	$71,827
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Providers to be Determined.	$0	$1,249,303	$1,249,303
a. Total Subcontracts	$0	$1,249,303	$1,249,303
4. Total Proposed PEI Project Budget	$0	$1,321,130	$1,321,130
B. Revenues (list/itemize by fund source)			
MediCal FFP	$0	$12,317	$12,317
Total Revenue	**$0**	**$12,317**	**$12,317**
C. Total Funding Requested for PEI Project	$0	$1,308,812	$1,308,812
D. Total In-Kind Contributions	$0	$0	$0

PEI PROJECT SUMMARY
PEI Revenue and Expenditure Budget Worksheet

County Name: RIVERSIDE Date: 06/30/09

PEI Project Name: 4 - TRANSITIONAL AGE YOUTH (TAY) PROJECT

Proposed Expenses and Revenues Narrative
A. Expenditure
1. Personnel
N/A
2. Operating Expenditures
c. Non-Reoccurring Cost: Estimated cost of Digital Storytelling (DST) Training and all electronic equipment needed for that program, as well as program development.
3. Subcontracts/Professional Services
The TAY Program will include contracted services providing suicide prevention and depression treatment to LGBTQ Youth, runaway youth, youth transitioning out of foster care and youth transitioning into college. Estimated annual cost includes contracted services, training, training materials, client materials, food, and a portion of the program's operating expenses.
4. Total Proposed PEI Project Budget
B. Revenues
New program generated Medi-Cal revenue.

PEI PROJECT SUMMARY

County: Riverside PEI Project Name: First Onset for Older Adults Date: July 15, 2009

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	☐	☐	☐	☒

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	☐	☐		

PEI PROJECT SUMMARY

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

Stakeholder Input

An extensive community planning process resulted in 108 focus groups and community forums, of which 19 focus groups and 1 community forum were dedicated to the older adult population and service providers for this population in Riverside County. RCDMH staff partnered with Riverside County Office on Aging staff to reach out to older adult consumers as well as service providers for older adults throughout the County. Additionally, RCDMH staff partnered with DPSS-APS, Community Health Agency-Public Health Nursing, and identified community older adult providers in the community, i.e.: Senior Centers, Grandparents Raising Grandchildren groups, CARE Teams (Curtailing Abuse) and other agencies to outreach into the older adult community to educate about prevention and early intervention as well get feedback and recommendations about the PEI needs of older adults in Riverside County. Collaboration with the Office on Aging resulted in a focus group for the LGBTQ older adult community. The RCDMH Older Adult Committee, a subcommittee of the Riverside County Mental Health Board, is responsible for the oversight of the implementation of the Community Services and Support programs. The Older Adult Committee attends to the needs of the older adult population within the County and Department. This committee was an instrumental component of the PEI planning process. Committee representatives (composed of community members as well as human services agency members) for the older adult population participated in a facilitated process to determine the priority needs for this group and two members from this committee participated in the PEI Steering Committee where final recommendations were developed. Through the community planning process the needs of older adults were identified as one of the priorities for prevention and early intervention services. Feedback from older adults and older adult service providers throughout the community planning process revealed:

Focus Groups:

- "Stigma of seniors at risk for suicide – identify and offer services to seniors with multiple losses."
- "Educate In-Home Supportive Services on screening for anxiety, depression, and trauma."
- "Providing coping skills will reduce suicide risk and stigma."
- "Prevent deep depression and suicide."
- "Develop programs to create opportunities for education and support groups."
- "Short term intervention for depression and anxiety."
- "Educate seniors on resources in Community (prevention early onset)."
- "Co-locate mental health services within other services for the elderly (senior centers)."

PEI PROJECT SUMMARY

Community Surveys

- "Identifying, supporting, filling the needs of the elderly homosexuals."
- "In-Home."
- "Family Practitioners can screen for mental illness, however we need training and help on referral information, early treatment interventions, and community resources to help these patients."
- "Training seminars to educate staff to identify signs."
- "Better interagency collaboration."

The Older Adult Committee recommendations developed as a result of community input included:

- "Decrease risk of suicide by training gatekeepers including friends, neighbors, ministers, doctors, nurses, office supervisors, police officers, advisors, caseworkers, firefighters, and many others who are strategically positioned to recognize and refer someone at risk of suicide."
- "Increase awareness of services available for older adults Countywide."
- "Reduce risk of mental health problems related to stress and caregivers."
- "Link seniors with PEI services."
- "Educate about mental health symptoms."
- "Decrease access disparities."

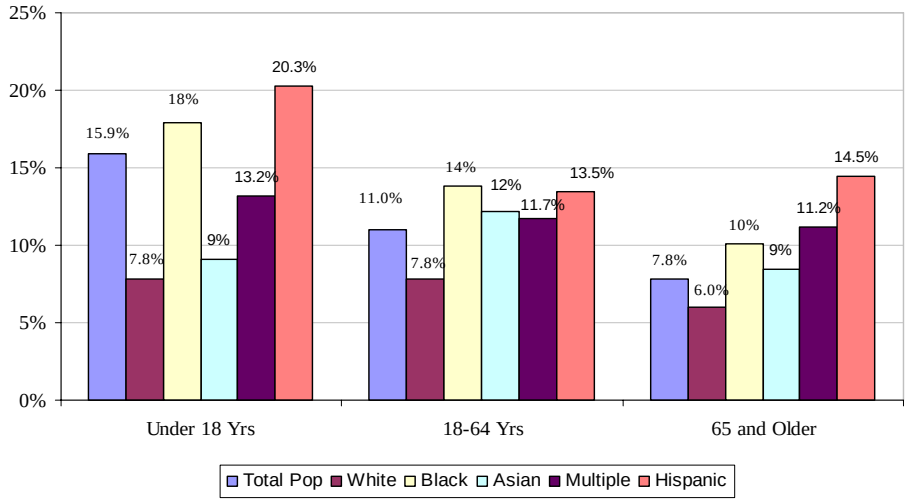
Data Analysis

The California Department of Aging reports that California is projected to be one of the fastest growing States in the nation in total population. In California, the elderly population is expected to grow more than twice as fast as the total population. In 2005, Riverside County had a population of 317,113 residents aged 60 years and older. Projections for the year 2020 indicate this age groups' population to be 503,456, a 74% increase in the total population for those aged 60 years+. The "Oldest Old" (those aged 85 years and older) is also on the rise in Riverside County. Total population for 85 years and older in the year 2005 was 29,982 and projections for the year 2020 are 46,766 which is a 61% increase in this age group.

Research shows that poverty and ethnicity, when combined, increases the risk of developing mental illness. This is most often related to an increase in community violence and a lack of community resources. The graph below shows the percentage of the older adult population by ethnicity living below the poverty level in Riverside County.

PEI PROJECT SUMMARY

Population Below Poverty Level by Race/Ethnicity and Age

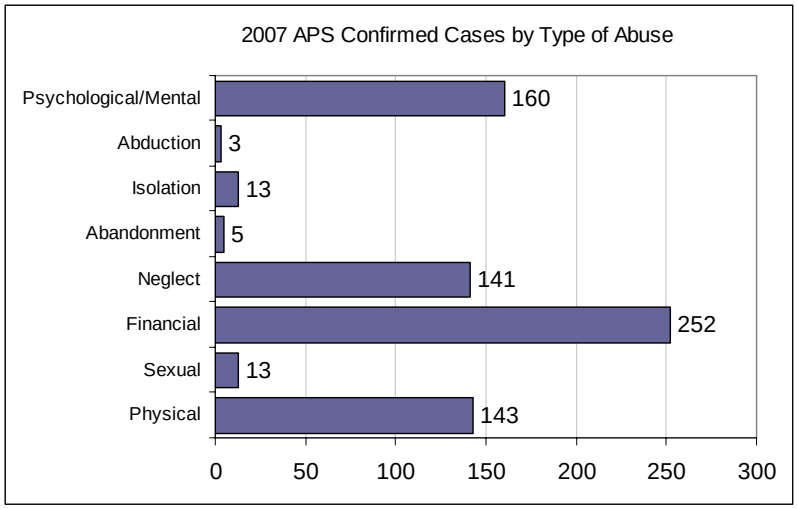


Source: U.S. Census Bureau, 2005-2007 American Community Survey
Note: White, Black and Asian are Non-Hispanic single race, data for
Native American, Native Alaskan, Pacific Islander, and some other race were unavailable.

The risk of developing mental illness (e.g.: depression, anxiety, suicidal thoughts and behaviors) also increases with age. Prevention and Early Intervention services can reduce the incidence of major mental illness and suicide in the older adult population. Riverside County and State data analysis of suicide rates support the recognized need of community members. "The rate of suicide increases significantly with age. In California, adults over the age of 85 have the highest suicide rate in the State at 22.5," (California Strategic Plan on Suicide Prevention, 2008). In addition, first onset of depression and chronic illness in older adults are significant risk factors for suicide. "Depression rates are particularly high among older adults receiving in-home care or living in institutions and among those with chronic diseases such as asthma, chronic obstructive pulmonary disease, arthritis, and heart disease," (California Strategic Plan on Suicide, 2008). Medical issues as well as some common experiences of older adults such as: loss of spouse, loss of social support, and increased isolation, add to the risk of developing mental health issues. Both the State and Riverside County data indicates that males are more likely to die by suicide than females, and white males over the age of 65 are at the highest risk of suicide completion. The LGBTQ population, a State identified underserved cultural group, has additional risk factors for the development of mental health problems and suicide risk. There are unique challenges in the aging process for LGBTQ older adults that need to be considered. The combined effects of ageism, heterosexism, homophobia, racism, and sexism throughout the life span of individuals are some of the risk factors associated with mental health issues in this population. In non-clinical samples, the proportion of gay males with a history of suicide attempts appears to range between 20-35% and 2x's that of heterosexuals, (Arbore, 2008). As increasing numbers of baby boomers approach the age of 65, the need to address the risk of suicide among older adults becomes more urgent. "Depression, one of the conditions most commonly associated with suicide in older

adults, is a widely under-recognized and undertreated medical illness. Studies show that many older adults who die by suicide — up to 75 percent — visited a physician within a month before death. These findings point to the urgency of improving detection and treatment of depression to reduce suicide risk among older adults," (http://www.nimh.nih.gov/).

Additional Riverside County data used when evaluating needs for this population in the PEI process included Adult Protective Service (APS) referrals and substantiations, violent crimes, poverty, and ethnicity. APS referrals and substantiations indicate abuse toward an older adult by either a family member or someone in a caregiver role. There are several types of abuse and the graph below indicates the various types of abuse as well as APS confirmed (substantiated) cases in Riverside County. An older adult who has experienced abuse is at higher risk for developing mental illness.



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

a.) 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 program planning process.

The RCDMH PEI community planning process resulted in the identification of prevention & early intervention needs for the older adult population. Utilizing information gathered in the Riverside County data analysis, focus groups, community forums, community surveys, the Older Adult Committee, and the PEI Steering Committee, priorities were identified and recommended for services. It was determined that the prevention & early intervention needs for the older adult community would be met through the implementation of suicide prevention services, depression services, caregiver support groups, trauma services (trauma for older adults is addressed in the Trauma-Exposed for All Ages Project), and mental health awareness and stigma reducing activities (see Mental Health Outreach, Awareness, and Stigma Reduction

Project). Grandparents raising grandchildren will also benefit from parenting programs listed in the Parent Education and Support Project.

This Older Adult Project will address the State identified Key Community Mental Health Needs of Disparities in Access to Mental Health Services, Stigma & Discrimination, and Suicide Risk and the Priority Populations The recommendations throughout the community planning process during each step, from focus groups through the PEI Steering Committee, were clear. The Priority Populations to be served are Individuals Experiencing First Onset of a Serious Psychiatric Illness and Underserved Cultural Populations. Program implementation will also provide additional activities as needed, such as consultation, screening, and training on mental health issues.

The Older Adult Project contains four components:

- **QPR for Suicide Prevention** - QPR stands for Question, Persuade, and Refer. People trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone for help. Thorough and targeted outreach and engagement efforts are required to adequately reach and address the older adult population. Often, depressive symptoms are not recognized or can be misinterpreted as a medical illness. Additionally, changes in physical health can lead to the development of depression. Due to the stigma associated with help seeking behavior, depression may go untreated even when recognized and may increase isolation as many older adults become homebound when symptoms persist. With this in mind, a clear initiative for this population includes gatekeeper training for first contact/first responder community members who have a natural interaction with older adults. The grid below shows possible partners for initial implementation.

QPR Gatekeeper: Initial Implementation Partners	
Office on Aging staff	Primary care staff
Peers	Postal Carriers
Caregivers	Staff at senior centers
Family members	Meals on Wheels providers
Staff at organizations that serve veterans	

The QPR for Suicide Prevention model will be used to train gatekeepers who interact with older adults in order to look for depression and suicidal behavior. “The fundamental premise of QPR’s effectiveness is based on the belief, and growing research, that those most at-risk for suicide do not self-refer. To locate these individuals, identify their suicidal communications and get them to needed services is at the heart of the QPR approach to suicide prevention,” (http://www.qprinstitute.com). This program helps identify at-risk older adults and will connect them to the additional programs/strategies listed in this project. Specific outreach to the older adult LGBTQ community has been identified as a priority through the PEI community planning process.

PEI PROJECT SUMMARY

- **Cognitive-Behavioral Therapy for Late-Life Depression** – This program is an early intervention service that reduces suicidal risk and depression in older adults. Cognitive Behavioral Therapy (CBT) for Late-Life Depression is an active, directive, time-limited, and structured problem-solving approach program that follows the conceptual model and treatment program developed by Aaron Beck and his colleagues. CBT for Late-Life Depression includes specific modifications for elderly depressed individuals who are being treated clinically in community-based settings. The intervention includes strategies to facilitate learning with this population, such as repeated presentation of information using different modalities, slower rates of presentation, and greater use of practice along with greater use of structure and modeling behavior. Consumers are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and to develop more adaptive and flexible thoughts. Where appropriate, emphasis is also placed on teaching consumers to monitor and increase pleasant events in their daily lives using behavioral treatment procedures. The intervention consists of up to twenty 50- to 60-minute sessions following a structured manual. A highlight of this model is its portability which allows implementation in a variety of settings including places where older adults are likely to go, e.g.: senior centers and Office on Aging's Title V programs. The identified gatekeepers in the QPR model listed above will link seniors to this program for early intervention of depressive symptoms. In addition, referral resources will include partnering agencies such as: Adult Protective Services, County Office on Aging, RCDMH Older Adult programs, and others.

- **Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)** - This is an early intervention for people 60 years and older who have minor depression or dysthymia and are receiving home-based social services from community service agencies. The program is designed to reduce symptoms of depression and to improve health-related quality of life. PEARLS is based upon the assumption that problems experienced by an older adult in their daily life can create the conditions for depression and maintain the depressive symptoms. However, by addressing these problems through a systematic approach, the older adult will experience a decrease in their depression symptoms. PEARLS provides eight 50-minute sessions with a trained social service worker in the consumer's home over the course of 19 weeks. Counselors use three depression management techniques: (1) problem-solving treatment, in which consumers are taught to recognize depressive symptoms, define problems that may contribute to depression, and devise steps to solve these problems; (2) social and physical activity planning; and (3) planning to participate in pleasant events. Counselors encourage participants to use existing community services and attend local events. This program is home based which was identified as crucial to providing age appropriate services for the older adults in the community. The identified gatekeepers in the QPR model listed above will link seniors to this program for early intervention of depressive symptoms. In

addition, referral resources will include partnering agencies such as: Adult Protective Services, RCDMH Older Adult programs, and others.

- **Caregiver Support Groups** – As a result of the extensive community planning process which included specific focus groups, community forums, survey completion, and the Older Adult Committee participation, there was an overwhelming request for caregiver services, specifically support groups for those at risk for the development of mental health issues such as depression. RCDMH will partner with local community-based organizations and social service agencies to develop psycho-education curriculum and supportive interventions which may include: how to talk to the doctor, stress reduction techniques, assertion training, self care skills, medication management, and exercise programs. Specific outreach, engagement, and linkage to the support groups will be to individuals and caregivers/family members of individuals receiving prevention and early intervention services, caregivers of seniors with mental illness, and caregivers of seniors with dementia. In addition, referral resources will include partnering agencies such as Adult Protective Services, County Office on Aging, Community Health Agency, RCDMH Older Adult programs, and others.

b.) Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

A key element in any service delivery program is a targeted and culturally competent outreach and engagement component. RCDMH stands by the guiding principles approved by the RCDMH Mental Health Board which are in line with MHSA PEI principles of bringing interventions to the community (see Attachment C). Partnership in this project will include individuals and organizations that know their community and have contacts throughout their area to increase access to referrals and resource information for the older adult population. Research has shown that older adults, who are at highest risk of suicide completion, had contact with a primary care provider within the 30 days prior to their suicide. Recognizing this, partnering with primary care practitioners and/or public health agencies allows for leveraging as well as accessing those at risk in a de-stigmatizing location. RCDMH will partner with the County Office on Aging and the Department of Public Social Services: Adult Protective Services, as both agencies provide a multitude of programs throughout Riverside County and advocate for the needs of older adults. This will allow for the ability to leverage with an established continuum of services and to allow for far reaching dissemination of information and resources for older adults and their families. In addition, RCDMH will partner with community-based organizations, such as senior centers and veteran serving organizations, to implement the services described in the project. The PEI community planning process brought forward a high recommendation to deliver PEI services to the LGBTQ older adult population. Additional partners will include

organizations that serve the LGBTQ older adult community member such as the Golden Rainbow Senior Center.

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

As stated earlier, data related to population by poverty, ethnicity, and Adult Protective Services reports and substantiations was analyzed to identify areas in the County where the older adult population is at increased risk of developing mental health issues. This data, along with recommendations from the Older Adult Committee, led the PEI Steering Committee to recommend that underserved cultural populations, including LGBTQ elders and caregivers of older adults, be a priority for older adult PEI services. RCDMH divides the County into three regions which are Western, Mid-County, and Desert. The analysis of the data, provided by the RCDMH Research and Evaluation Unit, resulted in the identification of high need, priority communities within each service delivery area that will be the initial target demographic. The priority communities in Western Region are: Rubidoux, CasaBlanca, Eastside, and Moreno Valley. The priority communities in Mid-County Region are: Winchester, Romoland and San Jacinto. The priority communities in Desert Region are: North Palm Springs, Desert Hot Springs, Cathedral City, and Blythe. Riverside County is diverse both in population and geographic make-up. Potential service providers will be required to identify the specific underserved cultural populations to be served and to identify specific outreach activities that will be utilized. Riverside County has areas of dense populations and rural areas with small groups of residents. To address this diversity we have identified various programs that include in-home services, mobile services, services offered in local community settings, and gatekeeper training to assist in identification and referral.

d.) Highlights of new or expanded programs.

All of the programs listed in the First Onset for Older Adults project are new to Riverside County. Significant partnering and leveraging will be utilized to implement these programs Countywide.

QPR for Suicide Prevention:

- Reduces stigma by utilizing individuals who have existing relationships with seniors in need of referral
- Addresses high-risk people within their own environments versus requiring individuals to initiate requests for support or treatment on their own
- Offers the increased possibility of intervention early in the depressive and/or suicidal crisis

Cognitive-Behavioral Therapy for Late-Life Depression

- Tailored to specifically address the needs and learning style of the older adult population

- Uses slower rates of presentation with greater use of practice along with greater use of structure and modeling behavior

Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

- Primarily delivered in the home; can be delivered at a senior center
- Teaches participants to recognize depressive symptoms and devise steps to solve these problems
- Increases social and physical activity

e.) Key milestones and anticipated timeline for each milestone.

- PEI plan approval by State DMH – Summer 2009
- Competitive Procurement Process – September '09 – November '09
- Recruitment and hiring of appropriate staff – December '09
- Training staff in evidence-based model (including cultural and linguistic needs of population) – January '10
- Program implementation – February - June 2010

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Question, Persuade, Refer (QPR) for Suicide Prevention	Individuals: 900 Families:	Individuals: Families:	10
Cognitive-Behavioral Therapy for Late-Life Depression	Individuals: Families:	Individuals: 180 Families:	10
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)	Individuals: Families:	Individuals: 240 Families:	10
Caregiver Support Groups	Individuals: 2340 Families:	Individuals: Families:	10
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 3,240 Families**:	**Individuals: 420 Families**:	10

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

The QPR gatekeeper program is an outreach and engagement project that will encounter a wide range of potential health and other needs. This will present a natural opportunity to link and refer community members to any services throughout the County from which they could benefit. Additionally, one of the selected programs, PEARLS, works with homebound older adults and aims to reduce depression through many interventions, one of which is to connect the older adult to community events and programs that can enrich their lives socially, recreationally and interpersonally. This offers an opportunity for partnerships and linkage to the local community and senior centers.

This project will strengthen and rely upon ongoing referral mechanisms to link individuals who may need a mental health assessment and treatment to County Mental Health or other appropriate community providers. This project also has a goal of increasing the use of other needed community resources and project partners will also work with those receiving the programs in accessing those needed services, such as employment, housing, substance abuse, and healthcare services.

6. Collaboration and System Enhancements

This PEI project provides multiple opportunities for collaboration and system enhancement. RCDMH will partner with community based organizations that have extensive knowledge and experience in working with older adults throughout the County. In efforts to decrease access disparities and serve underserved cultural populations, it is critical that services be provided by community and/or faith based organizations that are located within identified communities, know the culture of, and have existing relationships within those communities. RCDMH will work with local agencies that provide respite services for older adults and will leverage with the County Office on Aging as well as the Department of Public Social Services: Adult Protective Services and In-Home Supportive Services, as well as community and faith based organizations, including senior centers. In addition, the feedback during the community planning process included recommendations for the outreach and provision of services to the LGBTQ senior community. In efforts to address this underserved cultural group, RCDMH will partner with community based organizations who serve the LGBTQ senior population.

System enhancement will occur as RCDMH partners with agencies that currently provide a continuum of services to the older adult population of Riverside County to effectively reach into communities and provide an expanded continuum of services. Through awareness of the signs of depression and suicide and available services, older adults will have the opportunity to receive services early in the manifestation of symptoms.

All providers will be expected to leverage supports and provide in-kind resources. The infrastructure of the established community based organizations that will be the program providers allows for leveraging of provider time, space, utilities, and experience.

7. Intended Outcomes

Person-Level outcome
- Reduced depression and re-occurrence of depression in older adults
- Improved overall adjustment and coping strategies
- Increased awareness of prevention and early intervention services for older adults

System-Level outcome
- Enhanced collaboration with other agencies to provide mental health services
- Reduction in access disparities for mental health services
- Earlier recognition and identification of depression

Each of the evidence based practices identified in this project also includes specified outcome measures that will be used. In addition, specific measures will be developed in conjunction with providers in order to ensure collection of appropriate data and cultural and linguistic appropriateness.

8. Coordination with Other MHSA Components

The First Onset for Older Adults Project includes early identification, in-home services, interventions for depression, and support services for caregivers. Through these programs, an older adult, family member, or another member of the community, may be identified as in need of additional mental health services. Providers have the opportunity to link and refer individuals to other MHSA programs, such as a CSS program, that will better serve their needs. The Older Adult Committee will continue to meet and have input regarding the needs of older adults in Riverside County and will coordinate with the PEI unit regarding any needs or concerns that arise.

This project will enhance the delivery of prevention and early intervention services for the older adult population, focusing on assisting seniors before the need for a higher level of treatment. The overall goal of this project is to facilitate the process of healthy aging for older adults, thereby avoiding the need to access services provided by the CSS plan.

9. Additional Comments (optional)

In addition to this PEI project, the older adult population will also benefit from activities and programs throughout the PEI plan including, the Mental Health Outreach, Awareness, and Stigma Reduction Project, the Parent Education and Support Project, the Trauma-Exposed Services Project, and the Underserved Cultural Populations Project.

PEI PROJECT SUMMARY

In accordance with the guidelines of the MHSA PEI component, Riverside County will be implementing many evidenced based practices. In order to adequately establish and sustain these programs a solid infrastructure is required. From the community planning process feedback, the need for infrastructure to provide thorough and supportive training, maintenance of skills for providers, and accountability across settings to ensure fidelity to the practices came through as necessary activities.

It is important that evidence based programs are model adherent, that the core concepts and theoretical background are carried out in service delivery, and that guidelines for outcome (pre- and post- test) measures are accurately maintained. RCDMH will utilize clinical staff members to ensure that training in evidence-based practices is provided to all service providers. The Department will also assist the service providers in implementation of those evidenced based programs. The clinical staff will hold monthly team meetings with all practitioners of a particular model in order to maintain fidelity, provide clinical consultation, and practice skills required for implementation. The staff member will also assist with infrastructure stability at each site by guiding practitioners to maintain all needed materials and environment set-up. This will allow for greater adherence to the often stringent requirements of evidence-based practices as well as provide assistance to smaller organizations when staff turn-over impacts service delivery. Consistent training and coordination of needs will be available to all PEI programs within the County system as well as any partner agency delivering PEI programs.

PEI PROJECT SUMMARY
PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: RIVERSIDE Date: 06/30/09
PEI Project Name: 5 - FIRST ONSET FOR OLDER ADULTS
Provider Name (if known): TBD
Intended Provider Category: OLDER ADULT SERVICE CENTER

Proposed Total Number of Individuals to be served:	FY 08-09	N/A	FY 09-10	3,554
Total Number of Individuals currently being served:	FY 08-09	N/A	FY 09-10	N/A
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	N/A	FY 09-10	N/A
Months of Operation:	FY 08-09	N/A	FY 09-10	9

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages:			
1.00 FTE Office Assistant III	$0	$45,075	$45,075
6.00 FTE Behavioral Health Specialist II	$0	$323,564	$323,564
0.15 FTE Psychiatrist II PD	$0	$45,805	$45,805
1.00 FTE MH Service Supervisor	$0	$97,634	$97,634
b. Benefits and Taxes	$0	$241,296	$241,296
c. Total Personnel Expenditures	$0	$753,374	$753,374
2. Operating Expenditures			
a. Facility Cost	$0	$72,234	$72,234
b. Other Operating Expenses	$0	$314,061	$314,061
c. Non-Reoccuring Cost	$0	$191,611	$191,611
d. Total Operating Expenses	$0	$577,905	$577,905
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Providers to be Determined.	$0	$1,086,646	$1,086,646
a. Total Subcontracts	$0	$1,086,646	$1,086,646
4. Total Proposed PEI Project Budget	$0	$2,417,925	$2,417,925
B. Revenues (list/itemize by fund source)			
MediCal FFP	$0	$400,759	$400,759
Total Revenue	**$0**	**$400,759**	**$400,759**
C. Total Funding Requested for PEI Project	$0	$2,017,166	$2,017,166
D. Total In-Kind Contributions	$0	$0	$0

PEI PROJECT SUMMARY
PEI Revenue and Expenditure Budget Worksheet

County Name: RIVERSIDE Date: 06/30/09

PEI Project Name: 5 - FIRST ONSET FOR OLDER ADULTS

Proposed Expenses and Revenues Narrative
A. Expenditure
1. Personnel
Estimated annual cost of salaries and benefits for 8.15 new program FTEs to provide intervention services to elderly depressed and/or suicidal individuals. This program helps identify at-risk older adults and will connect them to the additional program/strategies listed in this project.
2. Operating Expenditures
a. Facility Cost: Estimated annual cost of program rent, utilities, and building maintenance. b. Other Operating Expenses: Communication, transportation, office supplies and liability, malpractice and property insurance. c. Non-Reoccuring Cost: Estimated cost of Pearls Training and vehicles to serve all three regions on Mental Health. Additional expenses include cost to equip new 8.15 FTE PEI staff and program development.
3. Subcontracts/Professional Services
The First Onset for Older Adults Program will be providing Cognitive-Behavioral Therapy, Suicide Prevention, and Depression Early Intervention services, as well as Caregiver support groups. Estimated annual cost covers all costs for contracted services including training, training materials, client materials, food, and a portion of the program's operating expenses.
4. Total Proposed PEI Project Budget
B. Revenues
New program generated Medi-Cal revenue.

PEI PROJECT SUMMARY

County: Riverside for All Ages **PEI Project Name: Trauma-Exposed Services**
Date: July 15, 2009

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	☐	☐	☐	☐

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	☐	☐		

PEI PROJECT SUMMARY

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

A traumatic event is one in which a person experiences, witnesses or is confronted with actual or threatened death or serious injury, or threat to the physical integrity of oneself or others. Trauma can result from experiences that are private such as sexual assault, domestic violence, child abuse and witnessing interpersonal violence, or more public events such as community violence. Trauma occurring at any age can result in short and long term problems. “Research suggests that these can include physical health and emotional health conditions and put those exposed to trauma at risk for chronic ill health and premature death,” (Facts about Trauma for Policymakers, 2007).

Stakeholder Input:

As described in Form 2, the PEI community planning process included 108 focus groups with 1147 participants, as well as 2354 completed and returned community surveys. Throughout the input process, trauma exposed individuals across the age span were highlighted as a priority population.

Focus group feedback included recommendations specifically related to trauma:

- “Services to reduce the effects of trauma.”
- “Kids without a diagnosis need access to services to reduce exposure to trauma to prevent further development of mental illness.”
- “Trauma: elder abuse, robbery, physical abuse, not likely to seek treatment, home bound.”
- “Life skills classes including victims of domestic violence.”
- “You need to help rape victims.”

According to the information gathered from the community surveys, respondents most frequently chose “people facing trauma” as a high or very high need:

- “We need more counseling resources for sexual assault victims.”
- “Date rape and domestic violence programs.”
- “Victims of elder abuse need the most help.”

As a result of the information received from the focus groups and community surveys, a Trauma Workgroup was convened. Participants in the Workgroup included consumers, family members, and representatives of agencies that provide services to trauma exposed individuals. The goals for the Workgroup were to describe the population in need of prevention and early intervention services related to trauma exposure; to identify existing programs; to identify strategies, programs and/or practices that could be provided to the population described; and to identify ideal service delivery locations. The participants agreed that the populations most likely to experience disparities in Riverside County regarding trauma related services are: undocumented individuals; LGBTQ youth and adults; African Americans; older adults; and members of the deaf/hard of hearing community. The group expressed strong support for short-term

evidenced based trauma early interventions. Additionally, the Workgroup identified community settings in which these services could be offered in order to reduce access disparities. Specific ethnic neighborhood organizations; schools; home-based; family resource centers; and faith based organizations were mentioned. See Attachment O-1 for the Trauma Workgroup report.

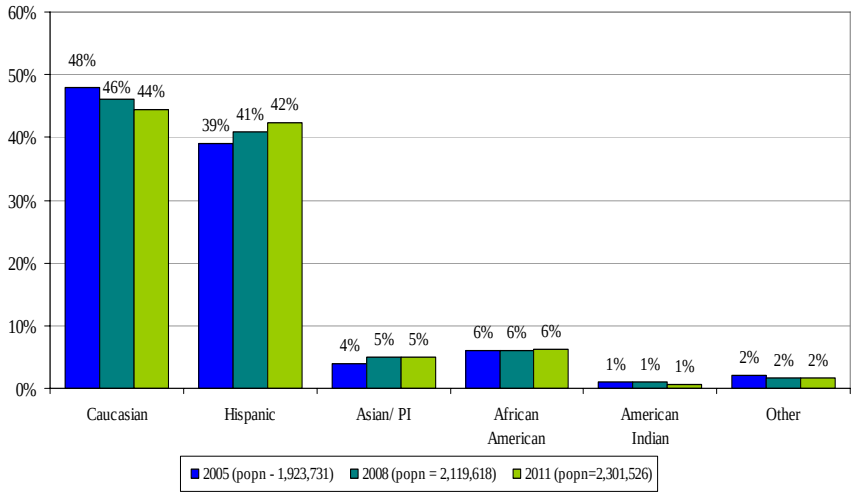
Each of the age group committees (Children, Transition Age Youth, Adult and Older Adult) participated in a facilitated process to determine the priority needs for the age group they represent. Each committee began with a review of PEI related recommendations that were gathered as a part of the CSS planning process. Committees also reviewed the analysis of the information gathered from the focus groups, community surveys and the three workgroups (Trauma, Reducing Disparities, and Reducing Stigma and Discrimination). The need for trauma related services was identified as a priority recommendation in each of the age group committees. Representatives from each committee and workgroup Participated in the PEI Steering Committee to convey their respective committee and workgroup recommendations. After much discussion, the Steering Committee agreed on services for trauma exposed individuals across the age span as a PEI project.

Data Analysis:

This PEI project targets trauma exposed individuals across the age span. The Research and Evaluation Unit compiled and analyzed a significant amount of data related to trauma experiences.

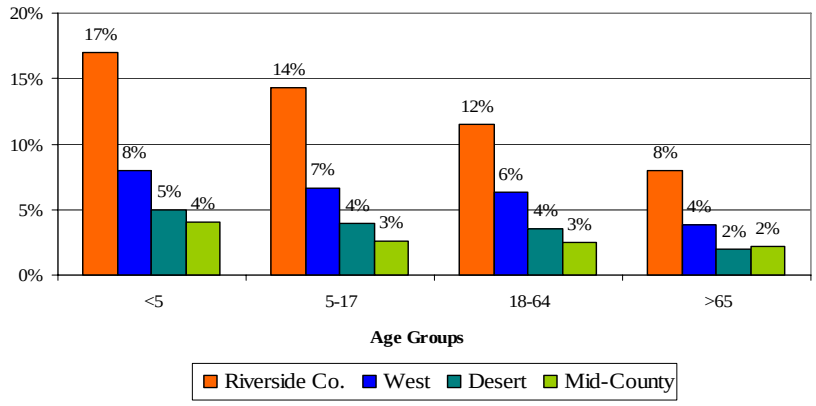
- Research has demonstrated that there is an increased risk of exposure to community violence among ethnic and racial minorities living in poverty. Riverside County population projections by race/ethnicity as shown in the graph below indicate the projected change from 2008-2011. The Hispanic population will increase over the three year period while the other ethnic populations remain stable.

Population Projections by Race/Ethnicity



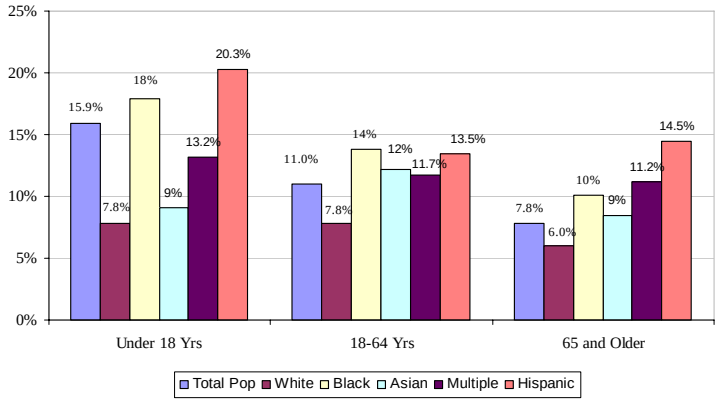
According to the census data, as shown in the graph below, of the total population of Riverside County, 11.5 percent of Riverside County residents live in poverty.

Percent of Population Below Poverty Level by Age, Region and County



Finally, the graph below shows the percentage of population by ethnicity living below the poverty line in Riverside County. This is of particular significance when looking at individuals most at risk of experiencing community violence.

Population Below Poverty Level by Race/Ethnicity and Age



Source: U.S. Census Bureau, 2005-2007 American Community Survey
Note: White, Black and Asian are Non-Hispanic single race, data for Native American, Native Alaskan, Pacific Islander, and some other races were unavailable.

- Violent crime rates in Riverside County (815 per 100,000) are 37% higher than the State rate. In 2007, the rates of rape and aggravated assault were as high as 50.1 per 100,000 and 816.2 per 100,000 respectively in Riverside County.

The Institute for Hispanic Health White Paper of 2005 states, “Domestic violence is a serious, widespread social problem with mental health consequences for victimized women and families of all cultural and ethnic groups.”

- Riverside County has high rates of domestic violence and was ranked among the 10 counties with the highest number of reported cases of domestic violence according to the CPOC (Chief Probation Officers of California) annual survey of 2006-2007. In 2005, the rate of domestic violence related calls for assistance was 396 per 100,000.

Data from the National Survey of Adolescents, as well as other surveys, indicate that one in four children and adolescents in the United States experience at least one potentially traumatic event before the age of 16 and more than 13% of 17 year olds have experienced Post Traumatic Stress Disorder (PTSD) at some point in their lives (The National Child Traumatic Stress Network; Making the Connection: Trauma and Substance Abuse). Traumatic experiences may lead to many negative emotional and physical consequences for youth including depression, anxiety, and PTSD along with problems with substance abuse.

- Riverside County has more children in foster care per capita (10 per 1,000) than the State foster care rate (7 per 1,000) indicating a significant number of youth who have been exposed to trauma.

- A 2008 article published by the National Association of Counties titled Identifying General Outcomes for Youth Aging Out Of Care states, “approximately twenty-five percent of foster care alumni or adults who had experienced foster care later experienced post traumatic stress. The general population by comparison experiences post traumatic stress at a rate of 4 percent,” http://www.naco.org/Content/ContentGroups/Issue_Briefs/IB-YouthAgingoutofFoster-2008.pdf.

- Adolescents who are victims of dating violence are not only at increased risk for injury, but are also more likely to report binge drinking, suicide attempts, and physical fighting. They also often carry unhealthy patterns of abuse into future relationships (Lynberg MC, Eaton D, et al., 2003 & Smith PH, White, JW Holland, LJ, 2003). The California Healthy Kids Survey surveys students in 7th, 9th, and 11th grades as well as students in non-traditional school settings regarding issues related to safety. One result of the survey for 2005-2007 in Riverside County revealed that between 4% and 11% of students surveyed answered “yes” the to the question, “During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?”

Older adults have increased vulnerability to trauma, both at the hands of strangers as well as those in care giving roles. There are a growing number of older adults in Riverside County and the Older Adult Committee recommended addressing the impact of trauma among older adults.

- In Riverside County, in 2005, there were 317,113 residents aged 60 years and older. Projections for the year 2020 state this age groups' population to be 503,456, a 74% increase in the total population for those aged 60 years+.

- There were 4,625 referrals to Adult Protective Services in 2007 and of those, 1,369 (29.6%) were confirmed.

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

a.) 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 program planning process.

The goal of this PEI project is to reduce the deleterious effects of trauma for individuals most at risk of developing mental health problems as a result of traumatic experiences. This project will address the State identified Key Community Mental Health Needs and Priority Populations in addressing the Psychosocial Impact of Trauma and Trauma Exposed Individuals and will include individuals in each of the identified age groups.

This project will utilize five evidence based practices (EBP) that have been proven effective in early intervention for trauma exposed individuals. In addition to the implementation of the EBPs, this project plans to conduct specific outreach to underserved communities in Riverside County to ensure that individuals who traditionally have not received services will be reached. RCDMH will partner with providers from the communities in which the services are being offered, whenever possible. Program implementation will also provide additional activities as needed, such as consultation, screening, and training on mental health issues.

The five identified early intervention EBPs are:

- **Cognitive Behavioral Intervention for Trauma in Schools (CBITS)** – CBITS is a cognitive and behavioral therapy group intervention to reduce children's symptoms of Post Traumatic Stress Disorder (PTSD) and depression caused by exposure to violence. It has been implemented successfully in inner city schools with multicultural populations. CBITS has three main goals: 1) to reduce symptoms related to trauma, 2) to build resilience, and 3) to increase peer and parent support. The program has been used primarily for children in grades six to nine (ages 10-15) who have witnessed or experienced violent events. The format consists of ten one-hour weekly group sessions with five to eight children, plus one to three individual sessions with each child, two parent education sessions, and a teacher informational meeting. A manual details step-by-step plans and provides scripts for implementing the program.

  This program was selected specifically due to overwhelming community request for trauma services as well as an overarching request to provide services in

school settings. Providing services in schools will reduce stigma and will allow for youth who traditionally would not receive services to receive the service.

This early intervention EBP requires training and consultation with the developers for a period of time to ensure fidelity to the model. In addition, this program requires the use of licensed or licensed eligible clinical staff for implementation. Due to the staffing requirements and the training required of the EBP, the cost to client ratio is slightly higher. This program was identified by the PEI Steering Committee as a priority trauma services for children and youth populations in Riverside County. As a result, there will be Countywide implementation of this program which will require several coordinated trainings by the developer of the program and ongoing oversight to ensure fidelity.

- **Safe Dates** - This program is a dating violence prevention program for middle and high school students. It works as both a prevention and early intervention tool for teens who have already begun to date and those who have not yet started dating. The goals are to: 1) change adolescent dating violence norms, 2) change adolescent gender-role norms, 3) improve conflict resolution skills for dating relationships, 4) promote victims' and perpetrators' beliefs in the need for help and awareness of community resources for dating violence, 5) promote help-seeking by victims and perpetrators, and 6) improve peer help-giving skills. Intended for middle and high school students, the Safe Dates program can stand alone or fit easily within a health education, family, or general life-skills curriculum. Because dating violence is often tied to substance abuse, Safe Dates also may be used in conjunction with drug and alcohol prevention and general violence prevention programs. The program includes a curriculum with nine 50-minute sessions, a 45-minute play to be performed by students, and a poster contest. Safe Dates involves family members through parent letters and a parent brochure.

  This program was selected in response to a significant request for a program to address dating violence by many stakeholders, including parents, teachers and youth. The program will be implemented within school settings, but also community based settings, such as faith based organizations, family resource centers and other places that youth naturally gather. There will be specific outreach to underserved cultural populations including LGBTQ and Deaf and Hard of Hearing youth.

  This EBP is a prevention program that includes training by a developer approved trainer and includes the cost of a manual for each provider.

- **Seeking Safety** – This program is a present focused, coping skills program designed to simultaneously help individuals with a history of trauma and substance abuse. It is a manualized, flexible program that is adaptable to various populations and settings. It has been conducted in group or individual format; for female, male or mixed gender groups; for people with both substance abuse and

dependence issues; and, for people with Post Traumatic Stress Disorder (PTSD) and for those with a trauma history that do not meet criteria for PTSD. Seeking Safety focuses on coping skills and psycho-education and has five key principles: (1) safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions); (2) integrated treatment (working on 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, and case management: and (5) attention to clinician processes (helping clinicians work on counter-transference, self-care, and other issues).

This intervention was identified by the PEI Steering Committee based upon the community planning process for use with transition age youth and adults. Seeking Safety addresses issues specifically related to substance abuse. According to The National Child Traumatic Stress Network: Making the Connection: Trauma and Substance Abuse, studies indicate that up to 59% of young people with PTSD subsequently develop substance abuse problems. This then leads to an increased risk of trauma exposure. This program aims to help participants avoid or interrupt that cycle.

The early intervention EBP requires structured training for providers in order to ensure fidelity to the model. This program was identified by the PEI Steering Committee as a priority trauma services for both the TAY and adult populations in Riverside County. As a result, there will be Countywide implementation of this program which will require several coordinated trainings by the developer of the program and ongoing oversight to ensure fidelity.

- **Trauma Recovery and Empowerment Model (TREM)** – This intervention is a fully manualized group based early intervention designed to facilitate trauma recovery among men and women with histories of sexual, physical, and emotional abuse who have been economically and socially marginalized and for whom traditional recovery work has been unavailable or ineffective. This approach emphasizes survivor empowerment and peer support, teaches techniques for self-soothing and recognizing social boundaries, and helps participants learn to focus on manageable steps of problem solving. It addresses both the short and long-term consequences of violent victimization, including mental health symptoms, especially Post Traumatic Stress Disorder (PTSD) and depression. TREM is structured as a comprehensive group intervention program of 33 (75 minute) sessions offered over a 9 month period, led by trained clinicians.

  This program was specifically requested for use with underserved cultural populations due to evidence of effectiveness with the Hispanic and African American populations.

This early intervention EBP requires training and consultation with the developers for a period of time to ensure fidelity to the model. In addition, this program requires the use of licensed or licensed eligible clinical staff for implementation. This program was identified by the PEI Steering Committee as a priority trauma services for adults in Riverside County. As a result, there will be Countywide implementation of this program which will require several coordinated trainings by the developer of the program and ongoing oversight to ensure fidelity.

- **Prolonged Exposure (PE) Therapy for Post Traumatic Stress Disorders** – This early intervention is a cognitive-behavioral treatment program for adult men and women with PTSD who have experienced single or multiple/continuous traumas. It is a course of individual therapy designed to help individuals process traumatic events and reduce their PTSD symptoms along with depression, anger, and general anxiety. PE has three components: 1) post trauma difficulties, 2) imaginal exposure (also called revisiting the trauma memory in imagination), repeated recounting of the trauma memory, and 3) in vivo exposure, gradually approaching trauma reminders that are feared and avoided despite being safe. Treatment is individualized and can be shortened or lengthened depending on the needs and pace of the client. It is conducted by social workers and other therapists trained to use the PE manual, which specifies the agenda and treatment procedures for each session. Standard treatment consists of 8-15 sessions conducted once or twice weekly for 90-minutes each.

  This program was specifically identified by the PEI Steering Committee for use with the older adult populations after reviewing community input and data which included information regarding crime rates and rates of Adult Protective Service referrals and substantiations. Specific and targeted outreach will also be made to include LGBTQ older adults as well as other underserved cultural populations.

  This early intervention EBP requires training and consultation with the developers for a period of time to ensure fidelity to the model. In addition, this program requires the use of licensed or licensed eligible clinical staff for implementation. In accordance with the EBP, due to the nature of the needs of the individuals receiving the service, and the program being an individual service, the program is not a high volume program. This program was identified by the PEI Steering Committee as a priority trauma services for older adults in Riverside County. As a result, there will be Countywide implementation of this program which will require several coordinated trainings by the developer of the program and ongoing oversight to ensure fidelity.

b.) Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

The implementation partners for this PEI project are numerous due to the need to serve individuals across the age span as well as the importance of partnering with community providers to provide the services in natural community settings. Potential partners include providers throughout communities who have relationships with underserved communities and who currently provide trauma related services, both at their locations as well as in communities in order to reach the broader population in need. This may include partnerships with Rape Crisis Centers and providers for victims of domestic violence, such as Alternatives to Domestic Violence. In addition, other partners include, but are not limited to, education, faith based organizations, senior centers, Family Resource Centers, community centers (especially those serving the LGBTQ populations), Youth Opportunity Centers, RCDMH Friday Night Live chapters, County Office on Aging, and the Department of Social Services.

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

As stated in the data analysis portion of this project, data related to population by poverty, ethnicity, crime, Child Protective Services and Adult Protective Services substantiations, and domestic violence was analyzed to identify areas in the County where individuals are at increased risk of developing mental health issues. This data, along with recommendations from the Trauma Workgroup and the four age group committees led the PEI Steering Committee to recommend that underserved cultural populations across the age span, including LGBTQ youth and elders be a priority for trauma related services. RCDMH divides the county into three regions which are Western, Mid-County, and Desert. Communities within each of the three regions of the county were identified as high need and will be the initial target demographic. The analysis of the data, provided by the RCDMH Research and Evaluation Unit resulted in the identification of priority communities within each service delivery region. Using the data listed above priority areas for the children, transition age youth, and adult populations in Western Region are: Rubidoux, CasaBlanca, Eastside, Arlanza, and Moreno Valley. The priority communities in Mid-County Region are: Lake Elsinore, San Jacinto, Perris, Winchester, Romoland and San Jacinto. The priority communities in Desert Region are: portions of the Coachella Valley, Mecca, East Side Banning, Indio, North Palm Springs, Desert Hot Springs, Cathedral City, and Blythe. For the older adult population, data identified different priority areas for each region. Priority areas in Western Region are: Rubidoux, CasaBlanca, Eastside, and Moreno Valley. The priority communities in Mid-County Region are: Winchester, Romoland and San Jacinto. The priority communities in Desert Region are: North Palm Springs, Desert Hot Springs,

Cathedral City, and Blythe. Service providers will be asked to identify the specific needs and populations of those that will be served, specific underserved cultural populations to be served, and specific outreach activities that will be utilized.

d.) Highlights of new or expanded programs.

Each of the identified programs is new to Riverside County Department of Mental Health.

Cognitive Behavioral Intervention in Schools (CBITS):

- Accurately identifies trauma exposed youth using an evidenced based screening tool
- Reduces stigma related to mental health services by providing the service at schools
- Provides service to the youth, caregivers, and the teachers

Safe Dates:

- Builds resiliency skills in youth
- Is portable so that youth in a variety of settings can attend the program
- Addresses individuals at high risk of trauma

Seeking Safety:

- Addresses issues related to trauma and substance abuse
- It can be implemented in an individual or group format allowing for flexibility to meet the needs of the individual receiving the service
- The manual allows for flexibility so the individuals can focus on the topics that most meet their needs

Trauma Recovery and Empowerment (TREM):

- TREM has been successfully implemented with diverse racial and ethnic populations in a range of settings
- There are specific interventions based upon the gender of the individual(s) receiving the service

Prolonged Exposure Therapy for Post Traumatic Stress Disorders:

- This program was designed for those who meet diagnostic criteria for Post Traumatic Stress Disorder
- This intervention has been shown effective with adult and older adult populations

PEI PROJECT SUMMARY

e.) Key milestones and anticipated timeline for each milestone.

- PEI plan approval by State DMH – Summer 2009
- Competitive Procurement Process – September ’09 – November ‘09
- Recruitment and hiring of appropriate staff – December ’09
- Training staff in evidence-based model (including cultural and linguistic needs of population) – January ’10
- Program implementation – February - June 2010

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	Individuals: Families:	Individuals: 432 Families:	10
Safe Dates	Individuals: 240 Families:	Individuals: Families:	10
Seeking Safety	Individuals: Families:	Individuals: 1260 Families:	10
Trauma Recovery and Empowerment (TREM)	Individuals: Families:	Individuals: 1152 Families:	10
Prolonged Exposure Therapy for PTSD	Individuals: Families:	Individuals: 600 Families:	10
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 240** **Families**:	**Individuals: 3,444** **Families**:	10

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

This Prevention and Early Intervention project will target youth, transition age youth, adults and older adults who have experienced traumatic events as well as youth who have, or are at risk of, experiencing dating violence. Through the implementation of the identified evidenced based practices within this project, there will be identification of needed support services and resources for those individuals receiving the services. RCDMH and project partners will ensure that an organized system of referrals is developed between community based organizations and County programs. The referral system will ensure that individuals served through the identified programs within this project are able to access services based upon their individual needs. The partners will be aware of up to date and accurate referral information.

This project will strengthen and rely upon ongoing referral mechanisms to link individuals who may need a mental health assessment and treatment to County Mental Health or other appropriate community providers. This project also has a goal of increasing the use of other needed community resources and project partners will also work with those receiving the programs in accessing those needed services, such as employment, housing, substance abuse, and domestic violence services.

6. Collaboration and System Enhancements

This PEI project provides multiple opportunities for collaboration and system enhancement. RCDMH will partner with community based organizations that have extensive knowledge and experience in working with individuals who have experienced trauma. This may include, but not be limited to, rape crisis centers, domestic violence shelters, homeless shelters, the Department of Public Social Services, and the County Office on Aging. Additionally, collaboration with youth serving organizations will be essential in implementation of those programs identified for youth. This may include, but not be limited to, schools, including elementary, junior, and high schools, community colleges and universities, and faith based organizations.

System enhancement will occur as each of the programs effectively reach into communities. Through awareness of trauma related symptoms and available services, individuals exposed to traumatic events will have the opportunity to receive services early and thus reduce the impact of the trauma.

All providers will be expected to leverage supports and provide in-kind resources. The infrastructure of the established community based organizations that will be the program providers allows for leveraging of provider time, space, utilities, and experience.

7. Intended Outcomes

The following outcomes apply to all programs within the Trauma-Exposed PEI project:

Person-Level outcomes

- Reduction of psycho-social impact of trauma by receiving early intervention
- Increased use of coping skills
- Reduction in substance use/abuse

System-Level outcomes

- Increased community awareness of traumatic events and identification of individuals in need of trauma related services
- Increased collaboration with community based providers
- Increased number of trauma related services to unserved and underserved cultural populations

Each of the evidence based practices identified in this project also includes specified outcome measures that will be used. In addition, specific measures will be developed in conjunction with providers in order to ensure collection of appropriate data and cultural and linguistic appropriateness.

8. Coordination with Other MHSA Components

Through implementation of the components of this project, it is anticipated that individuals and families will be identified as meeting criteria for additional mental health services. For those that can be served through the CSS Full Services Partnerships, PEI or other CSS services, referrals will be made and they will be assisted with needed linkage. In addition, individuals and families who may not meet criteria for a referral to a CSS program will be provided a referral and assisted with linking with other RCDMH or community based services that will meet their needs.

Through the Workforce, Education, and Training component of the MHSA, Riverside County has hired a University Liaison position in order to establish relationships with high schools, community colleges, and universities. The Liaison will assist service providers in connecting with schools to implement the school based programs.

9. Additional Comments (optional)

In accordance with the guidelines of the MHSA PEI component, Riverside County will be implementing many evidenced based practices. In order to adequately establish and sustain these programs a solid infrastructure is required. From the community planning process feedback, the need for infrastructure to provide thorough and supportive training, maintenance of skills for providers, and accountability across settings to ensure fidelity to the practices came through as necessary activities.

PEI PROJECT SUMMARY

It is important that evidence based programs are model adherent, that the core concepts and theoretical background are carried out in service delivery, and that guidelines for outcome (pre- and post- test) measures are accurately maintained. RCDMH will utilize clinical staff members to ensure that training in evidence-based practices is provided to all service providers. The Department will also assist the service providers in implementation of those evidenced based programs. The clinical staff will hold monthly team meetings with all practitioners of a particular model in order to maintain fidelity, provide clinical consultation, and practice skills required for implementation. The staff member will also assist with infrastructure stability at each site by guiding practitioners to maintain all needed materials and environment set-up. This will allow for greater adherence to the often stringent requirements of evidence-based practices as well as provide assistance to smaller organizations when staff turn-over impacts service delivery. Consistent training and coordination of needs will be available to all PEI programs within the County system as well as any partner agency delivering PEI programs.

PEI PROJECT SUMMARY
PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: RIVERSIDE Date: 06/30/09
PEI Project Name: 6 - TRAUMA-EXPOSED SERVICES FOR ALL AGES
Provider Name (if known): TBD
Intended Provider Category: MENTAL HEALTH TREATMENT/SERVICE PROVIDER

Proposed Total Number of Individuals to be served:	FY 08-09	N/A	FY 09-10	3,684
Total Number of Individuals currently being served:	FY 08-09	N/A	FY 09-10	N/A
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	N/A	FY 09-10	N/A
Months of Operation:	FY 08-09	N/A	FY 09-10	9

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages:			
	$0	$0	$0
b. Benefits and Taxes	$0	$0	$0
c. Total Personnel Expenditures	$0	$0	$0
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	$0	$0	$0
c. Non-Reoccuring Cost	$0	$79,489	$79,489
d. Total Operating Expenses	$0	$79,489	$79,489
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Providers to be Determined.	$0	$5,755,933	$5,755,933
a. Total Subcontracts	$0	$5,755,933	$5,755,933
4. Total Proposed PEI Project Budget	$0	$5,835,422	$5,835,422
B. Revenues (list/itemize by fund source)			
MediCal FFP	$0	$489,463	$489,463
Total Revenue	**$0**	**$489,463**	**$489,463**
C. Total Funding Requested for PEI Project	$0	$5,345,959	$5,345,959
D. Total In-Kind Contributions	$0	$0	$0

PEI PROJECT SUMMARY
PEI Revenue and Expenditure Budget Worksheet

County Name: RIVERSIDE Date: 06/30/09

PEI Project Name: 6 - TRAUMA-EXPOSED SERVICES FOR ALL AGES

Proposed Expenses and Revenues Narrative
A. Expenditure
1. Personnel
N/A
2. Operating Expenditures
c. Non-Reoccuring Cost: Estimated cost of Cognitive-Behavioral Intervention for Trauma in Schools, Safe Dates, Seeking Safety, Trauma Recovery and Empowerment (TREM), and Prolonged Exposure Therapy for PTSD Training, as well as program development.
3. Subcontracts/Professional Services
The Trauma-Exposed Services Program will include contracted services providing adolescents with curriculum on dating abuse prevention, trauma therapy to adults with a history of sexual and/or physical abuse, and group/individual therapy for those with trauma, post-traumatic stress disorder (PTSD) or substance abuse problems. Estimated annual cost covers contracted services including training, training materials, client materials, food, and a portion of the program's operating expenses.
4. Total Proposed PEI Project Budget
B. Revenues
New program generated Medi-Cal revenue.

PEI PROJECT SUMMARY

County: Riverside PEI Project Name: Underserved Cultural Populations Date: July 15, 2009

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	☐	☒	☒	☐

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	☐	☐		

PEI PROJECT SUMMARY

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

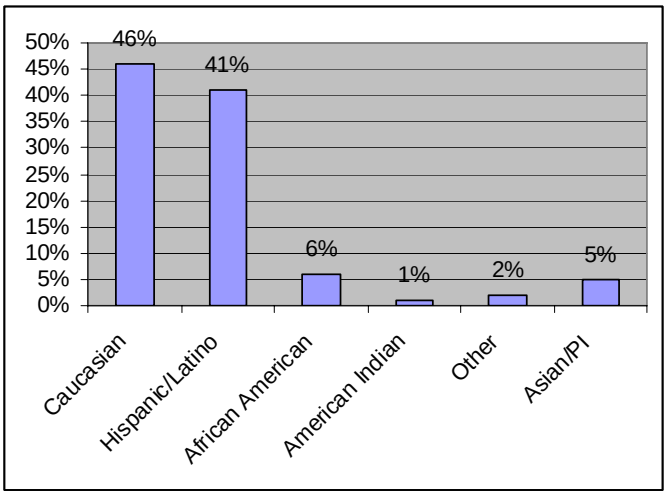
Stakeholder Input

"Historically unserved and underserved communities are those groups that either have documented low levels of access and/or use of mental health services, face barriers to participation in the policy making process in public mental health, have low rates of insurance coverage for mental health care, and/or have been identified as priorities for mental health services," (UC Davis Center for Reducing Health Disparities, 2008). Specific outreach into unserved, underserved, and inappropriately served ethnic/cultural communities was a priority during the community planning process. The community planning process included 108 focus groups and community forums, four age group committees (Children, Transition Age Youth (TAY), Adult, and Older Adult), three workgroups (Trauma, Reducing Disparities, and Reducing Stigma & Discrimination), and the PEI Steering Committee which included members from each of the committees and workgroups listed. In addition, 2,354 community surveys were completed and returned. All of the above listed resources, in addition to data collected through the Riverside County Department of Mental Health, Research and Evaluation Unit, were used to determine the priorities for this project. The Reducing Disparities Workgroup (RDW) was instrumental in identifying the underserved populations to target through implementation of PEI projects. The recommendations from the RDW are listed in attachment O-2, as well as the membership list of RDW in attachment K-2. The RCDMH PEI Team made concerted efforts, as with any of the committees and workgroups, to include key community leaders and stakeholders in membership in order to have a comprehensive assessment of needs and recommendations for the underserved cultural populations within Riverside County.

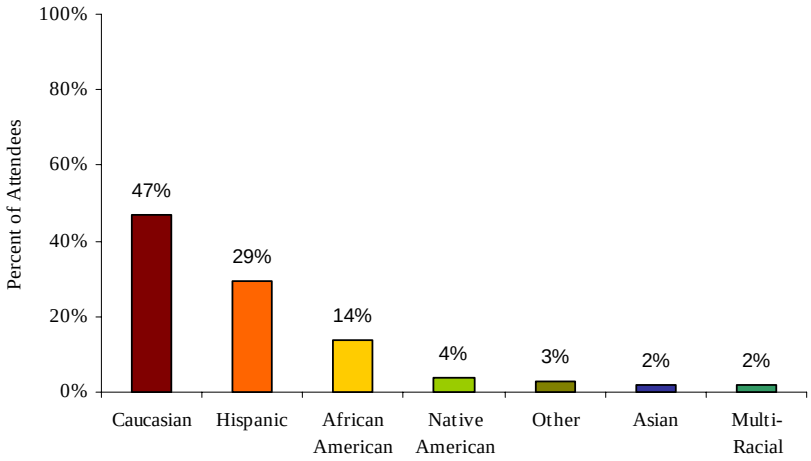
Data Analysis

The UC Davis Center for Reducing Health Disparities identified key considerations when engaging underserved communities under the Mental Health Services Act. Their report notes, "racial and ethnic minority groups are at increased risk for mental health problems given exposure to discrimination and racism as well as elevated levels of poverty and social and geographic isolation. Racism and discrimination are directly associated with psychological distress and major depression." RCDMH recognized the need to include and engage underserved populations in the community planning process so that the voice of the community could be heard and addressed through the implementation of prevention and early intervention services within the County. Riverside County is a diverse community and the ethnic make-up is demonstrated in the graph below.

PEI PROJECT SUMMARY



With the concerted outreach for focus group and community forum participation, representation reflected these efforts. The make-up of participants in focus groups and community forums is demonstrated in the graph below:



Ethnicity

Underserved cultural populations refer to those who are unlikely to seek help from any traditional mental health service because of stigma, lack of knowledge about mental health services, lack of suitability (i.e.: cultural competency) of traditional mainstream services, or other barriers (such as for members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, etc. as well as linguistic barriers: monolingual non-English speakers or limited English proficiency) . Improving access to mental health services for underserved communities and reducing

disparities in mental health across racial/ethnic and socioeconomic groups are key priorities of the MHSA. PEI projects can contribute to this goal through three major approaches:

- Providing culturally and linguistically competent and appropriate programs
- Facilitating access to PEI programs
- Improving individual and family outcomes of participants in PEI programs

Substantive data from consumer and family self-reports, ethnic match, and ethnic-specific services outcome studies suggest that tailoring services to the specific needs of these groups will improve utilization and outcomes (Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General, 2001). In particular, adaptation of messages to underserved ethnic, racial and cultural populations is necessary for successful interventions. Feedback from focus groups, committees and workgroups support this:

Focus Groups

- "Culturally based services teaching and emphasizing culture."
- "Cross-cultural cohesiveness/education increase evidenced based programs for minorities cultural sensitivity."
- "Evidence based programs including ethnic minorities."
- "Parent education that is culturally tailored (SPIRIT Incredible Years)"
- "Distribute pamphlets for parents in English and Spanish with a checklist of symptoms of mental illness and drug abuse."
- "Outreach centers in low income communities outreach workers…"
- "Better outreach to the Spanish-speaking community through the schools, church and media about available services and program."

Community Surveys

- "Be culturally aware – people respond better to those they are familiar with (go into communities)."
- "Early intervention and cultural understanding based on high Hispanic population in a rural setting."
- "There must be counselors that reflect the identity of those they counsel. The last thing many of us need is one more straight white middle class professional 'servicing' us."
- "More bi-lingual professionals."
- "Language barriers – need information in Spanish."

The Reducing Disparities Workgroup (RDW) was formed and the membership reflected the diversity of the community of Riverside County and included community leaders,

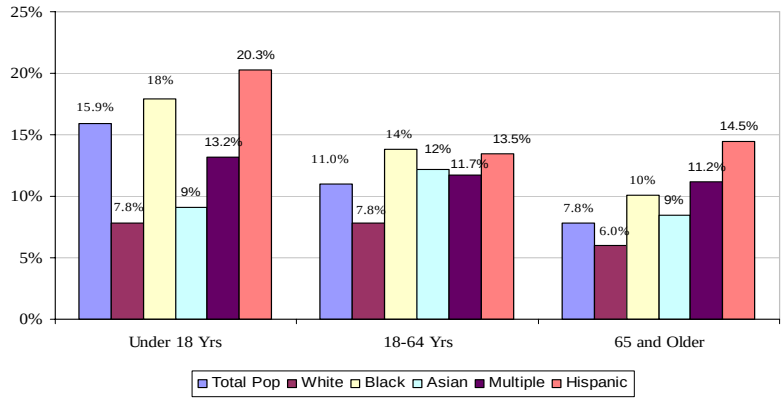
community based and faith based organizations, public agencies, consumers and family members, and members of unserved and underserved ethnic and cultural populations. The goals of the Workgroup were to provide feedback to ensure that County Mental Health efforts to reduce mental health disparities are integrated into the PEI plan and to prioritize PEI related activities for specific unserved and underserved populations. Members of the Workgroup met with key community leaders as well as community members of specific underserved populations and worked with those leaders and community members to develop PEI recommendations. The Workgroup participants had an opportunity to meet, conduct focus groups, and conduct interviews with key leaders in the community. Through this process, specific recommendations were developed for the unserved and underserved ethnic and cultural populations. In addition to recommendations for specific unserved and underserved cultural populations, the workgroup also developed general recommendations for reducing disparities in accessing PEI services. Some of the specific recommendations identified below are addressed in the Mental Health Outreach, Awareness, and Stigma Reduction Project.

- Native American:
    1. Culturally-Tailored evidence-based parenting
    2. School drop out prevention program
    3. Traditional healing blended with mainstream education regarding stress reduction, substance abuse and mental health disorders
- African American:
    1. Development of community based youth and family optimal wellness programs directed by and delivered by African American community based providers in a community setting
    2. Long term investment in African American community partnership with DMH & MHSA through development of a culturally competent African American outreach component, including but not limited to a funded African American outreach coordinator, through the development and implementation of a culturally competent community based education and awareness initiative
- Latino/Hispanic:
    1. Develop and fund a Promotores de Salud program
    2. Develop and fund Accessibility to MH services program
    3. Increase funding to support and integrate Mental Health activities with local cultural community activities
- Asian American:
    1. Develop resources in different languages that are simple and understandable
    2. Greater outreach to the Asian community at community centers, faith/spiritual groups, cultural festival and fairs, adult schools, etc.

3. Integrate mental health into useful and relevant topics such as stress management, stress relief, well-being, wellness, etc. and not so much on MH services. Help to build "better" family relationships

The Underserved Cultural Population project is designed to address specific minority groups that have been identified through the Riverside County PEI community planning process. The prevention of mental illness hinges on the identification of modifiable risk and protective factors. A guiding principle of the MHSA is to identify and address the needs of the underserved cultural populations that is, focus on the risk and protective factors that disproportionately affect racial and ethnic minorities. Such risk factors include poverty, immigration, violence, racism, and discrimination, whereas protective factors include spirituality and community and family support, (Surgeon General Report, 2001). Poverty disproportionately affects racial and ethnic minorities. It is known that people living in poverty, regardless of race or ethnicity, have the poorest overall health (Krieger, 1993; Adler et al., 1994; Yen & Syme, 1999). It then stands to reason that poverty is also linked to poorer mental health. Studies have consistently shown that people in the lowest strata of income, education, and occupation (known as socioeconomic status, or SES) are two to three times more likely than those in the highest strata to have a mental disorder (Holzer, et al., 1986; Regier et al., 1993; Muntaner et al., 1998). They are also more likely to have higher levels of psychological distress (Eaton & Muntaner, 1999). For Riverside County, the following graph shows poverty and ethnicity for our population.

Population Below Poverty Level by Race/Ethnicity and Age



Source: U.S. Census Bureau, 2005-2007 American Community Survey
Note: White, Black and Asian are Non-Hispanic single race, data for Native American, Native Alaskan, Pacific Islander, and some other race were unavailable.

The Presidents' New Freedom Commission on Mental Health (2003) stated "resilience means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses – and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by a positive childhood and includes positive individual

traits, such as optimism, good problem-solving skills, and treatments. Closely-knit communities and neighborhoods are also resilient, providing supports for their members." Much research about the prevention and early intervention of mental illness centers on building resilient traits in individuals. Building resiliency focuses on increasing protective factors. In minority communities these protective factors are supportive families, strong communities, spirituality, and religion. The evidence-based practices selected for implementation in Riverside County all work to increase resiliency in the individuals participating in the programs.

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

a.) 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 program planning process.

Through the process of conducting a comprehensive scientific review for the Supplement to Mental Health: A Report of the Surgeon General, and with recognition that mental illnesses are real, disabling conditions affecting all populations regardless of race or ethnicity, the Surgeon General has determined that disparities in mental health services exist for racial and ethnic minorities, and thus, mental illnesses exact a greater toll on their overall health and productivity (U.S. Department of Health and Human Services, 2001). This is the foundation for the MHSA Prevention and Early Intervention mission to address the needs of ethnic and cultural minorities.

There is consensus from Riverside County data as well as from community feedback (including stakeholders, key community leaders, and community members at large); that the largest minority ethnic/cultural group is the Hispanic/Latino population and it is also agreed that this population is largely underserved. Therefore, all of the Riverside County Prevention and Early Intervention plan projects will aim to work with this population by utilizing targeted outreach to the Hispanic/Latino community in order to increase access to mental health services and reduce the disparity that currently exists in the County. As noted in previous projects, all evidence based practices chosen for this plan have shown effectiveness with one or more cultural populations, with evidence for Hispanic individuals shown for almost all of the evidence based practices selected.

The Underserved Cultural Populations project will highlight evidence based practices that were developed specifically for the cultural population identified. The cultural populations selected for a specific PEI project/program were a direct result of the PEI community planning process. RCDMH built upon the Community Supports and Services Outreach and Engagement project which included targeted outreach to the Hispanic/Latino community, the Native American community, the Asian American/Pacific Islander community and the LGBTQ community. These cultural groups were very involved during the PEI community planning process and made recommendations for appropriate services for their population. Additionally, the African American community had a prominent role in the PEI community planning process. While data shows that the African American population is over-represented within the

Department, feedback from the community, along with national and local data, suggest this population is inappropriately served. Therefore, PEI services are imperative to address the unique needs of the African American population which include distrust of the mental health system and government agencies, and to intervene in communities with high risk factors for the development of mental illness due to the stressors associated with poverty and impartial discipline policies. Although there is not a specific LGBTQ evidenced based practice, there was recognition throughout the community planning process that LGBTQ individuals, from adolescents to older adults, are an underserved population. Several of the PEI projects clearly state the needs of the LGBTQ community and that engagement and participation of individuals and families from that population in the PEI programs will be a priority. Those projects are the Mental Health Outreach, Awareness, and Stigma Reduction Project; the Transition Age Youth Project; the First Onset for Older Adults Project; and the Trauma-Exposed Services for All Ages Project.

The State identified Key Community Mental Health Needs addressed in this project are: Disparities in Access to Mental Health Services; At Risk Children, Youth and Young Adult Populations; Stigma and Discrimination; and Suicide Risk. The Priority Populations addressed in this project are: Children/Youth in Stressed Families; Children/Youth at Risk for School Failure; and Underserved Cultural Populations.

The PEI Steering Committee selected evidence based practices and other prevention and early intervention programs to serve the underserved ethnic/racial populations listed below. Program implementation will also provide additional activities as needed, such as consultation, screening, and training on mental health issues.

- **Hispanic/Latino Culture** –

  In 2007, the Public Policy Institute of California reported that, “fertility rates are higher in California than in any developed country in the world. This is partly due to the composition of the state’s population, which includes large numbers of foreign-born women, who tend to have more children than U.S.- born women. Thus, in addition to its direct contribution to state growth, migration also plays an important indirect role in its fertility rates.” “Approximately 10%-15% of new mothers develop clinically significant depressive symptoms, commonly known as postpartum depression. Maternal depression places children of all ages at high risk for psychopathology in general, and for depressive disorders in particular. Because pregnancy is generally a period of increased contact with health care professionals, it is an ideal time to intervene to prevent the deleterious effects of post-partum depression” (Munoz, et al. 2007). In the Community Supports and Services plan RCDMH outlined an initiative to participate in the Women’s Mental Health Champions Project through the Women’s Mental Health Policy Council in order to better understand the specialized needs of women. Through this endeavor, and utilizing the data of the County, gender specific programs have been identified to address the Hispanic/Latina population. The following programs target women and some of their specific needs.

- **Mamás y Bebés (Mothers and Babies):** This is a manualized 12-week mood management course during pregnancy (women who are between 12 to 32 weeks pregnant) with post partum booster sessions at 1, 3, 6, and 12 months post-partum. It is an adapted model from the Depression Prevention Course and Cognitive Behavioral Treatment manuals. The manual was designed to address the socio-cultural issues relevant to a low-income, culturally diverse population. The purpose is to teach participants to recognize which thoughts, behaviors, and social contacts have influence on their mood, the effect of mood on health, and the benefits of strengthening maternal-infant bonding. Significant and targeted outreach will be done through the use of the Promotores de Salud (as outlined in the Mental Health Outreach, Awareness and Stigma Reduction Project). The group model appears to be "culturally congruent with the collectivist nature of the Latino culture and can provide mutual support among group members, and decrease stigma associated with mental health problems," (Munoz, et al., 2007). This program has also shown effectiveness with African American women.

- **Cognitive-Behavioral Therapy (CBT) for Depression (with antidepressant medication):** This program was developed for use with low-income Latina women. It uses an adapted format of CBT to address cultural issues associated with the Hispanic culture. There is considerable evidence that CBT, alone or in combination with medication, is effective in the treatment of Major Depression. The use of Promotores de Salud is a key element in the engagement of the Latina women. Mental Health workers trained through the Promotores de Salud model are from the targeted community and are able to outreach to and engage with the women within the culture of their community. Antidepressant medication is also a component of the program and used in conjunction the CBT show a decrease in depression and an improvement in overall functioning.

- **African-American** –

The African-American project was designed with key community leaders within the African-American community. Some of the concerns from community members in Riverside County include:

- Lack of prevention programs at neighborhood level
- Lack of education and knowledge regarding resources
- Department of Mental Health staff's (and other agencies) stigma about the community (approach community with fear)
- Constant stress and fear of surviving in the community
- Inability or unwillingness of DMH staff to identify/address mental illness that can be attributed to internalizing prejudices
- Inability to work with consumers where they are
- Lack of adequate child/youth services

PEI PROJECT SUMMARY

RCDMH has a commitment to serving all underserved cultural populations within Riverside County and has a desire to address the needs of the African-American community in order to provide appropriate and adequate resources and programming. According to a nationally representative survey (Pescosolido et al., 2000), at times of adversity, people turn to family and friends for support and when mental illness develops family and friends are sought out for help first. Researchers have identified 10 characteristics of resilient African American families:

1. Strong economic base
2. Achievement orientation
3. Role adaptability
4. Spirituality
5. Extended family bonds
6. Racial pride
7. Respect and love
8. Resourcefulness
9. Community involvement
10. Family unity (Gary et al., 1983)

A literature review on African American children raised in inner-city neighborhoods concluded that, "there was at least one adequate significant adult who was able to serve as an identification figure. In turn, the achieving youngsters seemed to hold a more positive attitude towards adults and authority figures in general," (Garmezy & Neuchterlein, 1972). For urban elementary students chronically exposed to violence, support of teachers enhanced their social competence in the classroom, as did support from peers and family. Family support was also critical in relieving the children's anxiety (Hill & Madhere, 1996; Hill et al., 1996). With this in mind, it is clear that a program targeting the African American community offered in a natural community setting is essential. Three approaches have been identified to specifically serve the African American community of Riverside County:

- **Effective Black Parenting Program (EBPP):** The EBPP was originally developed for parents of African American children aged 2 to 12. Most of its evaluation studies have been conducted with this population. However, since beginning the national dissemination of the program in 1988, the program has been successfully used with teenage African American parents and their babies, and with African American parents of adolescent children. Thus, its widespread usage has been with parents whose children range from 0 to 18. The complete EBPP consists of fourteen 3-hour training sessions and a graduation ceremony. The complete program is usually taught for small groups of parents (8 to 20). A briefer version of the EBPP is also available (a one-day seminar version) which is taught with large numbers of parents (50 to 500). This is a cultural adaptation of the Confident Parenting Program. It

includes: culturally specific parenting strategies; general parenting strategies; basic parenting skills taught in a culturally-sensitive manner using African American language expressions and African proverbs; and special program topics such as single parenting and preventing drug abuse. The ideal instructor is an African American with a positive ethnic identification, and with a background in child development, African American studies, behavior modification, and group processes. Upon implementation, the weekly parent group will be facilitated by a clinician who will also offer one-day seminars throughout the year. Identified parents who complete the small group program will be provided training to facilitate one day seminars in their communities. A stipend will be offered to parents who facilitate the one-day seminars. Utilizing parents and community members to facilitate seminars will increase the cultural competence of the program, reduce disparities, and build community assets.

- **Africentric Youth and Family Rites of Passage Program**: This program developed by the MAAT Center for Human and Organizational Enhancement, Inc. of Washington, D.C. is designed for African American male youth between ages 11 and 15. The goal of the MAAT program is empowerment of black adolescents through a nine-month rites of passage program. Youth can be referred from a variety of places including courts, mental health, and schools. The program provides a multi-faceted, therapeutic intervention to 15-member youth groups. The first eight weeks are an orientation for the youth, the parents, and the referring agency personnel. A major component of the program is the afterschool program, held for two hours, three days per week. It offers modules on knowledge and behaviors for living; module topics include manhood development, sexuality, and drugs. Modules on creative arts, math, and science are also offered. After each module is completed, the youth develop topic-related projects, such as the production of culturally oriented T-shirts, anti-substance abuse buttons, videotapes, and concerts. For effective prevention, all programming activities need to be interesting and prosocial so that youth are engaged and benefit from the resiliency building aspects of the activity. Family and caretaker involvement is stressed in this program. Family enhancement and empowerment buffet dinners are held monthly. The objective of the dinners is to empower adults to advocate on behalf of their children and families and to work toward community improvement. The dinner conveys to parents that they are valued and that the program is hospitable and nurturing. This message is necessary because initially most parents distrust the MAAT program because of previous negative experiences with human services organizations. Staff demonstrate their caring to parents through ongoing outreach and communication. Another component of the program includes casework and counseling with linkage to needed services. The staff includes a clinical social worker as well as non-professionals who can provide formal, informal, and crisis counseling. Outreach is an essential component to engage the students and families as

well as maintain them in the program. Staff outreach via telephone and transportation to and from the program (Harvey et al., 1997).

- **Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)** – The CBITS program is a cognitive and behavioral therapy group intervention for reducing children's symptoms of Post Traumatic Stress Disorder (PTSD) and depression caused by exposure to violence that has been used successfully in inner city schools with multicultural populations. CBITS has shown cultural evidence for African American youth. CBITS has three main goals: to reduce symptoms related to trauma, to build resilience, and to increase peer and parent support. CBITS was designed for use in schools, but can also be implemented in a community setting, for children ages 10-14 who have had substantial exposure to violence and who have symptoms of PTSD in the clinical range. Treatment includes group with 5-8 students for 10 sessions along with 1-3 individual sessions, two parent education classes, and a teacher informational meeting.

- **Native American** –

According to U.S. Census data, Native American & Alaskan Natives have the highest percentage of poverty in the United States at 26% compared to 13% for the United States as a whole and 8% for white Americans. According to Dr. Renda Dionne, Native American consultant for RCDMH, there is a perception that many American Indians residing in Riverside County are wealthy. In fact, gaming wealth is the exception and 19% of American Indians live below poverty. The long history of discrimination and poor treatment from the government has created many risk factors for this population.

Although little is known about rates of psychiatric disorders among American Indians and Alaskan Natives in the United States, a recent study reported much higher rates of frequent distress – nearly 13 percent compared to nearly 9 percent in the general population, which suggest that American Indians and Alaskan Natives experience greater psychological distress than the overall population (Centers for Disease Control and Prevention, 1998). In the CSS plan, RCDMH outlined steps to be taken to build strong relationships and clearly understand the needs of ethnic groups in the County. As a result, a consultant for the Native American community was utilized to establish relationships and work jointly on the mental health needs of this population. The consultant was also a member of the Reducing Disparities Workgroup and was instrumental during the PEI community planning process in organizing focus groups and providing feedback for the Native American community in Riverside County. Parenting programs, school drop out prevention, and substance use prevention were the primary recommendations that came out of the community planning process for this ethnic population. Evidence based programs have been selected and are listed below:

PEI PROJECT SUMMARY

- **Incredible Years – Native American adaptation (SPIRIT):** Incredible Years is a set of comprehensive, multifaceted, and developmentally based curricula targeting 2-12 year old children, their parents, and teachers. The parent training intervention focuses on strengthening parenting competencies and fostering parents' involvement in children's school experiences to promote children's academic and social skills and reduce delinquent behaviors. The model was developed as a group intervention; however SPIRIT is a culturally-tailored evidence-based practice that was adapted by Dr. Renda Dionne for the Riverside County American Indian community. The adaptation is a 15 week in home parenting program for children ages 0-11 years old.

- **Guiding Good Choices (GGC)**: GGC is a prevention program that provides parents of children in grades 4 through 8 (9-14 years old) with the knowledge and skills needed to guide their children through early adolescence. It seeks to strengthen and clarify family expectations for behavior, enhance the conditions that promote bonding within the family, and teach skills that allow children to resist drug use successfully. Due to the historical trauma within Native American populations, substance abuse is inextricably linked with the development of depression and major mental illness, including Bi-Polar Disorder and Post Traumatic Stress Disorder. Therefore a program to address substance abuse prevention is essential in addressing the prevention of mental health problems. This family group intervention is a five-session curriculum that addresses preventing substance abuse in the family, setting clear family expectations regarding drugs and alcohol, avoiding trouble, managing family conflict, and strengthening family bonds. This program can be adapted to be implemented in-home with individual families. Sessions are interactive and skill based, with opportunities for parents to practice new skills and receive feedback, and use video-based vignettes to demonstrate parenting skills.

In addition, the Native American community will benefit from the services which will be implemented through the Mental Health Outreach, Awareness and Stigma Reduction Project. Through this project, the Ethnic and Cultural Community Leaders in a Collaborative Effort for the Native American community (see the MH Outreach, Awareness and Stigma Reduction project), will outreach to key community leaders within the Native American communities to develop mental health specific materials related to the needs of this population. Effective outreach strategies will also be developed to reduce stigma related to mental health and increase engagement in services. The work that has been done through Dr. Dionne thus far will continue and evolve into the coordination of community activities such as Pow-Wow's and the Gathering of Native Americans (GONA).

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- **Asian American/Pacific Islander (AA/PI) –**

In Riverside County in 2005, the Asian American Population made up 4% of the total population. By 2008 the percentage of Asian Americans in Riverside County increased to 5% and that figure is expected to be maintained through 2011. There continue to be unmet needs in Riverside County for this community and greater outreach and engagement in prevention and early intervention activities is needed.

In the CSS plan, RCDMH outlined steps to be taken to build strong relationships and to clearly understand the needs of ethnic groups in the County. As a result, the Outreach and Engagement Program and the Riverside Asian American Community Association (RAACA) worked together to initiate the evaluation of mental health needs of the Asian American population living in Riverside County. RAACA assisted in the development and implementation of an Asian American Survey in 4 languages identified as the most common languages: Thai, Lao, Vietnamese, and Chinese (standard and traditional). The survey was distributed at the Asian American Health Conference in 2008. The survey examined factors including: emotional history, preferred language for services, perceived risk of emotional issues, and preferred assistance and levels of comfort in receiving mental health services. The RCDMH Cultural Competency/Ethnic Services Manager, Myriam Aragon, worked closely with RAACA during the PEI community planning process, in coordination with individual experts' interviews, to obtain information on the mental health needs of the Riverside County Asian American community. Building "better" family relationships, stress relief, well-being, and wellness programs were the primary recommendations. Data from RAACA showed that, of the AA/PI community in Riverside County, the target ethnic/cultural population is of Southeast Asian descent including Vietnamese, Laotian, and Cambodian. In addition, the ethnic/cultural make-up of the AA/PI in the County includes Chinese and Korean. The following program was selected for service delivery to the AA/PI community:

- **Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF): A Curriculum for Immigrant Families** – This is a selective prevention intervention. The target populations of the SITIF program are immigrant parents and/or caregivers with inadequate parenting skills to effectively discipline and nurture their children. The primary strategies of the three components of the program are: (1) Community Education/Outreach Workshops: these are one-time workshops on effective bi-cultural parenting and family management. The workshops help demystify the stigma associated with parenting classes and mental health issues, provides tips to parents, and are an effective recruitment strategy; (2) Bicultural Parenting Class Series: This is a 10-week, culturally competent, skill-based, interactive, and manualized parenting and family management curriculum to the target parents and/or primary caregivers once a week for 2 hours per week in a group format; (3) Family Support Service Linkage: When parents indicate additional need for mental health and/or other social services, staff provide consultation and linkages to linguistically and culturally

competent community service entities. The curriculum has been applied to immigrant parents of various ethnic origins. The curriculum has various language versions including Chinese and Vietnamese. The intervention uses a team approach with 2 Parent/Family Specialists who are bi-lingual in the language of the immigrant families they work with. They will conduct the parenting curriculum and provide consultation on an as needed basis. The team also works in the capacity of a community organizer to serve as a liaison between the program and the community. They have a good understanding of the local community and immigrant experience and are able to network with people and recruit them to the program. The activities are delivered at locations that are natural congregation places for the immigrant families such as schools, community service delivery settings, community-based and culturally competent behavioral healthcare center.

The Asian American community will also benefit from the programs in other projects of the PEI plan. The Asian American Ethnic and Cultural Community Leaders in a Collaborative Effort (described in the Mental Health Outreach, Awareness, and Stigma Reduction Project) will outreach to key community leaders within the Asian American communities to develop mental health specific materials related to the needs of this population. Effective outreach strategies will also be developed to reduce stigma related to mental health and increase engagement in services. This community will have access to all of the other PEI services available in their community.

b.) Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

One of the State identified PEI Key Community Mental Health Need is to reduce disparities in access to mental health services. The Underserved Cultural Population Project will address this need by partnering with agencies throughout Riverside County to implement each of the racial/ethnic group programs that specifically work with, and outreach to, the identified racial/ethnic groups. The evidence based practices and interventions used are culturally-tailored and in order to adequately implement each of the programs the lead agency must know the culture and have a stake in the community they serve. Therefore, it is essential that these programs be delivered in community-based and/or faith-based organizations within the identified cities/neighborhoods as revealed through the extensive data evaluation completed during the community planning process. In order to achieve this, potential partners may include, but not be limited to, The Latino Commission, The Latino Network, The Dubois Institute, Community Health Agency: Infant Black Health Program, Indian Child and Family Services, Riverside-San Bernardino County Indian Health, and the Riverside Asian American Community Association. The Ethnic and Cultural Community Leaders in a Collaborative Effort will assist in the identification of additional partners. This method of implementation addresses

the community mental health need identified by the State, but more importantly, addresses the recommendations and voice of the Riverside County community members and stakeholders who were an integral part of the PEI community planning process.

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

Research shows that poverty and ethnicity, when combined, increases the risk of developing mental illness. This is most often related to an increase in community violence and a lack of community resources. Data provided by the RCDMH Research and Evaluation Unit provided data related to these factors and were instrumental in identification of communities at highest risk for the Hispanic/Latino and African American populations.

Hispanic/Latino – This population is Riverside County's largest racial/ethnic minority group. Specific locations within each regional service delivery area have been identified through the data with a high density of Hispanic population and areas of poverty, as these are indicators of risk for the development of mental illness. The communities identified for Western Region are: Rubidoux, East Side, Arlanza, and Moreno Valley. The communities identified for Mid-County Region are: Lake Elsinore, San Jacinto, and Perris. The communities identified for Desert Region are: portions of the Coachella Valley, Desert Hot Springs, and Eastside Banning. There are many community and faith based organizations (such as the Latino Commission, churches, community centers) that serve the Hispanic population and collaborating with these organizations within the local community setting of those being served will decrease access disparities, reduce stigma, and increase the likelihood that community members will participate in services.

African American – This population is the second largest minority ethnic/cultural population in Riverside County. There are community and faith based organizations that serve the African American population. RCDMH will partner with these agencies to offer services within a trusted community setting. Collaborating with these organizations within the local community setting will reduce access disparities, reduce stigma, and build trust within the African American community by following through with recommendations that came forward with strength from key community leaders in the community planning process. The communities identified for Western Region are: Rubidoux, East Side, Arlanza, and Moreno Valley. The communities identified for Mid-County Region are: Lake Elsinore, San Jacinto, and Perris. The communities identified for Desert Region are: Coachella Valley, Desert Hot Springs, and Eastside Banning.

Native American – Riverside County has a large and diverse American Indian population. It is home to 31,948 American Indians, which is 1.4% of the Riverside County population (Census 2000). Approximately 15% of the American Indians are

from the 11 local tribes located within Riverside County. American Indian reservations in Riverside County are located in the Mid-County and Desert regions of the Department of Mental Health. There are tribal schools, both middle and high school, in the Western and Mid-County Regions. As stated earlier, there are also several agencies that serve American Indians in the County who would be natural partners for implementation of these programs.

Asian American/Pacific Islander – RCDMH is committed to follow the recommendations set forth through the Reducing Disparities Workgroup regarding the AA/PI community in Riverside County which are to build relationships and increase outreach and engagement in mental health services. The Department will partner with the Riverside Asian American Community Association (RAACA) to locate populations of Asian Americans as well as natural settings where families gather. This will allow for an opportunity to establish relationships and outreach to community members and families for engagement in prevention and early intervention services. Service delivery will take place in safe and familiar community settings including community and faith based organizations that serve the Asian American community.

d.) Highlights of new or expanded programs.

Each of the evidence based practices listed in this project are new to Riverside County with the exception of the Incredible Years Program. While RCDMH offers the Incredible Years children and parenting programs in school-based and outpatient clinic-based (respectively) settings, the Native American adaptation, SPIRIT, is an expansion into this underserved community by partnering with an organization that serves Native American children and families.

Mamás y Bebés (Mothers and Babies) –
- Culturally-tailored perinatal group
- Increases coping and problem-solving skills
- Addresses and decreases post-partum depression

Cognitive-Behavioral Therapy with antidepressant medication –
- Decreases depressive symptoms and improves functioning
- Utilizes Promotores de Salud to increase access to mental health services
- Reduces risk of suicide in Hispanic women

Effective Black Parenting –
- Culturally-tailored parenting intervention
- Can be provided by community leaders
- Enhances family relationships

PEI PROJECT SUMMARY

Africentric Youth and Family Rites of Passage Program –
- Addresses specific needs of African American youth
- After school program that increases resiliency
- Increases positive connection to the community

Cognitive-Behavioral Intervention for Trauma in Schools –
- Small group format
- Addresses trauma as a result of community violence exposure early
- Increases social competencies and problem-solving skills

Incredible Years (SPIRIT) –
- Culturally-tailored approach
- Increases effective parenting skills
- In-home services increase access to mental health services

Guiding Good Choices –
- Increases family involvement that is rewarding and enhances parent and child bonds
- Encourages consistent and moderate discipline
- Teaches parents skills that help mitigate the risk factors associated with drug abuse

Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF): A Curriculum for Immigrant Families –
- Culturally and linguistically competent
- Increases parental skills and enhances parent-child relationship
- Selected prevention targets children who feel "trapped" between two cultures and reduces their risk of developing behavioral and emotional problems

e.) Key milestones and anticipated timeline for each milestone.

- PEI plan approval by State DMH – Summer 2009
- Competitive Procurement Process – September '09 – November '09
- Recruitment and hiring of appropriate staff – December '09
- Training staff in evidence-based model (including cultural and linguistic needs of population) – January '10
- Program implementation – February - June 2010

PEI PROJECT SUMMARY

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Mamás y Bebés (Mothers and Babies)	Individuals: Families:	Individuals: 480 Families:	10
Cognitive-Behavioral Therapy w/ antidepressant medication	Individuals: Families:	Individuals: 180 Families:	10
Effective Black Parenting	Individuals: 1800 Families:	Individuals: Families: 120	10
Cognitive-Behavioral Intervention for Trauma in Schools	Individuals: Families:	Individuals: 54 Families:	10
Africentric Youth and Family Rites of Passage Program	Individuals: 60 Families:	Individuals: Families:	10
Incredible Years - SPIRIT	Individuals: Families:	Individuals: 60 Families:	10
Guiding Good Choices	Individuals: 100 Families:	Individuals: Families:	10
Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF): A Curriculum for Immigrant Families	Individuals: Families:	Individuals: 100 Families:	10
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 1,960** **Families**:	**Individuals: 994** **Families**:	10

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

The Underserved Cultural Populations project will provide culturally-tailored prevention and early intervention services in natural settings for the identified ethnic/cultural populations noted above and were selected based upon the data reviewed during the community planning process. As individuals and families are identified, assessed and provided services providers will be expected to address all needs that are presented. This can be accomplished through accurate and relevant referral to more intensive mental health services if needed, as well as additional community supports including substance abuse treatment, domestic violence or sexual violence prevention and intervention and basic needs including healthcare.

6. Collaboration and System Enhancements

This multi-faceted project involves several natural settings as the location for services provided. In this regard, collaborative relationships will be built and nurtured in order to establish and maintain effective prevention and early intervention services in the community that best serve the identified populations. A natural by-product of this project is the system enhancement to RCDMH of providing services to historically unserved, underserved, and inappropriately served communities. The system enhancement includes increased trust from the community, an increase in appropriate, culturally and linguistically competent services in communities, and opportunities for stronger relationship building with key community leaders. In this project collaborative efforts will be made with healthcare providers, e.g.: neighborhood clinics as well as family resource centers, community centers, and culturally-specific agencies. In addition, collaboration will occur with a community based organization that has developed a Perinatal Task Force.

7. Intended Outcomes

Person-Level outcome

- Decreased depressive symptoms and improved functioning (Hispanic programs)
- Improved parenting
- Fewer behavioral problems in children
- Increased resilient traits

System-Level outcome

- Decreased stigma associated with mental health services
- More prevention and early intervention services provided in non-traditional settings
- Enhanced use of ethnic/cultural community partners
- Enhanced quantity and quality of co-operative relationships with other organizations and systems

Each of the evidence based practices identified in this project also includes specified outcome measures that will be used. In addition, specific measures will be developed in conjunction with providers in order to ensure collection of appropriate data and cultural and linguistic appropriateness.

8. Coordination with Other MHSA Components

Providing prevention and early intervention services in natural community settings will reduce stigma associated with mental health services and reduce access disparities, and as a result, engage community members that may not have otherwise had contact with the County Department of Mental Health. With this in mind, there will likely be individuals and/or families identified who will require additional and more intensive services. Therefore, linkage and referral to other MHSA programs will be important to provide a continuum of care. For those that can be served through the CSS Full Services Partnerships, PEI or other CSS services, referrals will be made and they will be assisted with needed linkage. In addition, individuals and families who may not meet criteria for a referral to a CSS program will be provided a referral and assisted with linking with other RCDMH or community based services that will meet their needs.

9. Additional Comments (optional)

In accordance with the guidelines of the MHSA PEI component, Riverside County will be implementing many evidenced based practices. In order to adequately establish and sustain these programs a solid infrastructure is required. From the community planning process feedback, the need for infrastructure to provide thorough and supportive training, maintenance of skills for providers, and accountability across settings to ensure fidelity to the practices came through as necessary activities.

It is important that evidence based programs are model adherent, that the core concepts and theoretical background are carried out in service delivery, and that guidelines for outcome (pre- and post- test) measures are accurately maintained. RCDMH will utilize clinical staff members to ensure that training in evidence-based practices is provided to all service providers. The Department will also assist the service providers in implementation of those evidenced based programs. The clinical staff will hold monthly team meetings with all practitioners of a particular model in order to maintain fidelity, provide clinical consultation, and practice skills required for implementation. The staff member will also assist with infrastructure stability at each site by guiding practitioners to maintain all needed materials and environment set-up. This will allow for greater adherence to the often stringent requirements of evidence-based practices as well as provide assistance to smaller organizations when staff turn-over impacts service delivery. Consistent training and coordination of needs will be available to all PEI programs within the County system as well as any partner agency delivering PEI programs.

PEI PROJECT SUMMARY
PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: RIVERSIDE Date: 06/30/09
PEI Project Name: 7 - UNDERSERVED CULTURAL POPULATIONS
Provider Name (if known): TBD
Intended Provider Category: ETHNIC OR CULTURAL ORGANIZATION

Proposed Total Number of Individuals to be served:	FY 08-09	N/A	FY 09-10	3,314
Total Number of Individuals currently being served:	FY 08-09	N/A	FY 09-10	N/A
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	N/A	FY 09-10	N/A
Months of Operation:	FY 08-09	N/A	FY 09-10	9

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages:			
	$0	$0	$0
b. Benefits and Taxes	$0	$0	$0
c. Total Personnel Expenditures	$0	$0	$0
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	$0	$0	$0
c. Non-Reoccuring Cost	$0	$163,966	$163,966
d. Total Operating Expenses	$0	$163,966	$163,966
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Providers to be Determined.	$0	$3,145,522	$3,145,522
a. Total Subcontracts	$0	$3,145,522	$3,145,522
4. Total Proposed PEI Project Budget	$0	$3,309,488	$3,309,488
B. Revenues (list/itemize by fund source)			
MediCal FFP	$0	$351,171	$351,171
Total Revenue	**$0**	**$351,171**	**$351,171**
C. Total Funding Requested for PEI Project	$0	$2,958,317	$2,958,317
D. Total In-Kind Contributions	$0	$0	$0

PEI PROJECT SUMMARY
PEI Revenue and Expenditure Budget Worksheet

County Name: RIVERSIDE Date: 06/30/09

PEI Project Name: 7 - UNDERSERVED CULTURAL POPULATIONS

Proposed Expenses and Revenues Narrative
A. Expenditure
1. Personnel
N/A
2. Operating Expenditures
c. Non-Reoccuring Cost: Estimated cost of Mamas y Bebes (Mothers & Babies), Cognitive-Behavioral Treatment with AntiDepressant Medication, Africentric Rites of Passage Program, Incredible Years - SPIRIT, Guiding Good Choices, and SITIF Training, as well as program development.
3. Subcontracts/Professional Services
The Underserved Cultural Populations Program will include contracted services specific to Latino/Hispanic, African American, Native American and Asian/Pacific Islander populations. Services will include cognitive behavioral therapy, prenatal intervention to prevent postpartum depression, effective parenting, after school programs for children, substance abuse prevention intervention, and positive behavior management. Estimated annual cost covers contracted services including training, training materials, client materials, food, and a portion of the program's operating expenses.
4. Total Proposed PEI Project Budget
B. Revenues
New program generated Medi-Cal revenue.

PEI Administration Budget Worksheet – Form 5

Form No. 5

County: Riverside County Date: 06/30/09

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2008-09	Budgeted Expenditure FY 2009-10	Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Personnel & Support Staff:					
Accountant II		1.00	$0	$57,974	$57,974
Accounting Assistant II		1.00	$0	$34,870	$34,870
Admin Services Analyst II		2.00	$0	$123,464	$123,464
Admin Services Assistant		0.25	$0	$11,059	$11,059
Admin Services Supervisor		1.00	$0	$70,489	$70,489
Behavioral Health Specialist II		1.00	$0	$44,726	$44,726
Clinical Therapist II		1.00	$0	$68,295	$68,295
MHS Program Manager		1.25	$0	$113,479	$113,479
MHS Supervisor		1.00	$0	$80,104	$80,104
Office Assistant III		1.00	$0	$30,534	$30,534
Secretary I		1.00	$0	$43,407	$43,407
Social Service Planner		1.00	$0	$68,295	$68,295
Volunteer Services Coordinator		1.00	$0	$45,206	$45,206
b. Employee Benefits			$0	$415,927	$415,927
c. Total Personnel Expenditures			$0	$1,207,828	$1,207,828
2. Operating Expenditures					
a. Facility Costs			$0	$131,236	$131,236
b. Other Operating Expenditures			$0	$532,432	$532,432
c. Non-Reoccuring Cost			$0	$414,475	$414,475
d. Total Operating Expenditures			$0	$1,078,143	$1,078,143
3. County Allocated Administration					
a. Total County Administration Cost			$0	$801,294	$801,294
4. Total PEI Funding Request for County Administration Budget			$0	$3,087,265	$3,087,265
B. Revenue					
Total Revenue			$0	$521,219	$521,219
C. Total Funding Requirements			$0	$2,566,046	$2,566,046
D. Total In-Kind Contributions			$0	$0	$0

PEI Administration Budget Worksheet – Form 5

County Name: RIVERSIDE Date: 06/30/09

PEI Project Name: PEI ADMINISTRATION

Proposed Expenses and Revenues Narrative		
A. Expenditure		
1. Personnel Expenditures		
1.00	Accountant II	Responsible for Fiscal Functions throughout all PEI Programs.
1.00	Accounting Assistant II	Supports Accountant II.
2.00	Admin Services Analyst II	Monitors all PEI Programs.
0.25	Admin Services Assistant	Supports MHS Program Managers.
1.00	Admin Services Supervisor	Responsible for the Management of all PEI Programs.
1.00	Behavioral Health Specialist II	Responsible for the Network of Care Program.
1.00	Clinical Therapist II	Monitors all contracted PEI Programs.
1.25	MHS Program Manager	Responsible for Overall Direction and Development of PEI Programs.
1.00	MHS Supervisor	Responsible for the Management of all PEI Programs.
1.00	Office Assistant III	Supports all Support Staff.
1.00	Secretary I	Supports MHS Supervisor.
1.00	Social Service Planner	Monitors all PEI Programs.
1.00	Volunteer Services Coordinator	Coordinates Volunteer Outreach Services.
2. Operating Expenditures		
a. Facility Cost: Estimated annual cost of Admin rent, utilities, and building maintenance. b. Other Operating Expenses: Research and evaluation, communication, transportation, office supplies and liability, malpractice and property insurance. c. Non-Reoccuring Cost: Estimated cost of a copier, vehicle, Network of Care Subscription, and employee cubicle installation and equipment, as well as program development.		
3. County Allocated Administration		
All general and regional overhead allocated to each of the PEI Projects, including the Fiscal Unit, Program Support, IT Services, Human Resources, and County Support Services.		
4. Total Proposed PEI Project Budget		
B. Revenues		
New Admin generated Medi-Cal revenue.		

PEI Project Budget Summary – Form 6

Form No. 6

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

County:	Riverside County
Date:	06/30/09

		Fiscal Year	Funds Requested by Age Group			
#	List each PEI Project	**FY 09/10**	*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
1	MH OUTREACH, AWARENESS and STIGMA REDUCTION	$1,660,630	$419,642	$435,262	$441,582	$364,145
2	PARENT EDUCATION & SUPPORT	$4,081,365	$4,081,365			
3	EARLY INTERVENTION FOR FAMILIES	$653,764	$653,764			
4	TRANSITIONAL AGE YOUTH (TAY) PROJECT	$1,308,812		$1,308,812		
5	FIRST ONSET FOR OLDER ADULTS	$2,017,166				$2,017,166
6	TRAUMA-EXPOSED SERVICES FOR ALL AGES	$5,345,959	$1,480,534	$619,855	$2,378,736	$866,835
7	UNDERSERVED CULTURAL POPULATIONS	$2,958,317	$1,428,208	$304,776	$1,225,333	
	Total PEI Project:	$18,026,013	$8,063,511	$2,668,705	$4,045,651	$3,248,145
	Administration	$2,566,046				
	Plus PEI Prudent Reserve	$5,584,954				
	Plus Optional 10% Operating Reserve	$2,059,206				
	Total PEI Funds Requested:	$28,236,219				

PEI Project Budget Summary – Form 6A

Form No. 6A

Prevention and Early Intervention Prudent Reserve Calculation
FY 2009/10 MENTAL HEALTH SERVICES ACT

County:	Riverside County
Date:	06/30/09

1. FY 2007/08 PEI Funding Total Amount of FY 2007/08 PEI Funding Approved	$	5,612,500.00
2. Less: FY 0708 PEI Expenditures Total Amount of PEI expended in FY 2007/08	$	27,545.60
3. Sub-total: Maximum Prudent Reserve	**$**	**5,584,954.40**

County: Riverside Date: July 15, 2009

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

PEI Project Name: Early Intervention for Families in Schools

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

RCDMH has selected the Early Intervention for Families in Schools Project for evaluation and report to the State. Within that project the specific program for evaluation is Families and Schools Together (FAST). FAST is an outreach and multi-family group process designed to engage parents into increased involvement with their children, other families, and community-based structures, including schools. Positive experiential learning activities for the family, such as playing and talking in dyads and small groups, maximize the relationship-building processes.

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

The Early Intervention for Families in Schools Project was selected for evaluation for the following reasons:

- The RCDMH community planning process included school representatives from several school districts throughout the County and highlighted 7 focus groups/community forums specifically targeted toward parents as well as school district staff. In addition, school representatives participated in the Children's Committee, the Transition Age Youth Committee, and the Stigma and Discrimination Reduction Workgroup.
- The Priority Populations of: Children/Youth in Stressed Families and Children/Youth at Risk of School Failure had significant priority ratings throughout the community planning process and most significantly with school district representatives and families throughout the County.
- The community planning process demonstrated strong community and stakeholder support for school-based services.
- School-based interventions were highly recommended due to the leverage opportunities, de-stigmatizing location, and increased access for families.
- Collaboration was a key ingredient when developing prevention and early intervention recommendations throughout the community planning process. This program is based on collaboration between RCDMH, schools, and community-based organizations.

- The community requested family based interventions for prevention and early intervention services. This program works with parents, the student, and siblings all at the same time.
- Another high priority throughout the community planning process was the need for parenting programs. FAST is designed to empower parents to be the primary prevention agents for their own children.
- FAST will be implemented in elementary schools in each of the three service delivery regions situated in high risk communities as identified through the data analysis.
- The FAST program is a well developed and highly structured model which includes evidence-based outcome evaluations.

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

Person-Level Outcome

- Reduced family conflict and stress
- Improved academic performance of FAST kids
- Improved child self esteem, social skills

System-Level Outcome

- Increases teacher support and climate of learning
- Connection of parents and children to their schools

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

PERSONS TO RECEIVE INTERVENTION

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/ DISCRIMINATION
ETHNICITY/ CULTURE							
African American			193	193			
Asian Pacific Islander			92	92			
Latino			1729	1729			
Native American			25	25			
Caucasian			429	429			
Other (Indicate if possible)			52	52			
AGE GROUPS							
Children & Youth (0-17)			1512	1512			
Transition Age Youth (16-25)							
Adult (18-59)			1008	1008			
Older Adult (>60)							
TOTAL			2520	2520			

Total PEI project estimated ***unduplicated*** count of individuals to be served ____2520_____

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

   Achievement of outcomes and objectives will be examined using standardized pre- and post test questionnaires designed to measure attributes and behaviors of children and their parents. The measures will be distributed to program participants at the start of the program and at the conclusion of the program. Pre to post intervention scores will be compared to measure changes and program effectiveness. Attributes and behaviors in several different areas will be measured to evaluate person-level and system-level outcomes. In addition, completion rates for the program will also be calculated for FAST families. Parents and teachers will be surveyed for satisfaction with the FAST program.

   Reduced family conflict and stress-The Family Relationship Index will be utilized to examine the degree of commitment, help, and support family members provide to one another, the level to which family members are encouraged to act openly and express their feelings to each other, and the amount of openly expressed anger, aggression, and conflict among family members.

   High functioning family management-A Self-Efficacy Scale and a Social Relationships Questionnaire will be utilized to examine parents' general sense of personal effectiveness and their social relationships. The surveys will measure the relationships parents have with their children, other people, and community agencies. The Self-Efficacy Scale measures a Parents' sense of personal effectiveness in building and maintaining social relationships and ability to support and nurture their children. The Social Relationships Questionnaire examines a parents' sense of social support from other people, such as other parents in the program; and their reciprocal reported support to these other parents.

   Improved Child self-esteem, social skills- Children's strengths in pro-social behaviors, difficulties in emotional issues, conduct problems, peer relationships, and hyperactivity problems will be measured with the Strengths and Difficulty Scale completed by both parents and teachers.

   System-level outcomes will be measured by utilizing questionnaires and a pre-to post measurement design.

   Increased teacher support and climate of learning-At the conclusion of the program teachers will complete a survey to rate the benefits of the FAST program to children, parent and themselves. Teachers will complete pre to post measures rating children's behavior, peer relationships, academic performance, attitude and attendance.

   Improved academic performance of FAST children-Teachers ratings of FAST children's academics improvements will be collected with a survey at the conclusion of the program.

   Connection of children and parents to their school-Parents' involvement in their school will be measured with a pre-to post questionnaire. The Parent Involvement in Education scale will be administered at the beginning of services and at the conclusion of services. The Parent Involvement scale measures parental school

involvement, parent initiated contact with teachers, and school initiated contact with the parents. Pre-to post scores will be compared to assess changes in parents' involvement in their children's education. Teacher pre to post ratings of parent involvement in the school will also be collected utilizing the Parent Involvement in Education scale.

5. How will data be collected and analyzed?

Data on attendance and completion rates will be recorded in an attendance log for all families participating. A family intake tool will be used to collect basic demographic data on families participating in the program. All FAST schools will use a standard protocol when contacting families. Once a family volunteers to participate in the program, they will receive a home visit from a member of the FAST team. During the visit, families will be informed about the nature of the intervention and asked to sign a consent form for participating. They will then be asked to complete the pre-intervention survey measures. Two weeks before the program ends, a member of the FAST team will ask each participating family to complete the post-intervention survey at the school site.

Teacher completed surveys will be collected for FAST families at the school site by FAST team members at the beginning of the program and at the conclusion of the program.

The completed surveys will be sent to Families and Schools Together, Inc. for analysis. They will enter and analyze the data using the Statistical Package for the Social Sciences Program (SPSS). A within subjects ANOVA will be carried out to examine the difference between pre and post-intervention scores on the standardized measures. The percentage of families reporting improvements and statistically significant percentage of increase will be reported.

Demographic information for FAST families will be collected and reported along with rates of program completion.

It is important to note that to protect confidentiality; each family will be assigned an identification number that will be used to match each family's pre and post-surveys. Only aggregated responses will be reported, and it will not be possible to match individual responses to a particular child or parent.

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

In line with the MHSA PEI Prevention and Early Intervention guidelines as well as the RCDMH PEI guiding principles, cultural competency will be an integral part of implementation of all PEI programs. The effectiveness of evidence-based programs has been shown through research and FAST has cultural evidence for the Hispanic/Latino, African American, American Indian/Alaska Native, Asian/Pacific Islander, and White ethnic/cultural populations. To reach the underserved ethnic/cultural groups within the County, programs used will demonstrate collaborative community-based approaches, will build community capacity within the

communities with the greatest need, will address challenges and barriers in serving ethnically diverse communities, and must show effectiveness with ethnically diverse individuals. In addition, the collaboration between community- and/or faith- based providers and the Mental Health Outreach, Awareness, and Stigma Reduction Project components will assist in reaching community members and families to engage in services. The use of Promotores de Salud, the Ethnic and Cultural Community Leaders in a Collaborative Effort, as well as collaborating with the outreach activities listed in that project will provide a culturally and linguistically competent approach to engage and maintain families in the FAST program. The Promotora and the Community Leaders are community members who are able to establish relations with the public and understand social values, culture traditions, beliefs, and language. The primary focus of this project is to engage Latinos (Riverside County's threshold underserved cultural population), therefore, instructions, questionnaires, materials, and screening tools will be included under these principles and available in Spanish. Any other linguistic needs, including American Sign Language, will be made available. A satisfaction survey will be included to address quality of services and cultural competence topics.

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

   It is the intent of RCDMH to implement evidence-based programs in order to meet the expectation of effectiveness as stated by community members. The implementation of any evidence-based practice requires initial training through the developer of the model or another developer approved trainer. FAST has a national training center, which offers the initial training, ongoing consultation, and a Training of Trainers (TOT) program. RCDMH will work together with partnering agencies to identify staff members who each will be trained in the model as well as identify particular staff who will be trained as trainers. This will build capacity throughout the County, increase fidelity and effectiveness of services, and provide sustainability of the program.

   RCDMH plans a system enhancement which will utilize clinical staff to oversee the evidence-based practices implemented through the MHSA PEI plan. The clinical staff will work with team leads from the multiple FAST sites and will be the contact for any additional training needs with the developer and/or training center. There will be monthly team meetings with all practitioners of FAST in order to maintain fidelity, assist with clinical consultation, and practice skills required for implementation. The team lead clinical staff member will also assist with infrastructure stability at each site by guiding practitioners to maintain all needed materials and environment set-up. In order to assist with sustainability throughout the County, it is important that infrastructure for all of the above needs noted exist for the community and/or faith based providers we will contract with for the implementation of the FAST program. This will allow for greater adherence to the often stringent requirements of evidence-based practices as well as provide assistance to smaller organizations when turn-over impacts service delivery.

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

   In efforts to maintain the spirit and intent of the MHSA PEI community planning process through implementation, it is important to share the evaluation findings from the Early Intervention for Families in Schools project with stakeholders and community members. A comprehensive report will be provided by the FAST training center to RCDMH for each site providing the program. The report will be shared with program managers/partners involved in the project as well as to the Mental Health Board, each of the three Regional Mental Health Boards, MHSA Stakeholder Leadership Committee, and members of the Children's Committee (all of which have membership to include consumers and family members). The evaluation report will be posted on the County's MHSA PEI web page for review by all interested constituencies and the general public. This report will also be made available in hard copy upon request. In addition, executive summary reports could be disseminated more broadly to consumers and agency employees via articles in Riverside County Department of Mental Health's newsletter "What's Up in Mental Health." Documents and web pages will be translated into Spanish.

Training, Technical Assistance and Capacity Building Funds Request Form
(Prevention and Early Intervention Statewide Project)

Date: 7/15/2009	County Name: Riverside County
Amount Requested for FY 2008/09: $327,100	Amount Requested for FY 2009/10: $327,100

Briefly describe your plan for using the Training, Technical Assistance and Capacity Building funding and indicate (if known) potential partner(s) or contractor(s).

The Riverside County Department of Mental Health (RCDMH) will utilize the allocated funding for Training, Technical Assistance and Capacity Building in the following ways:

1. RCDMH will expand the contract with the California Institute for Mental Health (CIMH) to allow for participation in trainings related to Evidenced Based and Promising Practices that are identified in the Prevention and Early Intervention (PEI) plan for providers within the community who will be contracted to provide the services as well as appropriate department staff. This may include opportunities for "train the trainers" in order to build the department's capacity for additional trainings.
2. The PEI Community Planning Process clearly identified the desire for PEI projects to include consumer and family members to participate in all aspects of implementation and service delivery. RCDMH will offer pre-employment training to consumers and family members to provide them with recovery and wellness principles and tools and show them how to utilize their lived experiences when working with the PEI service populations. The participants of these trainings will be those who are reflective of the communities and/or culture who will be receiving PEI services in order to more effectively outreach to unserved/underserved communities.
3. Through the PEI Community Planning Process, the voice of the community was clear in their request to provide law enforcement training. RCDMH, in collaboration with the City of Riverside Police Department, has developed a mental health training program. Through the training, officers receive an overview of mental illness and mental health law, learn to recognize signs of mental illness, and learn about the stigma related to mental illness as well as ways that they can reduce stigma through their response to the individual. This funding will expand the trainings that law enforcement receives by incorporating the training into the police academies and expanding the training beyond the City of Riverside to include all law enforcement throughout Riverside County.
4. Through the Prevention and Early Intervention Community Planning Process, and in support of the implementation of the PEI plan, training for school personnel and other County and community providers is included in this plan. RCDMH will collaborate with Riverside County Office of Education and local school districts to provide Student Assistance Program training. In addition, RCDMH has developed a training which includes an overview of the signs and symptoms of mental illness. The training will also include information about referral sources. This funding will expand the implementation of this training to County and community providers, including substance abuse providers in order to increase awareness regarding mental health needs and to increase referrals to appropriate PEI programs.

The County and its contractor(s) for these services agree to comply with the following criteria:

1) This funding established pursuant to the Mental Health Services Act (MHSA) shall be utilized for activities consistent with the intent of the Act and proposed guidelines for the Prevention and Early Intervention component of the County's Three-Year Program and Expenditure Plan.
2) Funds shall not be used to supplant existing state or county funds utilized to provide mental health services.
3) These funds shall only be used to pay for the programs authorized in WIC Section 5892.
4) These funds may not be used to pay for any other program.

5) These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by WIC Section 5892.
6) These funds shall be used to support a project(s) that demonstrates the capacity to develop and provide statewide training, technical assistance and capacity building services and programs in partnership with local and community partners via subcontracts or other arrangements to assure the appropriate provision of community-based prevention and early intervention activities.
7) These funds shall be used to support a project(s) that utilizes training methods that have demonstrated the capacity to increase skills and promote positive outcomes consistent with the MHSA and PEI proposed guidelines.

Certification

I HEREBY CERTIFY to the best of my knowledge and belief this request in all respects is true, correct, and in accordance with the law.

Director, County Mental Health Program (original signature)

ATTACHMENTS

ATTACHMENT A

Mental Health Services Act (MHSA)
Prevention and Early Intervention
Orientation

The MHSA (formerly known as Proposition 63) was approved by California voters to provide a 1% tax on personal income over $1 million in order to expand and transform the county mental health service system. It became effective January 01, 2005.

The MHSA has five components. Each one of these components requires surveying people and organizations that are involved in mental health services including county mental health staff, community based organizations, consumers and their families, and other county and government organizations.

We are currently conducting the survey and needs assessment for the Prevention and Early Intervention (PEI) component of the MHSA. The ideas that are generated from this focus group and survey process will become the foundation for the Prevention and Early Intervention Plan that our county will submit to the State.

Per the State guidelines, an objective of PEI is to increase capacity for mental health prevention and early intervention programs. These programs need to be provided in places where mental health services are not traditionally given, such as schools, community centers, faith-based organizations, etc. The intent of PEI programs is to engage individuals before the development of serious mental illness or serious emotional disturbance or to alleviate the need for additional or extended mental health treatment.

What is Prevention?

- ✓ Prevention in mental health involves building protective factors and skills, increasing support, and reducing risk factors or stressors.
- ✓ Prevention efforts occur prior to a diagnosis for mental illness.
- ✓ Generally there are no time limits on prevention programs.

What is Early Intervention?

- ✓ Addresses a condition early in its manifestation
- ✓ Is of relatively low intensity
- ✓ Is of relatively short duration (usually less than one year)
- ✓ Has the goal of supporting well-being in major life domains and avoiding the need for more extensive mental health services
- ✓ May include individual screening for confirmation of potential mental health needs

Exception for Individuals Experiencing At Risk Mental State (ARMS) or First Onset of a Serious Psychiatric Illness with Psychotic Features. The standards of low intensity and short duration do not apply to services for these individuals. (There are identified programs that have been proven effective in reducing the risk of increased needs for services and maintenance of level of functioning.)

The State has, through a Stakeholder process, defined the following **PEI Key Community Mental Health Needs**:

- **Disparities in Access to Mental Health Services** – PEI Efforts will reduce disparities in access to early mental health interventions due to stigma, lack of knowledge about mental health services or lack of suitability of traditional mainstream services.
- **Psycho-Social Impact of Trauma on All Ages** (This refers to how the trauma is impacting the individuals level of functioning, emotionally and behaviorally.)
- **At-Risk Children, Youth and Young Adult Population** – PEI efforts will increase prevention efforts and response to early signs of emotional and behavioral health problems among specific at-risk populations.
- **Stigma and Discrimination** – PEI will reduce stigma and discrimination affecting individuals with mental health illness and mental health problems.
- **Suicide Risk** – PEI will increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide.

The State has also identified the following **PEI Priority Populations**:

- **Underserved Cultural Populations** – Those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, etc.).
- **Individual Experiencing Onset of Serious Psychiatric Illness** – Those identified by providers, including but not limited to primary health care, as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service.
- **Children/Youth in Stressed Families** – Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of care giving adults (e.g., as a result of serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.
- **Trauma-Exposed** – Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.
- **Children/Youth at Risk for School Failure** – Due to unaddressed emotional and behavioral problems.

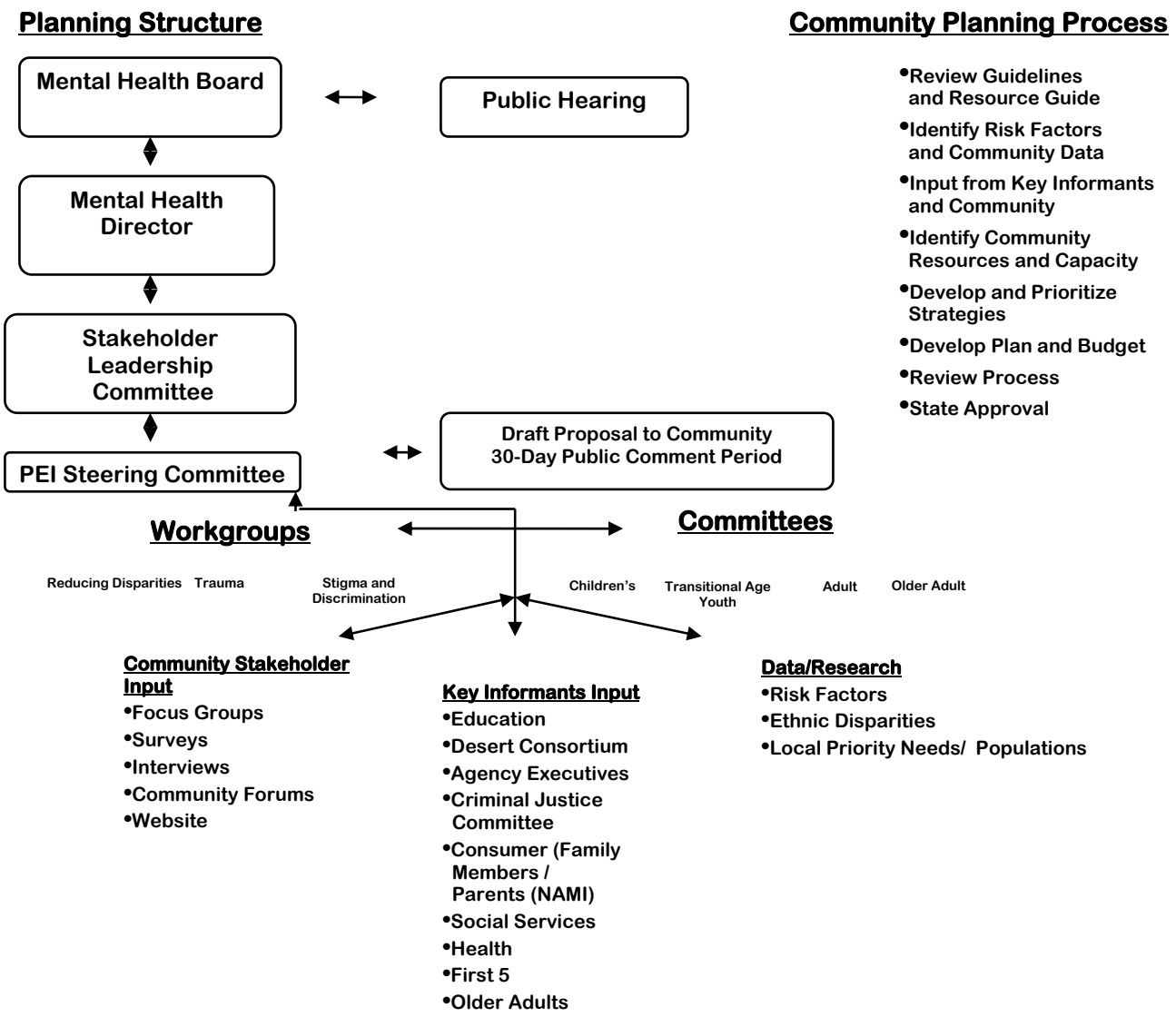
- **Children/Youth at Risk of or Experiencing Juvenile Justice Involvement** – Those with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately serviced through Community Supports and Services programs.

Per State guidelines, PEI plans will address all age groups and a minimum of 51% of the Plan budget must be dedicated to individuals between the ages of 0 through 25 years old. PEI funds **cannot** be used for filling gaps in treatment and recovery services for individuals who have been diagnosed with a mental illness or serious emotional disturbance and their families.

Many prevention and early intervention programs are expensive and there are many needs to be met. We cannot promise that every idea will be implemented or that everyone's needs will be met. Riverside County's needs assessment and plan development process is anticipated to take several months and will not be completed until early 2009. The final plan will go through intensive review and will include review by established MHSA committees, the Department's Cultural Competency Committee, the Mental Health Board, and will also include a public hearing.

Please feel free to go to our website at
http://mentalhealth.co.riverside.ca.us/opencms/
to complete our survey.

Prevention and Early Intervention



8/20/08

ATTACHMENT C

Riverside County Department of Mental Health
Guiding Principles for the Prevention and Early Intervention (PEI) Plan

As the planning proceeds for the PEI plan it is important to establish criteria for the evaluation of the overall plan and its strategies. Decisions about what is in the plan should address state requirements and needs as they are determined in the county. To assist in the process of determining priorities for what will be in the plan the following criteria have been established.

A. The overall PEI Plan must meet state requirements/priority areas and should meet the following criteria:

--Distribution of resources to the communities/populations in the county at highest risk of developing mental illness.

--Addresses all age groups.

--Demonstrates collaborative community based approaches including building on existing resources.

--Builds community capacity throughout the county prioritized in a manner which addresses areas of greatest need.

--Addresses the unique challenges and barriers in serving ethnically diverse communities.

B. Specific strategies/programs to be included in the PEI Plan should meet the following criteria:

--Shows evidence of effectiveness of the strategy including with ethnically diverse individuals.

--Shows greatest likelihood of positive impact on those at highest risk of mental illness.

--Expands and/or leverages other programs/resources whenever possible.

--Includes consumers and family members in planning and operation of programs and evaluation of results.

7/14/08

ATTACHMENT D
Mental Health Services Act Leadership Committee Membership List

#	First Name	Last Name	Title/Agency
1	Hal	Adams	NAMI Temecula Valley
2	Elaine	Barron	Mid-County Mental Health
3	Abbie	Blumberg	SEIU, Local 721
4	Bill	Brenneman	MHSA Manager, Mental Health
5	Christina	Brittian	Consumer, Banning
6	Deborah	Cournoyer	Senior Management Analyst
7	Donna	Dahl	Assistant Director, Mental Health
8	Georgia Ann	DeGroat	Consumer - Riverside
9	Ninfa E.	Delgado	Community Health Foundation
10	Richard	Divine	Chair, Mental Health Board
11	Ed	Fletcher	Older Adult Services, Mental Health
12	Harry	Freedman	First 5
13	John	Gollogly	Sheriff's Department
14	Sheila	Green	Public Guardian
15	Mark	Hake	Probation
16	Susan	Harrington	Department of Public Health
17	Robin	Hastings	Supervisor's Marian Ashley Office
18	Linda	Jefferson	LIUNA
19	David	Lundquist	Desert Region Manager, Mental Health
20	Roberta	Neff	Riverside Volunteer Center
21	Patti	Polly	DPSS
22	Robin	Reid	Supervisor Jeff Stone's Office
23	Richard	Rios	CHARLEE Group Homes
24	Javier	Rosales	Community Relations Consultant
25	Mike	Sepulveda	Office of Education
26	Christine	Spence-Fischer	Family Member
27	Ed	Walsh	Office On Aging
28	Diane	Wayne	Community Health Agency

ATTACHMENT E
Mental Health Board Membership List

Riverside County Department of Mental Health

Mental Health Board Membership 2009

NAME	Representation
Hal Adams	Family Member
Mary Allred	Family Member
Christopher Brewer	Consumer
Julie Crouch	Family Member
Georgia DeGroat	Consumer
Richard Divine	Family Member
Garnet Magnus	Consumer
Shenna Moqeet	Consumer
Sarah Nunley	Public
Moses Rangel	Public
Christina Salas	Public
Donald Sercombe	Public
Sherry Skidmore	Public
Donna Johnston	Board of Supervisors Representative District 2

ATTACHMENT F
Mental Health Regional Board Membership List

Western Regional Board Membership 2009

NAME	Representation
Angela Arauz-Castillo	Consumer
Greg Damewood	Family Member
Enrique Giron	Family Member
Robert Fussell	Public
Michael Maquire	Consumer
Caroline Martinez	Consumer
Keith J. Oddson	Family Member
Jane Qui	Family Member
Agostino Riccardi	Public
Suzanne Robedeaux	Consumer
Francis Matthew Sengle	Consumer

Mid-County Regional Board Membership 2009

NAME	Representation
Harold Adams	Family Member
Mary Allred	Family Member
Art Eisenheim	Consumer
Gloria Hernandez	Consumer
Virginia Marshall	Family Member
George Middle	Public
Donald Sercombe	Public
Horace Spears	Public
Dorothy Valenzuela	Family Member

Desert Regional Board Membership 2009

NAME	Representation
Joseph Butts	Public
Richard Divine	Family Member
Bonnie Gilgallon	Consumer
Stanley Jessop	Consumer
Louise Jones	Public
Mark Miller	Public
Janice Quinn	Public
Christina Salas	Public
Patricia Wilhite	Family Member
Edward Wood	Consumer

ATTACHMENT G
Focus Group & Community Forum Schedule

County of Riverside - Department of Mental Health
Mental Health Services Act (MHSA)
Prevention and Early Intervention
Focus Groups

0

Date	Facilitator	Co-Facilitator	Location/Address	Participant Description	Language	Attendance
30-Jul	Janine Moore	Charity Cason	Case Management	School representatives	English	12
8/5	Janine	Dr. Dionne	Hungry Hunter Restaurant	Native American	English	12
8/11	Myriam Aragon	Alfredo Huerta	KERU	Community members	Spanish	24
8/21	Maria K.	Valai Brown	Rubidoux FRC	Community members	English	2
8/23	Maria J.	Mario L.	Western Region MH Administration	Consumers - DBSA	English	7
8/26	Maria K.	Maria G.	Rubidoux FRC	Community members	Spanish	17
8/26	Janine Moore	Renda Dionne	UCR	Native American	English	13
8/27	Diana Brown	Rachaline Napier	Van Horn/Juvenile Hall	Staff	English	9
8/28	Diana Brown	Rachaline Napier	Van Horn	Youth	English	8
9/3	Lorie-Lacey Payne	Michelle Diaz	Banning Children's	Parents	English	3

ATTACHMENT G
Focus Group & Community Forum Schedule

9/3	Janine	Claudia Espinoza	Camelot/Nami San Jacinto	NAMI members	English	34
9/3	Diana Brown	Cindy Claflin	CTS Staff Meeting	Staff	English	8
9/5	Maria Jaquez	Mario Lopez	JTP - Riverside Peer Center	Peers	English	9
9/8	Claudia Espinoza	Lucretia	NAMI - Coachella Valley	NAMI members	English	9
9/8	Maria K.	Maria G.	Moreno Valley Children's	Parents	Spanish	5
9/8	Cindy Claflin	Valai Brown	Moreno Valley Children's	Parents	English	4
9/9	Lorie-Lacey Payne	Alicia Arredondo	Mt. San Jacinto Clinic	Parents	English	3
9/9	Janine Moore	N/A	Hemet	school representatives	English	11
9/11	Margo	Fabiola Miranda	Older Adult - Hemet	Consumers	English	8
9/11	Margo	Fabiola Miranda	Older Adult - Hemet	Staff	English	8
9/11	Barbara Mitchell	Margo Alexander	Linkage/MSSP Staff - Office on Aging	Staff	English	22
9/11	Valai Brown	Cindy Claflin	CTS/ISF Van Horn	Parents	English	3
9/11	Cristy Gaudette	Lisa Guynn	Western MDFT/Wraparound	Parents	English	4
12-Sep	Maria Jaquez	Mario Lopez	Riverside Peer Center	Consumers	English	15

ATTACHMENT G
Focus Group & Community Forum Schedule

9/12	Lorie-Lacey Payne	Jean Johnson	MDFT/Perris Clinic	Parents	English	3
9/15	Shannon McCleerey-Hooper	Debbie Katz	Banning MH	Parents	English	6
9/15	Claudia Espinoza	Eva Galvan	Temecula Mental Health Clinic	Parents	Spanish	7
9/16	Janine Moore	N/A	Betty Ford Center	school representatives	english	10
9/16	Maria Jaquez	Mario Lopez	JWC	Consumers	English	13
9/16	Diana Brown	Melissa Dovalina	at Hemet Clinic MH/ San Jacinto staff to attend	Staff	English	16
9/16	Janine Moore	Fabiola Miranda	Banning Mental Health	Staff - Parent Partners	English	18
9/17	Janine Moore	Fabiola Miranda	0-5 Program staff focus group	Staff	English	11
9/17	Diana Brown	Valai Brown	Wraparound/MDFT - Magnolia	Staff	English	10
9/17	Janine	Diana Brown	DMH/TRAC	Staff	English	10
9/17	Maria Rabago-Kidder	N/A	FACT of Corona	Parents	Spanish	6
9/17	Valai Brown	Rachel Douglas	0-5 Clinic	Parents	English	0
9/17	Janine Moore	Diana Brown	TAY Staff - Jefferson Wellness	Staff	English	6
9/18	Margo Alexander	Melissa Dovalina	Temecula Senior Center - Grandparent Raising Grandchildren	Consumers	English	5

ATTACHMENT G
Focus Group & Community Forum Schedule

9/18	Maria Gonzalez	Maria Rabago-Kidder	Mecca FRC	Parents	Spanish	4
9/18	Maria K.	Maria G.	Indio	Parents	Spanish	0
9/18	Robert Lopez	Nate Ramirez	Desert Hot Springs - FRC	Community	Spanish	0
9/18	Janine Moore	Diana Brown	Riverside Community Forum - Arlington Library	Community	English	14
9/18	Diana Brown	Maria Algarin	RCOE PPC Meeting	Parents	English	38
9/18	Barbara Mitchell	N/A	DPSS APS Administration Riverside	Staff	English	6
9/19	Valai Brown	Alicia Arredondo	Fruitvale Elem. - Hemet	Parents	English	6
9/19	Maria Jaquez	N/A	JWC - TAY	Consumers	English	5
9/22	Janine Moore	Fabiola Miranda	Perris MH	Staff	English	9
9/23	Barbara Mitchell	Margo Alexander	4063 County Circle Dr.	Public Health CHA	English	9
9/23	Cindy Claflin	Alicia Arredondo	San Jacinto Children's	Parents	English	11
9/23	Diana Brown	Shannon McCleerey-Hooper	Mead Valley Community Center	gatekeeper community forum	English	19
9/24	Melissa Dovalina	N/A	Hemet Elem.	Parents	English	8
9/24	Lorie-Lacey Payne	Cristy Gaudette	Temecula Children's	Parents	English	3

ATTACHMENT G
Focus Group & Community Forum Schedule

9/24	Janine Moore	N/A	Safe & Drugfree Schools Coordinators Meeting Substance Abuse Admin.	school representatives	English	12
9/24	Diana Brown	Cindy Claflin	ISF/MDFT	Staff	English	15
9/24	Maria Jaquez	Kent Rommereim	MHSA Admin Conference Room	Peer Support Specialists	English	12
9/24	Myriam Aragon	Anna Rodriguez	MH Admin A/B - Riverside	Deaf & Hearing Impaired	American Sign Language	7
9/24	Nate Ramirez	Robert Lopez	Cathedral City Clinic	Older Adult	English	6
9/24	Barbara Mitchell	N/A	Moreno Valley CARE Team	staff	English	4
9/25	Barbara Mitchell	Robert Lopez	St. Paul Episcopal Church - Palm Springs	LGBT Older Adult	English	19
9/25	Maria Jaquez	Moises Ponce	Mead Valley Community Center - Coffee Club	Community	Spanish	16
9/25	Alfredo Huerta	Robert Lopez	Mecca Resource Center	Parents	English	5
9/25	Robert Lopez	Nate Ramirez	Desert Hot Springs - FRC	Community	English	0
9/25	Cindy Claflin	Tina Squires	Case Management Riverside Open Doors Grp	Parents	English	2
9/26	Maria Jaquez	N/A	Hemet MH	Peers/Consumers	English	7
9/26	Hal Adams	Juanita Adams	Philips Senior Center Temecula	Consumers & Family	English	18
9/26	Ben Wilson	N/A	Cailfornia School for the Deaf - Riverside	Assessment Department - school staff	ASL/English	7

ATTACHMENT G
Focus Group & Community Forum Schedule

9/29	Cindy Claflin	Maria Murillo	FACT of Corona	Parents	English	0
9/29	Nate Ramirez	Robert Lopez	Oasis Outpatient - Stepping Stones	Consumers	English	8
9/29	Maria Jaquez	N/A	Blaine Street clinic	Consumers	English	5
9/30	Janine Moore	Cindy Claflin	Corona community Forum - Foundation for community Family Health	Adults - Community	English	28
9/30	Diana Brown	N/A	Corona community Forum - Foundation for community Family Health	Youth - Community	English	12
9/30	Maria Jaquez	N/A	Corona community Forum - Foundation for community Family Health	Adults - Community	Spanish	6
9/30	Robert Lopez	Nate Ramirez	SMART program Wellness & Recovery Clinic	Consumers	English	8
10/1	Diana Brown	Cynthia Magill	TRAC - DPSS Admin	Social Workers	English	28
10/1	Janine Moore	N/A	RUSD Office	District Staff	English	11
10/1	Janine Moore	N/A	MH Admin	MH Board	English	7
10/1	Alfredo Huerta	Robert Lopez	Mecca North-Shore Branch Library	Community Forum	bi-lingual	19
10/1	Diana Brown	Fabiola Miranda	FACT of Corona	Staff	English	9
10/1	Dr. Carolyn Murray	Benita Ramsey	Cesar Chavez Center - Bobby Bonds Park - Riverside	African American Community	English	17
10/1	Maria Jaquez	N/A	The Place	Peers/Consumers	English	12

ATTACHMENT G
Focus Group & Community Forum Schedule

10/2	Robert Lopez	Nate Ramirez	Banning Clinic	Consumers	English	9
10/2	Ben Wilson	N/A	CSDR - Counseling Department	Staff	ASL/English	8
10/2	Diana Brown	Janine Moore	Gatekeeper Key leaders - Sun City/Menifee at Kay Ceniceros Senior Center	Community Leaders & Service Providers	English	12
10/2	Margo Alexander	N/A	Jessie O. James Grandparent Raising Grandchildren Palm Springs	Consumers	English	4
10/3	Diana Brown	Fabiola Miranda	Family Resource Center - Perris	Community members	English	2
10/3	Maria Jaquez	N/A	Family Resource Center - Perris	Community members	Spanish	7
10/3	Margo Alexander	N/A	Older Adult/SMART Riverside	Staff	English	9
10/3	Ben Wilson	N/A	CODIE - Riverside	Community Agency & Consumers	ASL/English	6
10/6	Margo Alexander	N/A	Office on Aging - Moreno Valley	OoA Leadership	English	10
10/6	Maria Jaquez	Mario Lopez	Main Street Clinic - Corona	Peers/Consumers	English	3
10/6	Janine Moore	Diana Brown	Adolescent Family Services	Public health leadership	English	33
10/7	Barbara Mitchell	Margo Alexander	Wellness Group - Riverside	Consumers	English	7
10/7	Mario Lopez	Maria Jaquez	Perris Peer Center	Peers/Consumers	English	12
10/7	Mario Lopez	Maria Jaquez	Temecula Peer Center	Peers/Consumers	English	0

ATTACHMENT G
Focus Group & Community Forum Schedule

10/7	Janine Moore	N/A	Hulen Homeless shelter	Homeless men & women	English	12
10/7	Diana Brown	Cristy Gaudette and Cynthia Magill	Old Highway Church - Moreno Valley	Church leaders	English	18
10/8	Barbara Mitchell	Margo Alexander	DPSS - APS - Older Adults	staff	English	6
10/8	Janine Moore	Alfredo Huerta	Desert Consortium Palm Desert	Providers	English	20
10/8	Maria Jaquez	Cynthia Magill	Harmony Center	Peers/Consumers	English	13
10/8	Diana Brown	N/A	RIGHT Partnership Workshop - Moreno Valley	Service Providers	English	66
10/9	Maria Jaquez	Cynthia Magill	Cathedral City Adult Clinic	Consumers	English	14
10/9	Maria Algarin	Amanda Wilbur	MH Admin - NAMI Western Region	Family members	English	12
10/9	Barbara Mitchell	Margo Alexander	Older Adult Staff - Cathedral City	staff & community	English	5
10/9	Barbara Mitchell	Margo Alexander	Community Forum - Menifee/ Sun City	Community	English	11
10/9	Robert Lopez	Alfredo Huerta	Alzheimer's Association Group building 69-730 Highway 111, Ste. 202, Rancho Mirage CA	Community & Providers	English	9
10/9	Maria Jaquez	Doug Tavira	GEEL Place	Consumers	English	10
10/10	Maria Jaquez	Doug Tavira	Mental Health Admin	Peers	English	4
10/15	Barbara Mitchell	Nate Ramirez	Desert Indian Wells Office on Aging Advisory Council	Council members	English	22

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH

JERRY WENGERD, DIRECTOR

MHSA – Prevention and Early Intervention Community Survey

The Mental Health Services Act (MHSA), approved by voters in 2004 as Proposition 63, is launching its Prevention and Early Intervention (PEI) program. We want to know what you think about services to be offered and groups of people to be helped by mental illness prevention and early intervention programs in Riverside County. With your assistance, we can better plan for the needs of our community.

The prevention element of the PEI program is meant to reduce risk factors or stressors to prevent the initial onset of a mental health problem as well as promote and support the well-being of "at risk" individuals under challenging life circumstances in order to reduce suffering associated with mental health problems.

The early intervention element of the PEI program is designed to prevent a mental health problem from getting worse. These programs are directed toward people for whom a short-duration (< 1 year), relatively low-intensity intervention is appropriate to measurably improve mental health problems, avoid the need for more extensive mental health treatment or services, or prevent a mental health problem from getting worse.

For more information about the MHSA PEI program, please visit http://www.dmh.ca.gov/prop_63/MHSA/prevention_and_early_intervention/default.asp

Thank you in advance for taking a few minutes to complete the following survey. The information you provide is confidential and anonymous.

Riverside County Department of Mental Health
MHSA – Prevention and Early Intervention (PEI)
Community Survey

This survey is to give us ideas on how to make your community stronger and to decrease the need for mental health services by increasing awareness of emotional needs of the people who live in your community. Please help us by answering the following questions.

1. Please rate the following groups to indicate which ones you think have the greatest need for mental illness prevention and early intervention services in your community. ***(Select one score per item below)***

   A. Children/Youth in stressed families (children placed out-of-home, families with substance abuse, domestic violence, recent immigrant families, depression or other mental illness, etc.):

   ☐ Very low need ☐ Low need ☐ Moderate need ☐ High need ☐ Very High Need

   B. Children/Youth at risk for failing or dropping out of school:

   ☐ Very low need ☐ Low need ☐ Moderate need ☐ High need ☐ Very High Need

   C. People who have attempted or might attempt suicide:

   ☐ Very low need ☐ Low need ☐ Moderate need ☐ High need ☐ Very High Need

   D. Children/Youth at risk of or experiencing juvenile justice involvement:

   ☐ Very low need ☐ Low need ☐ Moderate need ☐ High need ☐ Very High Need

   E. People facing trauma (e.g., loss of loved one, home, and/or employment; isolation; repeated abuse, domestic violence, refugees):

   ☐ Very low ☐ Low ☐ Moderate ☐ High ☐ Very High

need need need need Need

F. People who often do not get the mental health services they need (e.g. based on race, culture, language, age, gender, lifestyle, or beliefs):

☐ Very low need ☐ Low need ☐ Moderate need ☐ High need ☐ Very High Need

G. People who start to show serious signs of mental illness:

☐ Very low need ☐ Low need ☐ Moderate need ☐ High need ☐ Very High Need

2. Please list any additional groups of people needing mental illness prevention and early intervention services. Please specify group(s) and level of need:

3. Above, you identified groups that you think have the greatest need for mental illness prevention and early intervention services in your community. What ideas do you have about how to help those groups (early screening, education & support services to parents, resource & referral information, more training for helping professionals, work-based programs, etc.)?

4. Where would you feel comfortable going if you or a family member needed prevention or early intervention services? (You may choose more than one.)

☐	Doctor's office	☐	Social Services	☐	Community organizations
☐	School	☐	Workplaces	☐	Other:
☐	Faith-based organization	☐	Unemployment Centers	☐	Other:
☐	Another Family Member	☐	In-Home	☐	Other:

5. Please take a moment to answer the questions below. The information you provide will remain confidential and anonymous. Your responses will assist Riverside County in determining how we can best meet the needs of the community.

Age:

- ☐ 15 and under
- ☐ 16 to 20
- ☐ 21 to 25
- ☐ 26 to 35
- ☐ 36 to 55
- ☐ 56 to 65
- ☐ Over 65

Gender:

- ☐ Male
- ☐ Female

If you represent an agency or organization, please tell us which one, and describe your role or position:

Agency:
Role/Position:

The Region of the County with which you are most involved or concerned:
(if not entire region, please specify areas)

☐ Mid-County
Hemet, Perris, Lake Elsinore, San Jacinto, Temecula

☐ Western
Norco/Corona, Moreno Valley, Riverside

☐ Desert
Banning, Blythe, Cathedral City, Indio

☐ Other

Your Race/Ethnicity?

- ☐ Native American – Tribal Nation:
- ☐ Asian
- ☐ Black / African American
- ☐ Pacific Islander
- ☐ White / Caucasian
- ☐ Other, please specify:

☐ Hispanic / Latino

Which of the following groups apply to you?

☐ Consumer
☐ Family Member
☐ Guardian or Foster Parent
☐ School Staff or Employee
☐ DMH Staff or Employee
☐ Community Agency
☐ Tribal Agency
☐ Another County Agency
☐ Member of the community at Large
☐ Other, please specify:

Your primary/preferred language:

☐ English
☐ Spanish
☐ Vietnamese
☐ Filipino
☐ Sign Language
☐ Other:

6. Do you have any additional comments?

Please return survey to:

MHSA - PEI Community Survey
RCDMH – Research and Evaluation
Mail Stop: 3825
3840 Myers Street, 1st Floor
Riverside, CA 92503

Or fax to: 951-358-7580

If you would like to be notified when the plan is complete for an opportunity to see the results of your input as well as to give additional input please provide the following information.

Name:
Address:
Email:

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH

JERRY WENGERD, DIRECTOR

MHSA – Prevención e Intervención Temprana Encuesta para la Comunidad

El Acta de Servicios de Salud Mental (MHSA por sus siglas en Inglés), aprobada por los votantes en el 2004 como Proposición 63, está lanzando su programa Prevención e Intervención Temprana. Queremos saber qué piensa Usted en cuanto a los servicios que serán ofrecidos y de los grupos de personas con enfermedades mentales que serán ayudadas mediante los programas de Prevención a Intervención Temprana en el Condado de Riverside.

El elemento Preventivo de el PEI (Prevención e Intervención Temprana por sus siglas en Inglés) tiene el propósito de reducir los factores de riesgo o los factores estresantes para prevenir el periodo inicial de un problema de salud mental y también para promover y apoyar el bienestar de personas "en-riesgo" que están pasando por circunstancias difíciles en la vida y así poder reducir el sufrimiento asociado con problemas de salud mental.

El elemento de Intervención Temprana de el Programa PEI está diseñado para prevenir que un problema de salud mental empeore. Estos programas están dirigidos hacia personas que con una intervención de corta duración (menos de 1 año), y una intervención de intensidad relativamente baja, puedan demostrar el mejoramiento del problema de salud mental, o la prevención del empeoramiento de los mismos.

Para mayor información acerca de los programas de MHSA PEI, por favor visite

http://www.dmh.ca.gov/prop_63/MHSA/prevention_and_early_intervention/default.asp

Le agradecemos de antemano por completar la encuesta que está a continuación. La información que nos proporcione es confidencial y es anónima.

Departamento de Salud Mental del Condado de Riverside
MHSA – Prevención e Intervención Temprana (PEI)
Encuesta a la Comunidad

El propósito de esta encuesta es para conseguir ideas de cómo hacer que nuestra comunidad sea más saludable, y para reducir la necesidad de servicios de salud mental, intensivos aumentando el conocimiento acerca de las necesidades emocionales de las personas que viven en su comunidad. Por favor ayúdenos contestando las siguientes preguntas:

1. Por favor califique los siguientes grupos para indicarnos cual de ellos en su comunidad, usted cree que tiene más necesidad de los servicios de salud mental de Prevención e Intervención Temprana. ***(Seleccione una calificación para cada grupo: A,B,C,D,F y G)***

   A. Niños y Jóvenes en familias con mucho estrés. Por ejemplo: Niños (as) alojados en casas fuera de sus hogares, familias con problemas de abuso de drogas, violencia doméstica, familias recientemente emigradas, depresión u otras enfermedades mentales, etc.

   ☐ Indice muy Bajo ☐ Indice Bajo ☐ Indice Moderado ☐ Indice Alto ☐ Indice muy Alto

   B. Niños y Jóvenes en riesgo de fracasar en la escuela o dejar la escuela.

   ☐ Indice muy Bajo ☐ Indice Bajo ☐ Indice Moderado ☐ Indice Alto ☐ Indice muy Alto

   C. Personas que hayan atentado o estén en riesgo de cometer suicidio:

   ☐ Índice muy Bajo ☐ Índice Bajo ☐ Índice Moderado ☐ Índice Alto ☐ Índice muy Alto

   D. Niños y Jóvenes en riesgo de estar involucrados, o que tienen problemas con el sistema Judicial:

   ☐ Índice muy Bajo ☐ Índice Bajo ☐ Índice Moderado ☐ Índice Alto ☐ Índice muy Alto

E. Personas con un trauma (por ejemplo: la pérdida de un ser querido, el empleo o la casa; aislamiento social, abuso, violencia doméstica, refugiados)

☐ Índice muy Bajo ☐ Índice Bajo ☐ Índice Moderado ☐ Índice Alto ☐ Índice muy Alto

F. Personas que por lo regular necesitan, pero no reciben los servicios de salud mental (por ejemplo: por su religión, por su cultura, lenguaje, edad, sexo, estilo de vida o creencias):

☐ Índice muy Bajo ☐ Índice Bajo ☐ Índice Moderado ☐ Índice Alto ☐ Índice muy Alto

G. Personas que muestran señales de enfermedades mentales serias:

☐ Índice muy Bajo ☐ Índice Bajo ☐ Índice Moderado ☐ Índice Alto ☐ Índice muy Alto

2. **Por favor liste otros grupos de personas que usted considera necesitan de los servicios de salud mental de Prevención e Intervención Temprana:**

3. **Ya identifico usted identifico los grupos que usted piensa tienen más necesidad de los servicios de salud mental de Prevención e Intervención Temprana en su comunidad. Qué ideas nos puede dar en cuanto a cómo ayudar a esos grupos. (Por ejemplo: evaluación temprana, servicios de educación y apoyo para los padres, información en cuanto a servicios disponibles y referencias, más entrenamiento para los profesionales que ayudan, programas que se podrían dar en los trabajos, etc.,).**

6. Donde se sentiría mas cómodo para recibir los servicios de de Prevención e Intervención Temprana en caso de que usted o su familia tuvieran esa necesidad. (puede escoger mas de uno)

☐	Oficina del Doctor	☐	Servicios Sociales	☐	Organización Comunitaria
☐	Escuela	☐	Su lugar de trabajo	☐	Otro:
☐	Organización Religiosa	☐	Centros de desempleo	☐	Otro:
☐	Casa de un familiar	☐	Su casa	☐	Otro:

5. **Por favor conteste lo siguiente. La información que nos proporcione será confidencial y anónima. Sus respuestas ayudarán al Condado de Riverside a determinar en qué forma más eficiente podría ayudar con la necesidades de la comunidad.**

Edad:

- ☐ 15 o menos
- ☐ 16 a 20 años
- ☐ 21 a 25 años
- ☐ 26 a 35 años
- ☐ 36 a 55 años
- ☐ 56 a 65 años
- ☐ 65 años o mas

Sexo:

- ☐ Masculino
- ☐ Femenino

Si usted pertenece a una agencia u organización, por favor déjenos saber a qué agencia o posición tiene.

Agencia:
Cargo/Posición:

Cual Región del Condado está usted más interesado. ***(Si no es toda la región por favor especifique, cual ciudad)***

☐ Región Central
Hemet, Perris, Lake Elsinore, San Jacinto, Temecula

☐ Región del Oeste
Norco/Corona, Moreno Valley, Riverside

☐ Región del Desierto
Banning, Blythe, Cathedral City, Indio

☐ Otro

¿Su Raza o procedencia étnica?

☐ Nativo Americano – Tribu :
☐ Asiático
☐ Negro / Afro-Americano
☐ Hispano / Latino
☐ Islas del Pacífico
☐ Blanco / Anglo Sajón
☐ Otro, por favor especifique:

¿A Cuál de los siguientes grupos usted pertenece?

☐ Consumidor/Cliente
☐ Miembro de Familia
☐ Guardián o Padre de Crianza
☐ Maestro o Empleado de la Escuela
☐ Agencia Comunitaria
☐ Agencia de una Tribu
☐ Otra Agencia del Condado
☐ Miembro regular de la Comunidad

☐ Empleado del Departamento de Salud Mental

☐ Otro, por favor especifique:

¿Su idioma preferido?:

☐ Inglés ☐ Vietnamés ☐ Lenguaje en señas
☐ Español ☐ Filipino ☐ Otro:

6. ¿Comentario adicional?

Por favor regrese esta encuesta a:

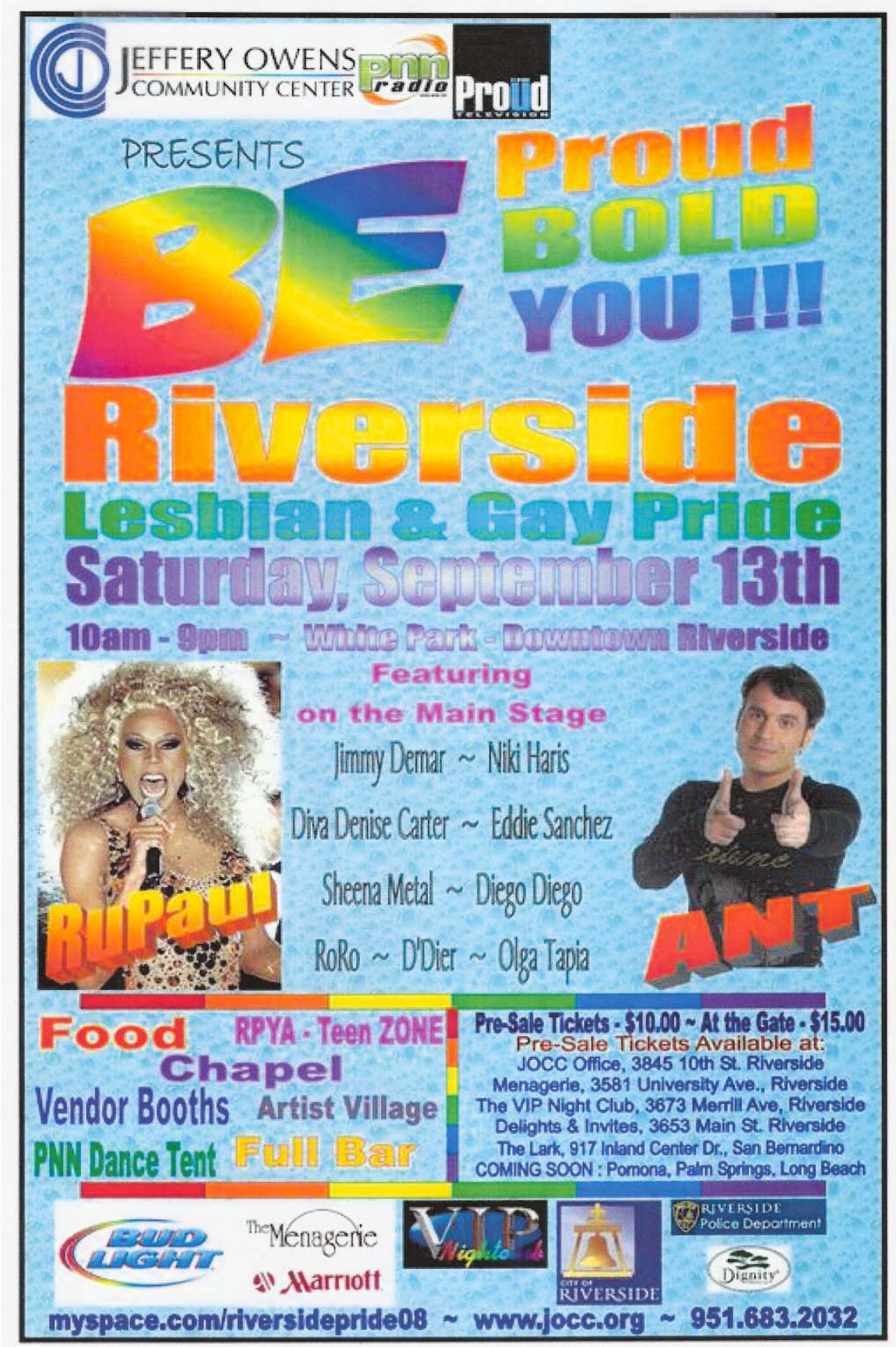
MHSA – PEI Community Survey
RCDMH – Research and Evaluation
Mail Stop: 3825
3840 Myers Street, 1st Floor
Riverside, CA 92503

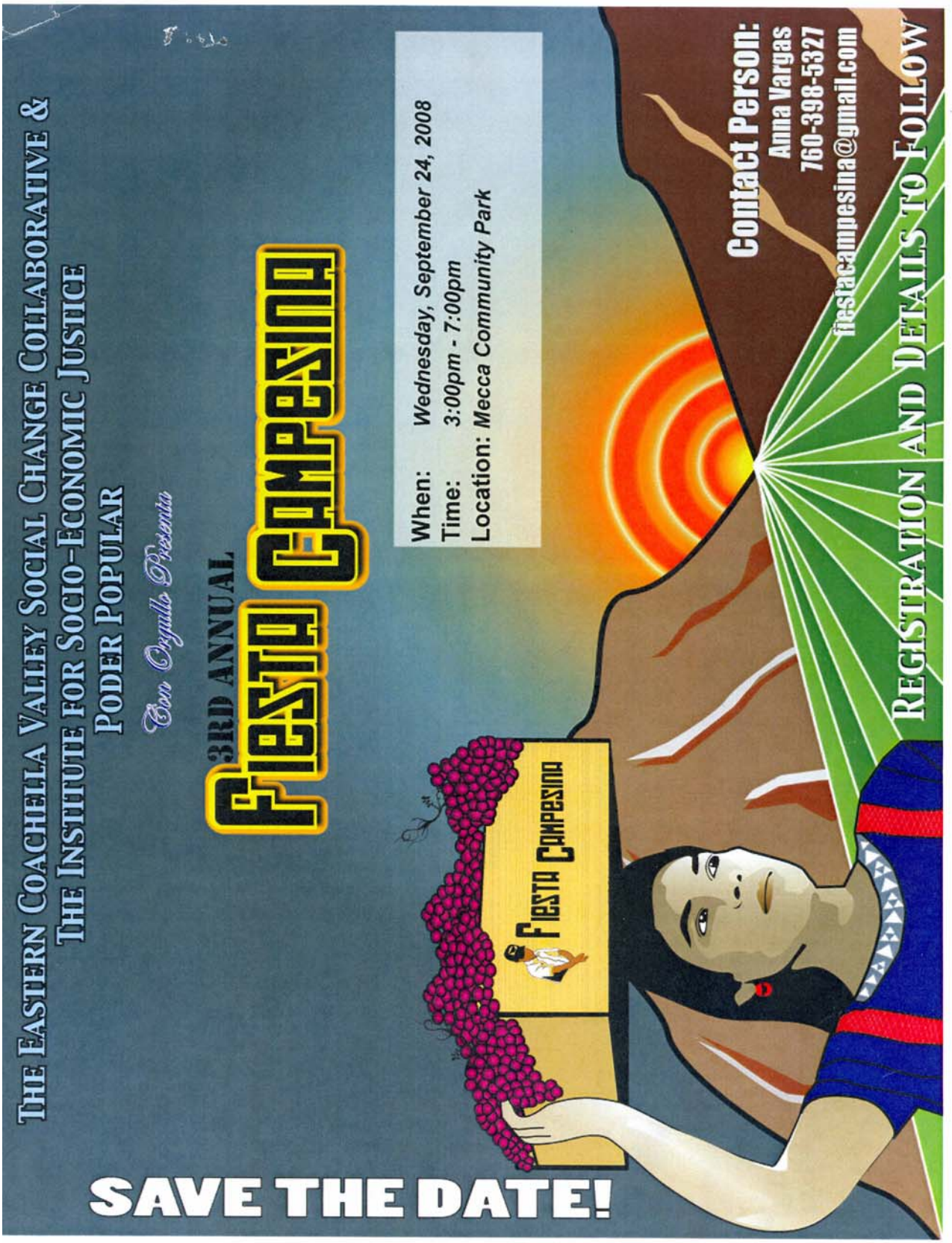
O al Fax: 951-358-7580

Si gustaría que le avisen cuando el plan este completo, para que usted tenga oportunidad de ofrecer algunas recomendaciones adicionales, por favor complete la información siguiente:

Nombre:
Dirección:
Correo Electrónico:


The County of Riverside
Department of Public Social Services
Perris Valley Community Resource Fair
FAIR
Friday, September 12, 2008
11:00am-6:00pm
Location: Perris Valley Family Resource Center
371 Wilkerson Ave., Suite L
Perris, CA 92570
Giveaways! • Music! • Free Food! • Fun Activities!
Entertainment! • Boxing Demonstration!
Many more resources available!
Job Fair 11:00 am-4:00pm
Participating employers include-
Starcrest, Peopleschoice, and many more...
For more information call 951.443.1158
Sponsored by City of Perris, DPSS—GAIN CalWorks, Oasis Perris Youth Opportunity Center
Full Armor of God Ministries, Miller-Jones Mortuary, Prevent Child Abuse Riverside County/SHIELD


JEFFERY OWENS COMMUNITY CENTER
pnn radio
Proud TELEVISION
PRESENTS
BE Proud BOLD YOU !!!
Riverside
Lesbian & Gay Pride
Saturday, September 13th
10am - 9pm ~ White Park - Downtown Riverside
Featuring
on the Main Stage
Jimmy Demar ~ Niki Haris
Diva Denise Carter ~ Eddie Sanchez
Sheena Metal ~ Diego Diego
RoRo ~ D'Dier ~ Olga Tapia
RuPaul
ANT
Food
RPYA - Teen ZONE
Chapel
Vendor Booths
Artist Village
PNN Dance Tent
Full Bar
Pre-Sale Tickets - $10.00 ~ At the Gate - $15.00
Pre-Sale Tickets Available at:
JOCC Office, 3845 10th St. Riverside
Menagerie, 3581 University Ave., Riverside
The VIP Night Club, 3673 Merrill Ave, Riverside
Delights & Invites, 3653 Main St. Riverside
The Lark, 917 Inland Center Dr., San Bernardino
COMING SOON : Pomona, Palm Springs, Long Beach
BUD LIGHT
The Menagerie
Marriott
VIP Nightclub
CITY OF RIVERSIDE
RIVERSIDE Police Department
Dignity
myspace.com/riversidepride08 ~ www.jocc.org ~ 951.683.2032


The Eastern Coachella Valley Social Change Collaborative &
The Institute for Socio-Economic Justice
Poder Popular
Con Orgullo Presents
3rd Annual
Fiesta Campesina
When: Wednesday, September 24, 2008
Time: 3:00pm - 7:00pm
Location: Mecca Community Park
Contact Person:
Anna Vargas
760-398-5327
fiestacampesina@gmail.com
Registration and Details to Follow
SAVE THE DATE!
Fiesta Campesina

SAVE THE DATE

4th Annual Family Partnership Summit

Clinicians & Families
"Making A Difference Together"

This years theme *"INSIDE OUT"*

SPONSORED BY
RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH

October 9, 2008
8:00 am—4:30 pm
Cal Baptist University
8432 Magnolia Avenue
Riverside CA 92504

This conference is free of charge to all that attend,
Lunch is included in registration

(CE's are under review)

Limited Seating. First Come First Serve Basis

Registration Deadline—October 2nd

Introducing:

Parent Partners
Lynne Marsenich, LCSW
Community and Staff

For more information
and registration
please call...

(951) 358-6858

In November 2004, voters in the U.S. state of California passed Proposition 63, the Mental Health Services Act (MHSA).

The Riverside County Department of Mental Health is currently developing the Prevention and Early Intervention Plan with community input. We want to know your ideas about services to be offered and groups of people to be helped by Mental Health Prevention and Early Intervention programs. With your assistance, we can better plan to meet the mental health needs of your community.

"Please fill out a survey and receive a Goody-Bag"

Join us at Saint Joan of Arc's Bazaar

October 10, 11, & 12, 2008

FOR MORE INFORMATION, PLEASE CONTACT MACHI AT KERU RADIO (760) 922-8485

ATTACHMENT I-6
Sample Press Release

Community Members We Need Your Voice!!!

Riverside County Public Library
Arlington Branch
9556 Magnolia Avenue
Riverside, CA 92503

Thursday September 18, 2008
5:00-7:00 pm

Refreshments will be served. Please come and be entered to win a raffle!!
Riverside County Department of Mental Health needs your help in looking at different approaches to best help our community through Prevention and Early Intervention.

We have a new opportunity through the MHSA (Mental Health Services Act) to identify Prevention and Early Intervention strategies that can help our children, families, & community members before they need intensive services.

PLEASE COME AND LET YOUR VOICE BE HEARD.

For more information contact: Janine Moore (951) 358-3941

Miembros de la Comunidad Latina Necesitamos su Opinión

Lo invitamos a participar en un Foro Comunitario en

La Biblioteca de Riverside
Arlington Branch
9556 Magnolia Avenue
Riverside, CA 92503

Jueves 18 de Septiembre del 2008
5:00 pm -7:00 pm

¡Habrán refrescos y la oportunidad de participar en el sorteo de un regalo!

El Departamento de Salud Mental necesita de su ayuda para buscar nuevas ideas de como proveer mejores servicios a nuestra comunidad a través de la Intervención Temprana y la Prevención.

Tenemos una nueva oportunidad por medio del MHSA (Acta de Servicios de Salud Mental) de identificar estrategias de Intervención Temprana y Prevención que podrían ayudar a nuestros hijos, familias y miembros de la comunidad antes de necesitar servicios intensivos de salud mental.

Por favor Asista y deje escuchar su Voz.
Para más información llame a: Janine Moore (951) 358-3941

Community Members
We Need Your Voice!!!

We need you to participate in a Community Forum

At the
Kay Ceniceros Senior Center
29995 Evans Road
Sun City, CA 92586

Thursday October 9, 2008
8:00-10:00 am

Free Breakfast will be served.

Please come and be entered to win a raffle!!
Riverside County Department of Mental Health needs your help in looking at different approaches to best help our community through Prevention and Early Intervention.
We have a new opportunity through the MHSA (Mental Health Services Act) to identify Prevention and Early Intervention strategies that can help our children, families, & community members before they need intensive services. Please come and let your voice be heard.

FOR MORE INFORMATION CONTACT:

Janine Moore (951) 358-3941
Diana Brown (951) 358-7363

ATTACHMENT I-9
Sample Flyers

Children's System of Care Committee

Attendance List for PEI 2-Day Facilitated Process

NAME	Representation
Becky Love	Probation
Claire Karp	Pacific Clinics
Erlys Daily	RCDMH
Susan Johnson Mora	Children's Health
Tori St. Johns	Desert Sands Unified School District - SAP
Denise Miller	Desert Sands Unified School District - SAP
Jan Ryan	RCDMH - Prevention Consultant
Jim Rothblatt	RCDMH/ INCIGHT
Jackie Moot	Operation Safehouse
Chatherine Behnke	Operation Safehouse
Phil Breitenbudy	DPSS
Michelle Burroughs	First 5 Riverside
Gregg Hillis	San Jacinto Schools
Dennis Bixler	DPSS
Bob Alkire	Substance Abuse
Kenneht White	Jefferson Transitional Programs
Drew Oberjuerge	Art Works - Jefferson Transitional Programs
Larry Searles	Riverside County Office of Education
Raquel L. Marquez	Riverside County District Attorney's Office
Mariah Andrews	RCDMH
William Harris	Substance Abuse Prevention
Chris Home	RCDMH
Renee Becker	RCDMH/ Family Member
Patty Rucker	Moreno Valley Unified School District
Christina Salas	Mental Health Board
Shari Wolf	Family Member
Mary Ault	Children's Protective Services
Maria Murillo	Family Services Association
Jackie Rangel	IEHP
Phil Takacs	Banning Unified School District
Veronica Hilton	Department of Public Health
Lyla Wilson	Mt. San Jacinto NAMI
Wes Wilson	Mt. San Jacinto NAMI
Hattie Byland	Riverside Unified School District
Mary Ellen Johnson	Department of Public Social Services/ Children's Protective Services
Bryce Hulstrom	Probation
Sue Moreland	Peer Support
Robert Diaz	Riverside Unified School District
Patricia Douglas	Department of Public Health

Transition Age Youth Committee

Attendance List for PEI 2-Day Facilitated Process

NAME	Representation
Vicki Butler	County SELPA
Rocco Cheng	Pacific Clinics
Robert Diaz	Riverside Unified School District
Cheryl English	Victor Community Support Services TAY FSP
Anthony Escalera	Riverisde Community College - ILP
Lisa Jackson	RCDMH
Frank Jefferson-Glipa	RCDMH
Lorie Lacey-Payne	RCDMH - Family Member
Dan Mannion	Probation
Lawanda Martinez	Public Defender
Kathy McAdara	Operation Safehouse
Megan Burrah	Consumer
Ann Miller	Operation Safehouse
Maria Murillo	Family Services Association
Steve Oppenheimer	Harmony Center - TAY FSP
Benita Ramsey	VFSJM
Jan Ryan	Prevention Consultant
Jose Sanchez	TAY Harmony Peer Center
Nancy Satterwhite	DPSS Wraparound
Brenda Scott	Anka
Larry Singh	Oasis, Mentoring
Steve Steinberg	RCDMH
Wanda Street	Anka
Mark Thuve	RCDMH - Substance Abuse
Chanel Wark	Jefferson Transitional Programs
Tiffany Keeler	Art Work - Jefferson Transitional Programs
Morgan Kiel	Consumer
Bob Alkire	Substance Abuse Prevention Consultant
Matthew Fuggent	Consumer
Christine Hynek	Consumer
Phil Takas	Banning Unified School District
Melissa Rini	Consumer

Adult System of Care Committee

Attendance List for PEI 2-Day Facilitated Process

NAME	Representation
Wanda Street	Community Agency - ANKA
Brande McKenzie	Consumer
Hilda Gallegos	RCDMH
Gina Cuevas	VCRC Helpline
Hal Adams	Family Member NAMI
Juanita Adams	Family Member NAMI
Don Sercombe	Riverside County Mental Health Board Member
Mary Allred	Riverside County Mental Health Board Member
Luis Zapata	RCDMH
Grace Kaelin	Family Member NAMI
Maria Jaquez	Consumer

Older Adult System of Care Committee

Attendance List for PEI 2-Day Facilitated Process

NAME	Representation
Pat Kendrick	Department of Public Social Services/ Adult Protective Services
Rena Moncrease	Department of Public Social Services/ Adult Protective Services
Nate Ramirez	RCDMH
Harvey Stern	Golden Rainbow Senior Center
Linda Parker	RCDMH
Ed Fletcher	RCDMH
Marshiq Wilson-Martin	Office on Aging
Valerie Wheat	Office on Aging
Kei Tiggs	RCDMH
Stephanie Bryant	Department of Public Health - Nursing
Mark Thuve	Riverside County Substance Abuse
Mario Lopez	Consumer
Debbie Katz	RCDMH
Grant Gautscle	Riverside County Veterans Services
Margo Alexander	RCDMH
Barbara Mitchell	RCDMH
Vikki Nuegebauer	Office on Aging
Donna Johnston	Board of Supervisors

ATTACHMENT K-1

MHSA Prevention & Early Intervention

Trauma Workgroup

NAME	Representation
Veronica Hilton	Public Health
Diane Mitzenmacher	RCDMH
Marshiq Wilson-Martin	Office on Aging
Ann Miller	Operation Safehouse - TLP
Lisa Lopez	Operation Safehouse - TLP
Lue Thao	Adult Protective Services/ In-Home Supportive Services
Jim Powell	Substance Abuse
Rachel Ligtenberg	Probation
Kate Thibault	Alternatives to Domestic Violence
Ruth Kantorowicz	CAP Center
Genevieve Aparicio	CAP Center
Marc Cruz	Rainbow Pride Youth Alliance
Paula Arnett	Rainbow Pride Youth Alliance
Sandra Williams	Parents Anonymous Inc.
Amanda B. Weil	Rainbow Pride Youth Alliance
Debora Monroe-Heaps	Riverside Rape Crisis
Jodee Palmer	Inland Agency
Becky Foreman	Inland Agency
Rachaline Napier	RCDMH – Research& Evaluation
Holly Chavez	Alternatives to Domestic Violence
Anne Johnson	RARCC
Augusto Minakata	Parents Anonymous
Don Sercombe	Mental Health Board Member
Jim Milliken	Mental Health Board Member
Charity Cason	RCDMH – Research & Evaluation
April Carroll	Substance Abuse
Maggie Hawkins	Rainbow Pride Youth Alliance
Mike O'Brien	Inland Regional Center
Jim Powell	Substance Abuse
Maria Marquez	RCDMH
Irma Ficere	RCDMH
April Carroll	Substance Abuse
Lynne Marsenich	RCDMH Consultant

MHSA Prevention & Early Intervention
Reducing Disparities Workgroup

NAME	Representation
Jasmine Alvarez	Riverside Latino Commission
Myriam Aragon	Ethnic Services/Cultural Competency Manager
Sara Berglund	Harmony Center
Charity Cason	RCDMH – Research & Evaluation
Alison Clark	Oasis Peer Support and Resource Center
Dalmino Crispin	St. Anthony's Church
Ninfa Delgado	Riverside Community Health Foundation
Renda Dionne	Native American Outreach Consultant
Miguel Duarte	Department of Rehabilitation
Martin Ekoumou	Global Health Promoter
Alison Emery	Director of Consumer Affairs
Claudia Espinoza	Family Advocate
Jan Hawkins	Boys & Girls Club of Coachella Valley
Gloria Hernandez	Consumer Liaison
Veronica Hilton	Department of Public Health
Alfredo Huerta	RCDMH
Maria Jaquez	Consumer
Ben Jauregui	IEHP
Brandon Lee	RCDMH
Mario Lopez	RCDMH
Rosa Lopez	Riverside County Office of Education Head Start
Luke Madrigal	Executive Director Coachella-Anza Indian Tribes
Virginia Marshall	Mid-County Mental Health Board Member
Ana Melgar	Coorinador de Formacion de la Fe
Daniel Miramontes	RCDMH
(Father) Arturo Monzon-Balagat	San Antonio de Padua Catholic Church
Carla Morgenstern	Indian Child & Family Services, Temecula
Sherry Morris-Logan	Mead Valley Community Center
Carolyn Murray	University of California Riverside Psychology Department
Eddie Pesqueda	Riverside Latino Commission
Moises Ponce	RCDMH
Benita Ramsey	LGBTQ Outreach Consultant
Javier Rosales	Community Advocate
Reina Solahes	St. Anthony's Church
Leslie Soto	RCDMH
Felipe Torres	San Antonio Parish
Jennifer Vaughn-Blakely	African American Community Group

MHSA Prevention & Early Intervention Stigma & Discrimination Reduction Workgroup

NAME	Representation
Gloria Hernandez	Consumer
Mary Crater	Community Member
Mary Allred	Mental Health Board Member
Bob Gleason	Consumer
Vikki Nuegebauer	Office on Aging
Shari Wolf	Family member
Melinda Krum	Community Member
Tiffany Keeler	Consumer
Kim Munkres	CAMFT/Marketing
Ron Stewart	Department of Public Social Services
Carl Dameron	Media Consultant
Tracy Hutchinson	Riverside Unified School District Community School
Jaclyn Jones	Staff Assistant
Benita Ramsey	RCDMH Consultant

ATTACHMENT L
Desert Consortium Attendance List

Name	Organization
Benson, Jean	Mayor, City of Palm Desert
Bornstein, Amy	Director, EXCEED, A Working Solution
Boyea, Jennifer	Riv. Co. Mental Health - Juvenile Hall Clinical Therapist
Brenneman, Bill	Manager, Mental Health Services Act (MHSA) - Riverside County
Brinkman, Michael	Riverside County Probation
Corona, Veronica	Harmony Center FSP/TAY - Mental Health
Cox, Judee	CEO Regional Access Program (RAP) Foundation
Craig, Donna	Chief Program Officer - Desert Healthcare District
Cummings, Dennis	Juvenile Hall, Asst. Director
Dingle, Pio	Riv. Co. Dept. Mental Health, Behavioral Health Specialist - Substance Abuse
Ducatte, Jim	Boys & Girls Club of Coachella Valley Foundation - CEO
Egson, Quinton	Boys & Girls Club of Coachella Valley - Chief Professional Officer
Evosevich, Jim	Palm Springs Unified School District
Funtanilla, Ray	EXCEED, Employment Specialist
Godwin, Juanita	B&G Club - Coachella Unit Director
Graham, Deanna	Environmental Prevention Specialist, CRUD/DMH
Harmon, Steve	Oasis Rehabilitation Center
Hauf, Sandra	COD Disabled Students Programs and Services (DSPS) Counselor Specialist
Hawkins, Jan	Boys & Girls Club of Coachella Valley - Director of Development
Hernandez, Manuel	Mental Health-Probation After Care Liaison
Hildebrandt, Isabel	COD, Training and Development - Workplace Learning
Hullana, E.J.	DreamCatchers Empowerment Network (Meeting facilitator)
Ison, Dave	City of Indio, Human Services Director
Leinow, Joanne	Big Brothers Big Sisters - Partnership Director
LiCalsi, Pam	Dean, Training & Development, College of the Desert
Lundquist, David	Desert Region Manager, Riverside County Dept. of Mental Health
Marrujo, Gil	DSUSD - Student Assistance Program (SAP) Facilitator
May, Judy	Riverside County Office of Education - (Works with hearing impaired)
Mejia, Leslie	University of Phoenix Coordinator/Intern
Moore, Janine	PEI Coordinator, MHSA
Muller, Denise	Student Assistance Program, DSUSD
Neal, Alonzo E.	Riverside County Resident
Nelson, Rick	EXCEED, A Working Solution - A Division of Valley Resource Center
Nix, Siah	Unit Director, B&G Club of La Quinta
Pollard, Vicki	DSUSD Student Assistance Counselor
Ramirez, Patsy	Harmony Center FSP/TAY - Mental Health Peer Support Center
Reed, Tracy	B&G Club - Indio Unit Director
Robinson, Scott	CPO, B&G Club of Cathedral City
Rothblatt, Jim	Coordinator, Incight & James O.Jesse Student Advocacy Project & Redleaf Resources
Ryan, Jan	Redleaf Resources
Soucy, Wayne	Private Consultant
St. Johns, Tori	Student Assistance Program, DSUSD
Strange, Troy	Building Horizons, Inc. - Executive Director

ATTACHMENT L
Desert Consortium Attendance List

Takacs, Philip	Student Assistance Coordinator, Banning USD
Thornton, Mary Jo	Licensed Marriage and Family Therapist
Toledo, Elizabeth	Supervisor Roy Wilson's Office, Riverside County
Trujillo, Scott	City of Indio, Human Services Supervisor - Youth
Williams, Tony	Boys & Girls Club of Coachella Valley - Director of Operations
Young, Peter	Desert Healthcare District Interim CEO

Foundations:
Prevention and Early Intervention

Riverside County Department of Mental Health
Mental Health Services Act

Prepared by:
Ryan Quist, Ph.D.
Research, Evaluation, and Quality Improvement
Riverside County Department of Mental Health
Lynne Marsenich, LCSW
California Institute for Mental Health

AGENDA

- **Summary of Initiative**
- **What is Prevention and Early Intervention?**
- **Priority Populations**
- **Request for Input**

The purpose of this presentation is to provide a foundation of information about Prevention and Early Intervention (PEI).

PEI is very different from the way the Mental Health System is used to doing things.

Prevention and Early Intervention, also known as PEI, is just one of the MHSA funding initiatives.

AGENDA

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Riverside County Department of Mental Health 5

What is Prevention and Early Intervention?

Bottom Line:

This is not just more of what we're already doing.

True Prevention Interventions are necessary to successfully transform the Mental Health System.

Riverside County Department of Mental Health 6

Important Differences From Traditional Mental Health Programs:

Decisions about who the program serves:

Traditional mental health services are primarily driven by referrals and because of extreme need for services

PEI programs do not wait for clients to come to them, the programs select populations and communities based on risk factors

How to tell if services are successful and/or complete?

In traditional programs, clients graduate when treatment goals are reached, and outcomes can be measured

For PEI programs it's difficult to tell if the program's goals are met.

Services are typically shorter in duration.

Riverside County Department of Mental Health 7

What Do Prevention and Early Intervention Programs Look Like?

Prevention Two Program Approaches		Early Intervention
Provided to entire groups without identifying specific individuals.	Provided to individuals identified based on risk factors.	Limited duration services provided to individuals identified by symptoms but not severe enough for diagnosis.
Examples: Health Promotion Positive Development Strategies Programs for Entire Schools	Examples: Programs to families that lack resources Programs for single-parent homes or young mothers	Examples: Programs for children at risk for school failure due to emotional/behavioral problems Children in trouble at school but not yet in juvenile justice

Riverside County Department of Mental Health 8

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State Guidelines for Prevention and Early Intervention

Community Needs

- Reduce Access Disparities
- Psycho-Social Impact of Trauma
- At-Risk Children, Youth, & Young Adult Populations
- Stigma and Discrimination
- Suicide Risk

Priority Populations

- Underserved Populations
- Children/Youth in Stressed Families
- Trauma Exposed
- At risk for school failure due to MH problems
- At risk or involved with Juvenile Justice due to MH problems
- Individual with an At-Risk Mental State

Riverside County Department of Mental Health 10

State Requirements for Funds

- At least half of PEI funds must benefit children and young adults ages 0-25 years.

Riverside County Department of Mental Health 11

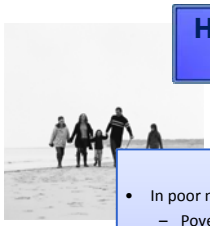
What Are Riverside County's Under Served Populations?

- Ethnic Minorities:
  - Almost every ethnic minority group is under served
  - The ethnic group with the largest number of underserved individuals is Latinos
- Compared to other counties, Riverside serves a smaller proportion of Foster Care children
- For ages 0-25, fewer girls are served than boys
  - Boys are more likely to act out, get in trouble for fighting or getting into the juvenile justice system
  - Girls are more likely to have depression or other disorders that escape notice by parents and teachers
- For older adults, more women are served than men
- Riverside County has a rather large Deaf community that is under served

Sources available on request.

Riverside County Department of Mental Health 12

How to Identify Youth Exposed to Family Stress or Trauma?



- In poor neighborhoods, families have multiple sources of stress:
  - Poverty, Malnutrition, Poor Healthcare
  - High Rates of School Dropout, Poor Academic Performance
  - Exposure to Violence, Crime, Alcohol, Drugs
- Neglect / Abuse, including un-confirmed by protective services
- When parents are Mentally Ill, Abuse Substances, or have Chronic / Fatal Physical Illness
- Children with parents involved in criminal justice system
- Inadequate income and/or social supports at home

Sources available on request.

Riverside County Department of Mental Health 13

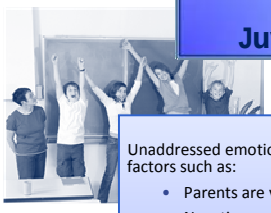
Which Children Are At Risk for School Failure?

Unaddressed emotional and behavioral problems plus additional risk factors such as:

- Lack of resources
- Substance use/abuse
- Low school bonding
- Depression/anxiety
- Family Conflict
- Family management problems
- Negative peers
- Delinquency
- Academic Failure beginning in late elementary school

Sources available on request.

Riverside County Department of Mental Health 14



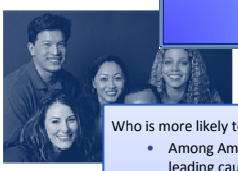
What Increases Risk for Juvenile Justice Involvement?

Unaddressed emotional and behavioral problems plus additional risk factors such as:

- Parents are very physical and arbitrary with discipline
- Negative peer group
- Regular exposure to aggression, physical violence, and/or frequent domestic arguments
- Exposure to sexually explicit materials on a frequent basis
- Families that use/abuse or have favorable attitudes about alcohol and drugs
- Weapons in the home or visibly present in the neighborhood
- Friends / family members have a criminal record

Sources available on request.

Riverside County Department of Mental Health 15



What Do We Know About Suicide Risk?

Who is more likely to attempt / commit suicide?

- Among American Indian/Alaska Natives ages 15-34, suicide is the leading cause of death
- Hispanic female high school students report the highest percentage of suicide attempts among all high school students
- Suicide is the leading cause of death among 15 to 24 year olds
- The rate of suicide for adults aged 65 and older is 14.3 per 100,000
- Gay, lesbian, and transgendered adolescents are more likely to attempt suicide than their heterosexual peers
- Risk factors for suicide (not an exhaustive list):
  - Family history of suicide
  - Lack of social support and sense of isolation
  - Stigma associated with help-seeking behavior
  - History of Trauma or abuse
  - Alcohol and other substance use disorders

Sources available on request.

Riverside County Department of Mental Health 16

How is PEI Affected By Stigma and Discrimination?

- Another focus identified in the State's Prevention and Early Intervention guidelines is the goal of reducing stigma and discrimination for mental illness
- Stigma makes it less likely that people will:
  - Recognize early signs of mental illness
  - Talk about problems, ask for help, seek treatment
- Discrimination makes it difficult for:
  - Recovery, belief that positive outcomes are possible, self-confidence

Sources available on request.

Riverside County Department of Mental Health 17

What Do We Know About Identifying Early Onset?

- History of prior mental health treatment
- Most common diagnoses are depression, anxiety, and ADHD
- Approximately 1/3 have been previously hospitalized
- Abuse / Use of Alcohol & Substances Higher for Youth Developing Mental Illness – especially cannabis use
- Early intervention is critical to avoid hospitalization and the loss of age appropriate role functioning

Sources available on request.

Riverside County Department of Mental Health 18

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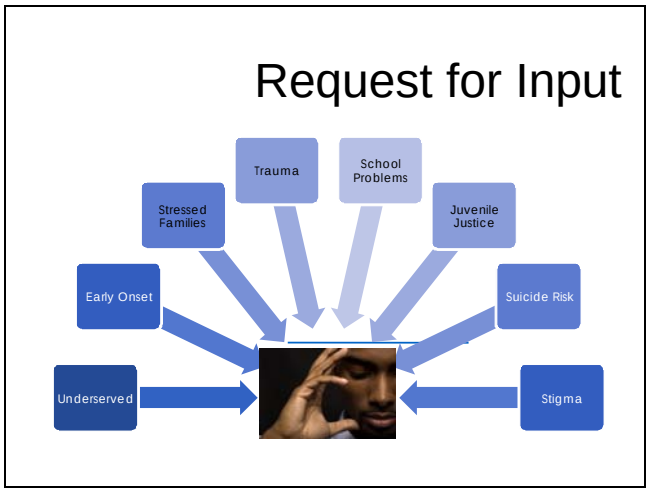
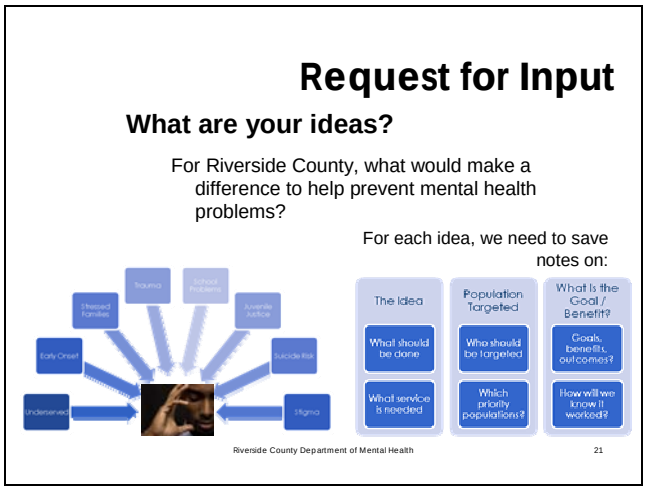

Request for Input
Trauma
School Problems
Stressed Families
Juvenile Justice
Early Onset
Suicide Risk
Underserved
Stigma


Request for Input
What are your ideas?
For Riverside County, what would make a difference to help prevent mental health problems?
For each idea, we need to save notes on:
The Idea
What should be done
What service is needed
Population Targeted
Who should be targeted
Which priority populations?
What is the Goal / Benefit?
Goals, benefits, outcomes?
How will we know it worked?
Riverside County Department of Mental Health
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Request for Input
Now, go back and rank the ideas
Here are some ideas about which should get higher ranks.
Addresses those most at risk
Priority Populations
Greatest Priority Need
Areas of Greatest Need
Fixes the Most Important Problems
Will save lives
Will avoid hospitalizations
In addition to priority populations, targets vulnerable populations (example: infants)
Impacts Lots of Priority Populations
Hits most or all priority populations
Can tell who benefits and how
Benefits Lots of People
Is easy or inexpensive to give to lots of people
Benefits Multiple Age Groups
Riverside County Department of Mental Health
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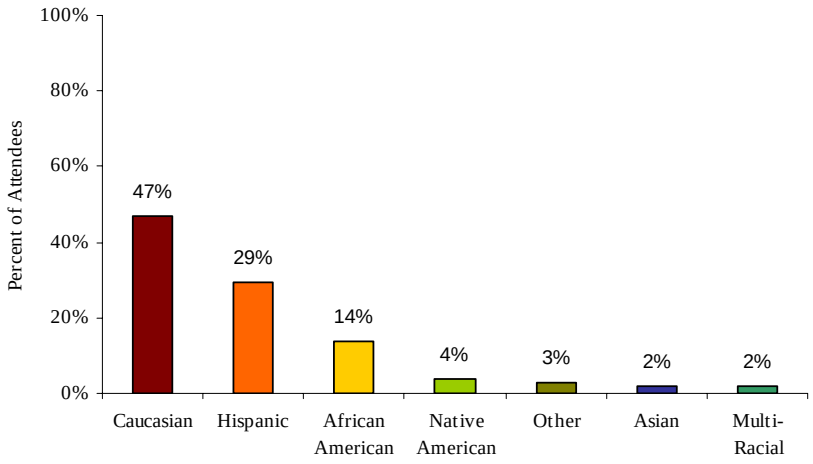
ATTACHMENT N-1
Demographic Overview of Focus Group Participants

Demographic information was collected from focus group participants including; gender; age; ethnicity; language; region; participant involvement and agency affiliation if any. Nine-hundred and thirty-five participants completed a demographic survey from the 1,147 that attended. Focus group participants were diverse and included: consumers, family members of consumers, mental health staff, community agencies, county agency staff, and staff from local school districts. Table 1 below represents the distribution of participants by involvement indicated on the demographic survey. Consumers or family members of consumers receiving services represented the largest proportion (32%) of focus group participants. County of Riverside employees (Mental Health and other County agencies) accounted for 23% of all focus group participants. School districts and community agencies accounted for 18% of participants.

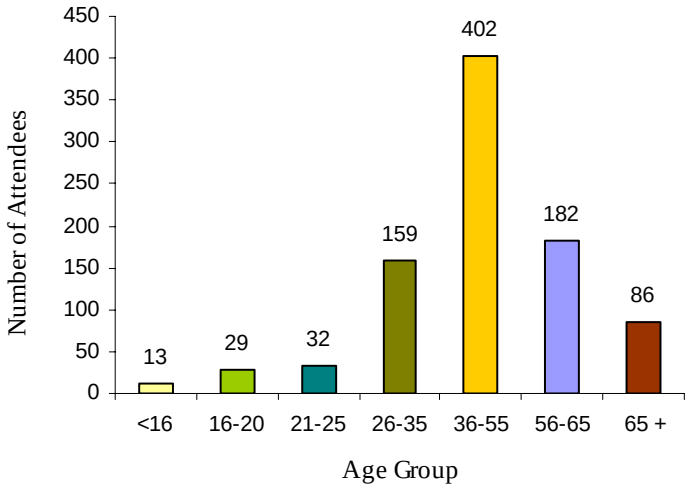
Participant Involvement	Count	Percent of Total
Consumer	146	16%
Family Member	124	13%
Guardian/Foster Parent	25	3%
Riverside Co. Mental Health staff	110	12%
Community Agency	106	11%
County Agency	101	11%
Community Member at Large	76	8%
School Staff	55	6%
Tribal Agency	3	<1
Other	116	12%
Unknown	73	8%

The following graph represents the ethnicity of focus group participants. Nearly half of the participants (47%) identified themselves as Caucasian. The next largest ethnic group represented were Hispanics at 29%. Ethnicity was unknown for 45 participants who did not indicate an ethnicity on the survey. Some attendees did not complete a demographic survey. The ethnic distribution of the focus groups was similar to the race/ethnic composition of Riverside County. Hispanics were slightly underrepresented at 29% although they make up 42 % of the population in Riverside County; however given that ethnicity was unknown for a number of participants it is possible Hispanic representation was higher. Caucasians were slightly over represented at 47% given that the Caucasian Non-Hispanic population of Riverside County was 42% in 2007 Census Bureau data. Fourteen percent of all participants identified themselves as African American which is more than twice the percentage of the African American population in Riverside. County which is 6%. The majority of participants (88%) indicated English as their primary language. Spanish was indicated as the primary language for 10% of participants. Other language and American Sign Language were reported by only 1% of attendees.

ATTACHMENT N-1
Demographic Overview of Focus Group Participants

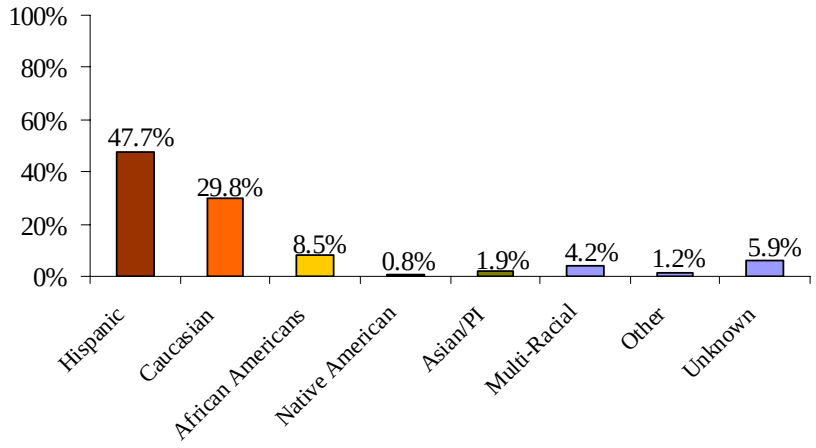


The majority (70%) of focus group participants were female while 30% of the participants were male representing more than a 2:1 ratio of female to male. Participants between the ages of 36-55 made up the largest proportion of focus group attendees who provided their age. Youth ages 25 and under represented the lowest percentage of survey participants at only 8% of the total sample.



ATTACHMENT N-2
Demographic Overview of Community Survey Participants

A majority of the surveys were completed by Hispanic / Latino individuals. Survey results were slightly over representative of Hispanics / Latinos who completed 47.7% of the surveys but representing only 42% of the county's population. African Americans were also overrepresented at 8.5% of survey respondents compared to the County population of 6%. Caucasian and Asian groups were slightly underrepresented.



The majority of respondents reported English as their preferred language. A number of respondents (11%) indicated two preferred languages. Out of those who indicated two languages the overwhelming majority (92%) spoke English and Spanish.

Language	English	Spanish	Multiple Language	Filipino	Vietnamese	American Sign Language
Percentage	72%	16%	11%	<1%	<1%	1.23%

Adults between the ages of 26-55yrs made up the largest proportion of survey respondents (51%). Transition age youth between the ages 16-25yrs were the next largest group of respondents at 25%. Transition age older adults (55-65yrs) and older adults (65+ yrs) were a smaller group of survey respondents at 10.3% and 5.8%, respectively. Youth under the age of 15 yrs were the smallest group at 7.6% of survey respondents. The majority of survey respondents (70%) were female and 30% were male representing more than a 2:1 ratio of female to male respondents.

ATTACHMENT N-2
Demographic Overview of Community Survey Participants

Affiliation

Which of the following groups apply to you?	Number
Consumer	620
Family Member	1,013
Guardian or Foster Parent	126
Member of the Community at Large	254
RCDMH Staff	127
County Agency Other than RCDMH	95
School Staff	182
Community Agency	188
Tribal Agency	8
Other	180

Survey respondents affiliation is presented in the table at left. Respondents could choose more than one group so the frequencies in the table are not unduplicated across groups. The following percentages are unduplicated: over half of the respondents (68%) indicated they were either a consumer, family member, guardian or foster parent, or member of the community at large. Fifteen percent of respondents indicated an organization or agency affiliation. Five percent of respondents indicated other affiliation and 11% percent did not indicate a response.

The Region of the County with which you are most involved or concerned?	Percentage
Desert	39.5%
Western	30.3%
Mid-County	13.6%
Other or multiple regions	7.7%
Blank	8.8%

More respondents indicated they were involved or concerned with the Desert or Western region

ATTACHMENT O-1

Report from the PEI Trauma Workgroup
Facilitator: Lynne Marsenich, LCSW
October 20, 2008

The trauma workgroup met four times for approximately two hours each meeting. The meeting dates were as follows:

- July 10, 2008
- August 20, 2008
- September 16, 2008
- September 23, 2008

The goals for the workgroup were to describe the population in need of prevention and early intervention services related to trauma exposure; to identify existing programs and to identify strategies, programs and or practices that could be provided to the population described and to identify ideal service delivery locations. It should be noted that the group was provided with a definition of trauma and resources describing risk and protective factors as well as examples of program strategies.

Population in Need – Trauma Exposed

The population in need was described by utilizing the MHSA age categories. The "Population Table" which accompanies this report contains the results of the discussion. The group had a very hard time narrowing the population in need and it was clear each member was speaking from their perspective as service providers rather than as potential recipients of services or as informal community leaders. However there was agreement regarding populations most likely to experience disparities: undocumented, gay, lesbian, transgender youth and adults, African Americans, older adults and members of the deaf/hard of hearing community.

The group was asked to identify in what areas of the county people were most likely to be trauma exposed. There was uniformity of response with the following communities being identified: Hemet/Pass Area, Moreno Valley and the Coachella Valley. There was strong agreement that people living in neighborhoods with high rates of violence would be very likely to suffer from the psychosocial effects of trauma but the group was unable to identify specific neighborhoods. **Information from the data download should be able to identify geographic areas with high levels of violence.**

Existing Programs

Most services currently being offered to community members who have been trauma exposed are for victims of domestic violence, child abuse and sexual assault and few are preventive in nature. It is important to note that the group was unable to identify programs to assist people who live in neighborhoods where there are high levels of community violence. In addition there were no programs identified to meet the needs of specific cultural populations with the exception of services for Gay, Lesbian and Transgendered youth in the Desert region of the county. Analysis of the existing programs (see attached survey) reveals regional gaps as well as population gaps. **Specifically, the Desert region is underserved as are older adults and cultural populations of all ages.**

Recommendations

The recommendations made by the group were primarily focused on increasing access through outreach and engagement strategies. In addition recommendations tended toward broad strategies rather than specific programs or practices with one exception. Specifically, there was strong support for ensuring that traumatized individuals received treatment in the form of short-term evidence-based trauma interventions.

Strategies for improving access and decreasing stigma – move service delivery to the community

- Provide in-home services
- Family resource centers
- Offer prevention programs in faith-based organizations – churches, temples and synagogues
- Boys and Girls clubs should be utilized for delivering prevention programs
- Senior centers
- Adelanto Community Center as an example of place and programs for prevention
- Offer services to Vets and their families in organizations that serve Veterans of Foreign Wars rather than the VA
- Prevention services should be offered on school campuses
- Work with the Visiting Nurses Association to offer prevention services to older adults with serious health problems
- Provide services in ethnic specific neighborhood organizations

Outreach strategies for ensuring that programs get to the population in need

- Partner with the Latino commission in the Desert Region
- Partner with the Perinatal coalition in Riverside

- Make sure that materials are in the language of potential users **and** demystify mental health problems by creating a universal strategy. An example – normalize "sadness" and give examples of how sadness is expressed by different people and cultures.

Prevention Strategies

- Offer youth no cost "engaging" after school activities – located in centers on school campuses or next to campuses. Programs should be offered to youth of all ages and income levels
- Peer to peer mentorship for youth who have been trauma exposed. Examples include: Desert Safe House training for peer mentors and San Bernardino County Probation Department – youth counseling other youth who are trauma exposed and at risk to juvenile justice involvement
- Desert Samaritans for the Elderly – provide training for health care providers – recommend they add a screening tool for trauma
- Corona Parks and Recreation – Teen Zone – a model to be built upon in other areas of the county
- Corona Library provides weekly youth education programs – can add psychoeducation on trauma and prevention education on dating violence or other forms of violence likely to be experienced by children and youth
- Provide school based violence prevention programs – promote healthy relationships and appropriate gender roles
- Provide vocational training in communities where youth live. Engage community leaders and local business to offer mentoring and internship opportunities. These strategies can fulfill community service hours for probation youth and provide meaningful experiences that build on youth strength

Specific practice

- Ensure that the psychosocial impact of trauma is reduced through effective early intervention. Examples are Trauma-Focused Cognitive Behavioral Therapy and Prolonged Exposure Therapy.
- Many problems such as child abuse and substance abuse are exacerbated by previous trauma experiences.

Ensure Accountability – many members of the trauma workgroup expressed dissatisfaction with previous prevention efforts, because, from their perspective, money was given to organizations without monitoring progress or expecting outcomes. The most salient example given was after school programs that become "glorified baby sitting" and offer little in the way of meaningful and engaging activities. There was also concern that many of these programs do not hire staff with the requisite skills to provide the service and that the student to adult ratio is too high.

Riverside County Department of Mental Health
Reducing Disparities Workgroup Initial Report
Recommendation for Reducing Disparities in Mental Health Services for Ethnic and Cultural Groups
November 3, 2008

Background

The Mental Health Service Act (MHSA) (formerly known as Proposition 63) was approved by California voters to provide a 1% tax on personal income over $1 million in order to expand and transform the county mental health service system. It became effective January 01, 2005.

The MHSA has five components. Each one of these components requires surveying people and organizations that are involved in mental health services including county mental health staff, community based organizations, consumers and their families, and other county and government organizations.

Per the State guidelines, "An objective of PEI is to increase capacity for mental health prevention and early intervention programs led by appropriately trained and supervised individuals in organizations and systems where people in the community currently go for purposes other than mental health treatment services." The intent of PEI programs is to engage individuals before the development of serious mental illness or serious emotional disturbance or to alleviate the need for additional or extended mental health treatment.

What is Prevention?

- ✓ Prevention in mental health involves building protective factors and skills, increasing support and reducing risk factors or stressors.
- ✓ Prevention efforts occur prior to a diagnosis for mental illness.
- ✓ Generally there are no time limits on prevention programs.

What is Early Intervention?

- ✓ Addresses a condition early in its manifestation
- ✓ Is of relatively low intensity
- ✓ Is of relatively short duration (usually less than one year)
- ✓ Has the goal of supporting well-being in major life domains and avoiding the need for more extensive mental health services
- ✓ May include individual screening for confirmation of potential mental health needs

Definitions

The Reducing Disparities Task force adopted the definitions of Disparities, underserved, unserved and inappropriately served presented by the 1999 Surgeon General Report on Mental Health, and the 2001 Supplemental that examines culture, race and ethnicity in mental health, highlighting the inequality that exist for minority groups needing mental health services; and the New Freedom Commission on Mental Health report Achieving the Promise: Transforming Mental Health Care in America.

The Surgeon General Report Supplement to Mental Health extensively documents the "striking disparities" that exist for racial and ethnic minorities in mental health. They found that "racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they received care, it is more likely to be poor in quality".[1]
The New Freedom Commission on Mental Health came to the conclusion that minorities are unserved, underserved or inappropriately served in the current mental health care. [2]

Riverside County Reducing Disparities Taskforce

The goal of the Reducing Disparities Task Force (RDTF) was to provide feedback to ensure that county mental health efforts to reduce mental health disparities are integrated into the PEI plan. Reducing disparities in mental health access, service utilization and outcomes for cultural, ethnic, and linguistic populations is one of the priorities for the Prevention and Early Intervention Planning. The Mental Health Services Act throughout its various components specifically aims to increase cultural competence and improve services to address unmet needs for unserved, underserved, and inappropriately served communities.
The Reducing Disparities Task Force provided a unique opportunity for community leaders and experts to come together to explore the current disparity issues in the county mental health system, and to benefit from each others' expertise and wisdom in strategically addressing these mental health disparities.

Group Process

- Forming of a diverse task force with representation of community leaders, community based organizations, faith based organizations, partner public agencies, mental health staff, consumers and family members.
- Based on information presented by the RCDMH Research unit and with group discussion the taskforce recommended working on recommendations on how to reduce mental health disparities among the ethnic and cultural groups where the disparity gap is higher.
- Taskforce members adopted "unserved, underserved, and inappropriately served cultural populations" as its priority population, with the understanding that it forms an umbrella for including all other identified priorities.
- Task force members divided into subgroups to address each of the identified unserved, underserved, and inappropriately served ethnic and cultural populations.
- Each of the subgroups worked on coming up with recommendations on how to reduce disparities. Although the time was limited due to PEI planning process

[1] United States Public Health Service Office of the Surgeon General (2001). Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service.

[2] New Freedom Commission on Mental Health (2003). Achieving the promise: Transforming Mental Health care in America. Rockville, MD: Department of Health and Human Services.

deadlines, each of the subgroups had an opportunity to meet, conduct focus groups, and conduct interviews with some key leaders in the community that voiced their concerns and recommendations.

- Taskforce membership reflects the diversity of the community of the community of Riverside County and included such community leaders, community based and faith based organizations, public agencies, consumers and family members, and members of the unserved, underserved, and inappropriately served ethnic and cultural populations.

Challenges and Opportunities

- Building community participation, engagement, and trust.
- Identification of community based and faith based organizations that are serving the unserved, underserved, and inappropriately served ethnic and cultural populations.
- Given the short time frame, this process was fruitful, but not exhaustive. Task members were able to involve the community due to their ongoing relationships they had established with the community. Although the community identified the need for more involvement.
- Created an ongoing process to look at disparities in mental health and provide recommendations on ethnic, cultural and linguistically appropriate strategies.

Proposed Recommendations for Reducing Mental Health Disparities

General Recommendations

I. Create the Reducing Mental Health Disparities Committee: This committee will be responsible for overseeing the Reduction of mental health Disparities in the County of Riverside Department of Mental Health.

a. Members of the committee will be recognized as key partners and have active involvement and representation on all MHSA policy recommendations, program reviews, and activities that address the needs of unserved, underserved, and inappropriately served racial, ethnic, cultural communities.

b. Members will be from racial, ethnic and cultural unserved, underserved, and inappropriately served groups representative of the community. An emphasis will be made to address regional and geographical differences among the ethnic and cultural groups, including the urban and rural communities.

c. Reach consensus on common priorities and present recommendations regarding implementation of strategies for reducing disparities.

d. Committee will have an active role in decision making.

e. Create a vehicle to provide recommendations for reducing disparities to the mental health department.

II. Increase awareness of cultural and ethnic disparities in mental health by providing information reports and data analysis on efforts taking to reduce disparities.

- Collecting ethnic and cultural data from external Sources
- Access to data that allow for measurement/analysis of disparities
- Using data to reduce mental health disparities by tailoring population specific interventions.
- Data results will be use to make funding priorities and program decisions

III. Promote mental health and combat stigma

- Allocate funding for community based and faith based organizations involvement.
- Develop mental health promotion of prevention and early intervention programs in the community, and with the community.
- Partner with community based organizations, faith based organizations, public agencies, and other non-mental health organizations to promote mental health.
- Utilize ethnic, cultural, and linguistic radio, television and newspaper media that serves Riverside County.

IV. Educate, empower, and support consumers and family members

- Provide education and training to Community Based organizations, faith based organizations, partner public agencies, advocacy agencies, and community at large on mental health prevention and early intervention.
- Funding and promoting sharing of resources with existing agencies in the community.
- Build community collaborative and partnerships.
- Change the name from mental health PEI to reflect wellness and empowerment.
- Continue inclusion of consumer and family members.

Ethnic and Cultural Specific Recommendations

Top Three Priorities [3]

V. Native Americans

Recommendations include A Native American Wellness Alliance (NAWA) housed across Native American organizations that serve the entire Riverside Native American Indian population. Tribal consortiums and tribal agencies within Riverside County that could be part of this alliance include Riverside San Bernardino County Indian Health Inc. (RSBCIHI), Indian Child and Family Services (ICFS), Torres Martinez Tribal TANF, Sherman Indian School and University of California Riverside- Native American Student Program. RSBCIHI and ICFS are tribal consortiums serving the entire Native American population. RSBCIHI has a behavioral health, substance abuse and health promotion department. ICFS serves Native American children and families. They have a prevention program and foster and adoption program. Noli is a tribal middle and high school (approx. 145 students) and Sherman is a boarding high school (approx. 500 students). They have students from a variety of tribes. Torres Martinez TANF has offices in Thermal, Anza, Hemet and Los Angeles. The provide job training and supportive services for welfare families. UCR has a summer program for youth to attend college exposure/enrichment classes.
The top three areas the Native American Wellness Alliance would provide services include:

- Culturally tailored, evidence based parenting. Indian Child and Family Services has culturally tailored and evaluated an evidence based program within the Riverside County American Indian community. The SPIRIT Incredible Years Program is a 15 week in home parenting program for children ages 0-11 years old. ICFS is not fully funded to deliver this program to families needing prevention services. With the NAWA, ICFS could provide this program to TANF families and RSBCIHI clients. Both tribal organizations have requested these services. In addition, ICFS could motivate referred families to engage in clinic and TANF services that are recommended and would be beneficial. For example, RSBCIHI has stated they would like to use ICFS' in home SPIRIT parenting program. ICFS conducts an Indian Family Wellness Assessment (IFWA) as part of these services. A menu of options is generated for each family based on their unique needs. RSBCIHI is interested in ICFS assessing families for interest in stress management services which the clinic could then provide. Additionally, the IFWA could be

[3] Only the three top priorities are presented in this document. For the list of all the recommendations for each ethnic and cultural specific group contact the Riverside County Department of Mental Health Cultural Competency Program. Aragon_m@co.riverside.ca.us

expanded to be a comprehensive motivational interviewing family assessment tool linked to referral sources for Native American families throughout the county.

- School drop out prevention program. This program would be two fold focusing on college exposure and culturally tailored substance abuse/gang reduction prevention education. Both Noli and Sherman have substance abuse prevention programs but limited finding. There is a need for funding cultural programs that educate and promote a substance free/gang free lifestyle. Noli has stated they could benefit from money for staffing, transporting kids, program supplies and materials, taking youth to conferences and food for youth events. In addition UCR has a summer program for Native American youth to live on campus for a week. Youth are exposed to college enrichment activities and a substance free lifestyle. The Native American Student Program Director stated funding to expand the length of time these students are on campus, up to a month, would beneficial.

- Traditional Healing blended with Mainstream education regarding stress reduction, substance abuse and mental health disorders. Establishing a network of traditional healing resources through the Tribal organizations is an important component of a prevention program for Native Americans. There is a lack of culturally appropriate service in the county for Native American clients. Funding NAWA could help to reduce this disparity. ICFS could hire cultural providers to conduct ceremonies, run sweat lodges and be involved in cultural activities. At weekly cultural meetings education could be provided about prevention of mental health disorders and stress reduction. RSBCIHI could provide services for stress reduction. The Behavioral Health Department at RSBCIHI has recently set up bio feedback machines to aid in reducing stress and is targeting this as an area they want to expand. NOLI and Sherman could provide these types of services to their students, using ICFS and RSBCIHI as a resource in addition to their own resources. Native American college students at UCR could be involved in providing prevention messages and mentorship for youth involved in these programs.

Native Americans have disproportionately high rates of child neglect, substance abuse and mental health programs. They also have high rates of school drop-out. Intervening early in parenting services, substance abuse prevention and school drop -out are top priorities for these youth. All the Tribal programs listed above are currently under-funded and the Tribal organizations/consortiums are overburdened and don't work together in ways to maximize service to the Native American Community. Establishing a Native American Wellness Alliance from within the community focusing on parenting, school drop out, which includes substance abuse and gang violence prevention and traditional healing, would be an innovative prevention program strengthening the Native American community in Riverside County. Costs for each priority are estimated to range from

$100,000-$300,000 annually depending on the extent of services. (Note: This is a rough estimate).
Three focus groups and five interviews were conducted with the Behavioral Health Director of RSBCIHI, school counselor of NOLI Indian School and Executive Director of ICFS. The Board Chairman of RSBCIHI and ICFS and Torres Martinez TANF staff at the Anza site attended focus groups.

VI. African American

African Americans live, work and play in a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health and leads to mistrust of Mental Health Systems. Annelle Primm, M.D states, deep-seated racism in the United States sets in motion a "vicious cycle" whose psychological and biological consequences have a crushing impact on health status. Depression and all its sequels are an inevitable and particularly devastating part of this cycle." In community focus groups, African American Community members echoed her sentiment in vivid language expressing their mistrust and suspicion of Department of Mental health and system given the history of mistreatment and inadequate care by government entities. Dr. Primm further shares in a speech to the Congressional Black Caucus, "When we have a mental illness like depression, we are very likely not aware that we are ill, we tend to stay away from psychiatrists and mental health professionals because of the stigma, we may stay away from physicians... because we are uninsured, but even if we happen to get in the door of some health provider, we are less likely to be diagnosed at all, we receive inferior or inadequate treatment, or, worse, our symptoms are misunderstood, and we are diagnosed with schizophrenia." Disparities exist in both access to and quality of mental health care for African Americans Examples of these disparities include: the underutilization of psychiatric services by persons from African Americans, problems in treatment engagement and retention of persons, the over diagnosis of schizophrenia among African Americans, the inappropriate use of antipsychotic medications among African Americans (and the use of these medications at higher dosages among African Americans), According to the 2001 Surgeon General's report on mental health, "the prevalence of mental disorders was believed to be higher among African Americans than among Whites, and African Americans were more likely than Whites to use the emergency room for mental health problems. African Americans with depression were less likely to receive treatment than Whites (16 percent compared to 24 percent). Only 26 percent of African Americans with diagnosed generalized anxiety disorder received treatment for their disorder, compared with 39 percent of Whites with a similar diagnosis... For certain disorders (e.g., schizophrenia and mood disorders), errors in diagnosis are made more often for African Americans than for whites. " Increasing evidence suggests that, in clinical settings, African Americans are less likely than whites to

receive evidence-based care in accordance with professional treatment guidelines.

- Development of Community Based Youth & Family Optimal Wellness programs directed by and delivered by African American community based providers in a community setting. The Youth & Family Optimal Wellness after school program will promote resilience in African American children and youth The program will be delivered in a culturally appropriate method and connect children/youth to positive role models and mentors. Based on the Self Enhancement Inc. (Oregon community based program), the Youth & Family Optimal Wellness resilience development program focuses on the strengths of the African-American community and deals directly with the deleterious effects of racism. African-American children, vulnerable victims of racism, are at significantly increased risk of Incarceration, School failure, Victimization by violent crime, Teen pregnancy, Reliance on social programs, Poverty.

  The Youth & Family Optimal Wellness PEI Project consists of a 12-week daily, intensive community-based program, followed by on-going weekly interventions, and tracking until adulthood. It is designed in two phases. The first phase is an intensive 12-week multimodal after-school program. The second phase involves weekly follow up, community and family engagement and leadership promotion. Students, ages 5 through 11, will work with health care educators, tutors and African-American professionals Monday through Friday. Through age appropriate African-American History education, bibliotherapy and story telling activities, exercise and health education, conflict resolution skills training and academic tutoring, the participants will gain academic competence, a sense of African-American identity, and the confidence that they can address life's challenges successfully within the African-American community and develop allies outside the community.

- Long term investment in African American community partnership with DMH & MSHA through development of a culturally competent African American Outreach component, including but not limited to a funded African American Outreach Coordinator, through the development and implementation of a culturally competent community based education and awareness initiative.

- Faith based outreach and education component such as PEWS Project

  PEWS (Programs for Emotional Wellness and Spirituality) was established in 2005, PEWS educates African American clergy, lay staff and church communities to better recognize mental illness and how to link parishioners to mental health services when needed. PEWS also works to address the negative attitudes surrounding mental illness in the African

American community. Although the Black Church taught religious doctrine and scriptures, it also taught Blacks how to contend with difficulties and adjust to life in a society that did not value or honor them or their heritage. The Black Church was a haven from societal injustices and a place where African Americans acquired skills, knowledge, and values through the church's educational programs. The belief and faith that one can rise above personal struggles, adversity, racism, and poverty is a familiar refrain that echoes throughout the African American church today. These beliefs have been inculcated through a variety of educational programming in the church. Two studies in 1994 and 1995 correlated religious involvement in the African American community with health status and reduced depression. PEWS (Programs for Emotional Wellness and Spirituality) have produced two short award-winning educational videos, Anything But Crazy: African Americans, Emotional Wellness and Spirituality, and Getting to the Other Side: African Americans and Co-Occurring Disorders. The program's most recent initiative is assisting historically black churches to develop mental health ministries to promote emotional wellness and help identify and assist those in need of mental health services. PEWS has been the recipient of Mental Health America's Betty Humphrey Cultural Competency Award, and has been featured on National Public Radio as well as in Positive Community Magazine, The (Newark) Star Ledger, Mental Health Monthly, and the recently published book Black Pain, among other publications.

VII. Latino/ Hispanic

- Develop and fund a Promotores de Salud (Health Promoters) program. The community member and leader involved in the PDS program engage in extensive outreach and prevention and early intervention community activities and community institutions' programs (Health Fairs, Community Fiestas, Academic, Legal, Social and Faith-Based programs). PDS services would help in the elimination of stigma by breaking the silence about mental health issues among the underserved/unserved Latino/Hispanic population throughout the Riverside County.

- Develop and fund "Accessibility to MH Services Program."- Latino/Hispanic communities are among the most underserved/unserved populations in the Riverside County. Accessibility to MH services is critical but often not a reality to this community due to lack of transportation services, literature translated into their language or due to immigration concerns. This program could create a system where these concrete needs are appropriately met so that MH services are within reach for those in need (e.g. One-Stop MH Mobile Out-reach Unit, purchase transportation vans, provide gas-vouchers, etc.).

- Increase funding to support and integrate Mental Health activities with local cultural community activities. Latinos/Hispanics are known to be family-oriented and highly involved in the local cultural, family-oriented activities or Fiestas, There needs to be additional funds allocated to support these events and to provide stipends for consumers and family members actively involved in the development and implementation of these events.

VIII. Asian American

- Develop resources in different languages that are simple and understandable.

- Greater outreach to the Asian community at community centers, faith/spiritual groups, cultural festival and fairs, adult schools, etc.

- Integrate Mental Health into useful and relevant topics such as stress management, stress relief, well-being, wellness, etc. and not such much on MH services. Help to build “better” family relationships.

IX. Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ)

- Implementation of a Targeted prevention and early intervention program directed to Lesbian, gay, bisexual, transgender and questioning (LGBTQ) children, youth and their families in a community based setting. The Rainbow Youth Leadership and Resiliency PEI Project addresses the isolation and invisibility of sexual minority youth. Many LGBTQI youth experience a hostile and unhealthy climate in schools and communities that is marked by violence, bullying, neglect and invisibility. Many are severely isolated and are at disproportionate risk for a range of problems including: suicide, violence, dropping out of school, substance abuse, HIV/AIDS and other STDs, incarceration, teen pregnancy, reliance on social programs, lack of medical insurance, unemployment or underemployment, poverty, and rejection from family and friends. (Special focus on High School Gay Straight Student Alliances, Rainbow Pride Youth Alliance, Bienestar Human Services Youth programs, Brothers United youth adult outreach, and Gay Associated Youth). (See attachment for more details)

- Implementation of a culturally competent Peer Based Community Mental Health Outreach Worker program designed to provided a targeted outreach and engagement campaign in the LGBTQI community in natural community settings (Pride Organizations, Open and Affirming Congregations, Health Fairs, HIV/AIDS programs, Depression screening, support groups, and targeted treatment slots). A special focus will place on LGBT seniors (Golden Rainbow Senior Center, Transgender Community (Trans-Soul) and Young Men of Color (Brothers United). Numerous studies have shown that LGBT individuals are exposed to higher levels of daily stress because of stigmatization, isolation from family and society, and discrimination. High levels of stress, in addition to contributing to physical illness, also may precipitate the development of certain types of mental illnesses. There is evidence of higher rates of depression, anxiety, and suicide in LGBT individuals. With the lack of social support, it is not surprising that LGBT individuals have higher rates of mental health care utilization than heterosexuals.

- Develop specific support to LGBT people through LGBT Organizations. Provide direct funding to support a community collaboration between the County Department of Mental Health, the Jeffrey Owen Center, Desert Pride Center, Golden Rainbow Senior Center, Gay Associated Youth, Rainbow Pride Youth Alliance, P-Flag, Transgender-Soul, and the open and affirming faith community (UFCSJC, FCC, UU) to support a targeted Anti-Stigma Campaign directed at addressing the dual stigma of mental illness within the LGBTI community.

X. Deaf and Hard of Hearing

- Education: Educate the Deaf (including any related consumers and family members) about MH, respect about deaf community, elimination of stigma about deaf and MH, signs of mental illness. Education about abuse, emotional, various parts of abuse. Education about risk factors that might lead to anger. Educate community about how particular behavior patterns lead to MH problems (anger, DV, substance abuse).

- Forums to educate Deaf community about MH programs. Greater outreach into the Deaf community (and related family members) to gain participation, e.g., establishing a Task Force.

- Accommodation: Deaf and HH communication accommodation to provide effective communication. (Use the appropriate wording to

be more inclusive of all communities.) Example, video phones, Telecommunications Device for the Deaf (TDD), Teletype machines (TTYs), effective communication (making sure to provide not just interpreting services but also Real Time Captioning (RTC), etc.

XI. Homeless

There are 4508 homeless adults and children on a given day in Riverside County, of which 30% have been diagnosed with mental illness, 47% have a substance abuse problem, and 25% have been a victim of assault while living on the street. Mental health issues among the homeless become even more complex due to a myriad of barriers. Not only are there language, cultural, housing, and transportation issues, but there is a factor of competing needs. Homeless individuals and families are faced with immediate needs of where they will sleep, what will they eat, where will they shower and mental health needs are more often than not, seen as less of an immediate priority. In addition it is challenging to provide any type of follow up care/treatment due to the transient nature of this population.

The Homeless Work Group of the Reducing Disparities Taskforce met and discussed the needs, methods, and services that are needed to make any progress in providing mental health care to the homeless. What became clear was that there is no mechanism in place for the prevention of mental health issues. There are services in place for severe cases but we have failed to assist individuals and families in prevention and support areas. The Work Group discussed different ways to engage homeless communities to develop effective strategies to reduce the mental health disparities among this population.

Conversations were also held with homeless service providers in which they stated that the stigma related to receiving treatment in a mental health facility is still a barrier to overcome. They also confirmed that transportation is an issue to access services and that many are turned away for services because their case is not severe enough. They also added that wait time to be seen, lack of insurance and the transferring of cases from county to county create additional barriers.

The top three recommendations were:

- Increase homeless outreach teams that include using peer support approaches with an emphasis on prevention and intervention strategies.

- Take the time to build relationships with community homeless serving organizations and identify central providers – where a variety of health and human services can be provided in a “one stop” center and all individuals would be assessed and case managed. This would in turn lessen the barriers of transportation, stigma, and follow up treatment, wait time, medication compliance, and where preventive approaches could be included.

- Identify different specialized homeless populations and develop specific strategies to work with these populations. **Example**: Veterans, parolees, substance abuse, immigrants, etc.

ATTACHMENT O-3

Riverside County Department of Mental Health
Reducing Stigma and Discrimination Workgroup Initial Report
Recommendations for Reducing Stigma and Discrimination in Mental Health
November 4, 2008

Background

The MHSA (formerly known as Proposition 63) was approved by California voters to provide a 1% tax on personal income over $1 million in order to expand and transform the county mental health service system. It became effective January 01, 2005. The MHSA has five components. Each one of these components requires surveying people and organizations that are involved in mental health services including county mental health staff, community based organizations, consumers and their families, and other county and government organizations. Per the State guidelines, "An objective of PEI is to increase capacity for mental health prevention and early intervention programs led by appropriately trained and supervised individuals in organizations and systems where people in the community currently go for purposes other than mental health treatment services." The intent of PEI programs is to engage individuals before the development of serious mental illness or serious emotional disturbance or to alleviate the need for additional or extended mental health treatment.

What is Prevention?

- ✓ Prevention in mental health involves building protective factors and skills, increasing support and reducing risk factors or stressors.
- ✓ Prevention efforts occur prior to a diagnosis for mental illness. Generally there are no time limits on prevention programs.

What is Early Intervention?

- ✓ Addresses a condition early in its manifestation
- ✓ Is of relatively low intensity
- ✓ Is of relatively short duration (usually less than one year)
- ✓ Has the goal of supporting well-being in major life domains and avoiding the need for more extensive mental health services
- ✓ May include individual screening for confirmation of potential mental health needs.

Riverside County Reducing Stigma and Discrimination Workgroup (RSDW)

One of the community needs identified by the State is the reduction of stigma and/or discrimination against people with mental illness as well as reducing stigma associated with either being diagnosed with a mental illness or seeking mental health services. The goal of the Reducing Stigma and Discrimination workgroup (RSDW) is to identify strategies to reduce mental health stigma and discrimination and provide feedback to ensure that county mental health Anti Stigma efforts are integrated into the PEI planning process.

What is Stigma?

Stigma refers to attitudes and beliefs that motivate individuals to fear, reject and avoid those who are labeled, diagnosed or perceived to have a serious mental illness – often anyone who is seen as "different."

What is Discrimination?

Discrimination occurs when people and societies *act* upon their feelings of rejection and discomfort with mental illness by depriving those associated with it the rights and life opportunities that are afforded to all other people.

Simply put **stigma** refers to an attitude. **Discrimination** is the behavior created by that attitude.

Consumers experience stigma as a mark of shame, disgrace or disapproval that sets its bearer apart from others. It makes them a target of scorn, censure, ridicule, or condemnation, constrains their opportunities and limits their options. The experience of stigma exerts a powerful influence on a person's identity and leads to the assumption of social roles that, over time, become central to the way in which the individual is viewed and, ultimately, views themselves. Any condition that deviates from what a given society considers 'normal', including mental illness, may become a target of social stigma. Consequently, stigmatized conditions vary across cultures and over time. In this culture, the stigma of mental illness has endured for centuries.

Three types of stigma have been identified:

- ✓ *"**Health-Related Stigma"*** can lead to exclusion, rejection, blame or devaluation of the individual affected by stigmatized conditions at a time when they are most in need of inclusion, acceptance and compassion. Negative social judgments about the conditions themselves can have significant implications for social and health policy.

- ✓ *"**Self Stigma"*** describes the process by which individuals internalize negative attitudes about their own condition - concluding that they are unworthy of anything other than poor treatment. They come to expect rejection, and they receive it – an experience which then reinforces the original expectation. In response, they develop coping strategies which often include secrecy and withdrawal.

- ✓ *"**Courtesy Stigma"*** describes the stigma-by-association experienced by those who are closely associated with stigmatized people. Families, friends and mental health professionals – all of whom may experience courtesy stigma – may be seen by the rest of society, as "normal yet different", by virtue of their affiliation. To protect themselves against the negative social judgment implicit in that label, close associates - including mental health professionals - may distance themselves from the stigmatized person, thus reinforcing the "us/them" dichotomy of which people with mental illness are so acutely aware. Some theorists suggest that chronic under-funding of psychiatric services and research is, at least in part, a manifestation of courtesy stigma on the part of policy makers

Stigma demonstrates a lack of understanding, compassion and knowledge of mental illness and the people it affects. Much discrimination, on the other hand, is illegal – a fundamental abridgement of the civil rights of people who are fully entitled to the same rights as all other citizens of the United States. Historically, stigma has been a key factor in why mental health problems are poorly funded (U.S. Department of Health and Human Services, 1999), and here in California, "mental health programs are the chronic losers in budget debates" (Little Hoover Commission, 2000, p. i). However, in November of 2004 California voters approved Proposition 63, entitled the Mental Health Services Act (MHSA), making California the first state in the country to levy a special tax to finance mental health services. The Act will not replicate old ways of doing business, but is designed to leverage funding to *transform* the old system to deliver client

driven, youth-and family-oriented services that reflect best and most effective practices and that clearly demonstrate outcomes and accountability.

The Reducing Stigma and/or Discrimination Workgroup provided a unique opportunity for community leaders, consumers, family members, media experts. public and private agencies to come together to explore issues of Stigma and Discrimination in the county mental health system and the community at large. The diverse forum allowed participants to benefit from each others' expertise and wisdom in strategically developing recommendations to reduce stigma and discrimination.

Group Process

- Workgroup membership reflects the diversity of the community such community leaders, community based and faith based organizations, private sector consumers and family members, and members of the underserved ethnic and cultural populations.

- Based on expert presentations on existing stigma and anti discrimination campaigns along with group discussions, the taskforce recommended working on recommendations on how to reduce stigma and/or discrimination against people with mental illness.

- The Reducing Stigma and/or Discrimination Workgroup identified seven key groups as having power to change stigma and support adoption of the recovery model. Workgroup members divided among themselves according to strategies and interest: Public Information and awareness campaign professional, public information and awareness campaign -youth and media campaign to work on recommendations.

- Although the time was limited due to PEI planning process datelines, each of the subgroups had an opportunity to meet, conduct interviews with some key leaders in the community that voiced their concerns and recommendations.

- Created an ongoing process to look at Stigma and Discrimination in mental health and provide recommendations on Ethnic, cultural and linguistically appropriate strategies.

Guiding Principles and Approaches

The Anti-Stigma and Discrimination Plan will look to the following fourteen principles and approaches for the development of an effective Stigma and Discrimination Plan in Riverside County.:

1. Communicate a clear, simple and enduring vision which includes:
    a. Reducing stigma is a shared responsibility – every person can make a difference.
    b. Recovery is the priority focus – it builds a sense of promise and hope.
    c. Changing attitudes about stigma is not enough – need for focus on reducing discrimination.

2. People with experience of mental illness must play a leadership role – RSDW will include them in program development and in determining message.

3. Focus efforts on promoting rights and reducing discrimination.

4. Target changing both attitudes and behaviors by developing evidence-informed educational resources and training activities.

5. Create multi-sector partnerships(Public Agencies, Private Sector, Media, Consumers, Community based Organizations, Faith based organization, Family, etc)

6. Target “high impact groups”-create messages that are target specific. (youth, senior, LGBT)

7. Work with media leaders to educate them on issues related to stigma and mental illness with the goal of improving public understanding of issues around stigma and discrimination.

8. An effective regional anti-stigma and anti-discrimination strategy will require a multi-pronged approach focused on specific target groups who have power and influence to support or impede recovery for people with experience of mental illness. It is crucial to engage the target communities in informing program development and delivery to ensure the greatest impact.

9. Repeated direct peer-based contact with people who have experienced mental illness reduces negative stereotypes. It also provides a message of hope by demonstrating the capacity for recovery.

10. By providing evidence-based education, about the impact of discrimination, people of influence are challenged to reconsider their beliefs and change their actions in a positive way

Proposed Recommendations for Reducing Stigma and/or Discrimination

General Recommendations

I. **Create the Reducing Stigma and Discrimination Committee:** This committee will be responsible for overseeing the Reduction of Stigma and Discrimination in the County of Riverside Department of Mental Health.

a. Members of the committee will be recognized as key partners and have active involvement and representation on all MHSA policy recommendations, program reviews, and activities that address Stigma and/or Discrimination.

b. Members will be community leaders, community based and faith based organizations, private sector, consumers and family members, and members of the underserved ethnic and cultural populations. An emphasis will be made to address regional and geographical differences among the ethnic and cultural groups.

c. Reach consensus on common priorities and present recommendations regarding implementation of strategies for Reducing Stigma and/or Discrimination.

d. The Reducing Stigma and Discrimination Committee will have an active role in decision making.

II. **Increase Awareness of Stigma and/or Discrimination** in mental health by providing information reports, best practices and data analysis on currents initiatives taken to reduce disparities.

a. Access to data that allow for measurement/analysis of change.

b. Using Data to reduce Stigma and/or Discrimination by tailoring population specific interventions.

c. Data results will be use to make funding priorities and program decisions

III. **Promote Mental Health and combat stigma**

a. Allocate funding for community and faith based organizations involvement.

b. Develop Mental Health Promotion of Prevention and Early Intervention Programs in the community.

c. Partnering with Community Based Organizations and other non-mental

health organizations to promote mental health.

d. Ethnic, cultural, and linguistic radio, television and newspaper media that serves Riverside County.

IV. Educate, empower, and support consumers and family members

a. Provide education and training to Community Based Organizations and advocate agencies on mental health prevention and early intervention.

b. Continue inclusion of consumer and family members.

V. **Recommend implementation of the California Statewide Reducing Stigma** and Discrimination Media Marketing Campaign plan tailored to appeal to the Riverside County diverse region.

Top Three Priorities

The Reducing Disparities Workgroup identified target three priorities: Public awareness campaign: youth; Public awareness campaign: *Target Identified Sectors and the General Public* and Consumers: Direct peer-based contact and personal stories.

1. ***YOUTH: Employ Social marketing strategies that will likely*** *reach youth* through technology. (YouTube, Facebook. My Space, blogs and on-line discussion forums).
    a. Adolescents aged 12 – 18 have been unanimously identified as an important early target for intervention. For more than 70% of adults with mental illness, onset occurred before they turned 18. Many young people lack knowledge about mental illness and have a reluctance to seek professional help. Many parents said that they would be embarrassed talking about their children's mental health issues. That leaves many young people who feel distanced from their families at a time when they need them most.
    b. Recruitment of youth and high impact celebrities to provide personal contact stories and key messages through the arts, peer outreach, theater.
    c. Targeting will also include families, friends, teachers and guidance counselors, and youth oriented programs. This broader approach is essential given that youth are more likely to turn to and friends, teachers and family for help. The presence of supportive social networks is recognized as an essential element of recovery.
    d. **Program examples**
        i. ***School-Based Anti-Stigma Curriculum Models:*** The short-term objective for this initiative will be to provide schools with models for identifying and assessing mental illness and responding effectively in making appropriate diagnoses and providing appropriate services

and referrals. There is an immediate need to develop successful strategies within Riverside County schools and higher educational settings to address discrimination and stigma associated with mental illness and to increase students' understanding of mental illness and recovery. Additionally, there is a need to appropriately train educators and student peer groups to identify at-risk students as well as students with emotional problems. Curriculum units will be developed to address and identify discrimination and stigma. Currently, a disproportionate number of multi-ethnic/multi-racial children are represented in special education classes.

ii. **Theater:** Mental Health Players: Using role play and interactive audience participation, volunteer actors expands awareness and educates community members about mental health issues, mental illnesses, relationship problems, substance use, and a comprehensive range of societal problems. Conflicts are presented through dialogue between actors, with a narrator facilitating audience responses. This flexible, spontaneous format allows the actors to tailor performances to a broad variety of topics and audiences.

2. ***Target Identified Sectors and the General Public with Campaign Materials***

   a. **Health and Mental care Providers (including Elder Care facilities):** Create an integrated social marketing approach to reach Health and Mental Care providers using the Pharmaceutical Sales model as an outreach tool.

      i. Anecdotal information says people who seek help with mental health problems often feel disrespected and discriminated against by health and mental care workers. Discrimination can prevent people from seeking help and/or not complying with treatment. It also can result in their loss of rights, loss of health care services, lowered expectations, and a diminished sense of hope for recovery.

      ii. Family physicians, who are frequently the first port of call in the

health care system, are under pressure to see as many patients as possible. Often they have too little time for patients with mental health concerns. In addition, training in mental health remains neglected in medical schools across the country. This can leave family physicians insufficiently trained to deal with the array of mental health problems and illnesses they encounter. It can also be difficult for them to access the specialized resources and backup to assist them in meeting their patient's needs.

b. **Outreach to Faith based community** through Diverse Clergy and Spiritual Leaders: Many people lean on their faith in difficult times and may seek help for their challenges from clergy and faith-based organizations.
c. **Program Examples: PEWS Program (Promoting Emotional Wellness and Spirituality)** educates African American clergy, lay staff and church communities to better recognize mental illness and how to link parishioners to resources, as well as assists church communities in starting PEWS Mental Health Ministries. PEWS also works to address the stigma surrounding mental illness in the African American community and to promote emotional wellness.

3. ***Use Direct peer-based contact and personal stories for advocacy, self-advocacy and education*.**

Direct peer-based contact and personal stories, targeted at changing the heart - not just the mind of the listeners, is consistently identified as the most persuasive strategy for addressing stigma. The need to 'normalize' the experience of mental illness and addictions, and move people from a sense of 'them and us' to 'we' was repeatedly stressed. Portraying 'normal' people from varied economic, social and ethno-racial, backgrounds and providing a forum for them to share their lived experience was believed to help reflect our shared 'human-ness'. Personal stories which realistically portray the challenges, obstacles, and losses people

encounter, their journey to finding help, the factors that made a difference in their lives and, most importantly, which convey a message of hope and recovery will have the greatest, most sustained impact on attitude.

a. Program models to achieve this goal: Consumer Speakers bureaus, Mental Health **players, public forums.**

b. Stamp Out Stigma: A community advocacy and educational outreach program dedicated to eradicating the stigma associated with mental illness. Stamp Out Stigma is unique in its anti-stigma approach, by creating a forum in which individuals with mental illness share their personal experiences with the community at large. The Stamp Out Stigma Model can be tailored as a Culturally and linguistically appropriate direct peer based campaigns targeted to **Older Adults, Ethnic and Cultural Populations using the trained voices of Older Adults, members of the LGBT community, hard of hearing, racial and ethnic groups.**

c. ***Elderly Outreach Project***- based on the The Abbe Center for Community Mental Health model provides In-Home Peer-based Outreach for Older Adults. The Elderly Outreach Project identifies and provides mental health services to the area's rural elderly. A multidisciplinary team (psychiatrist, nurse, and social worker) assesses and treats home-bound clients. Four major barriers prevent seniors from using traditional mental healthcare services: A lack of trained professionals. Because many professionals have not received training in geriatrics, those working with elderly clients should be encouraged to attend educational conferences to fill gaps in their knowledge. Organizational barriers. Transportation and cost may prohibit elderly persons from seeking mental healthcare. Facilities must revise policies detrimental to clients' well-being. Ageism. Many elderly persons have internalized negative and incorrect beliefs about what aging is or should be. Education about "normal" aging is essential. Stigma. The stigma of mental illness is particularly troublesome. Services such as in-home counseling allow clients to get the help they need while keeping their mental illness confidential. To eliminate the barriers to mental healthcare, increased financial resources are necessary to develop,

implement, and maintain innovative programs that can reach frail, isolated, hard-to-find persons in need of mental health, medical, and social services.

d. ***Deaf and Hard of Hearing***: Training of deaf and hard of hearing people to become mental health advocates to help consumers, family members, and friends to receive services that they need

Riverside County Department of Mental Health
Mental Health Services Act
Prevention and Early Intervention (PEI)
Public Hearing

We want to hear what you have to say!

Public Hearings will be held at the following times/locations:

July 1, 2009 2:30 PM	Mental Health Administration 4095 County Circle Drive, Riverside
July 6, 2009 3:00 pm	Regional Access Project Foundation 75-105 Merle Drive, Suite 800, Palm Desert

This is an opportunity for the community to voice their opinions, ask questions, and provide input!

For more information or special accommodations, please contact:
Cynthia Magill at 951-358-4052 or e-mail at MAGILL_C@co.riverside.ca.us

El Departamento de Salud Mental del Condado de Riverside
El Acta de Servicios de Salud Mental
Prevención e Intervención Temprana (PEI)
Audiencia Pública

¡Queremos escuchar lo que usted tenga que decir!
Habrá audiencias públicas en las siguientes fechas
y los siguientes lugares:

Julio 1, 2009 2:30 pm	Administración de Salud Mental 4095 County Circle Drive, Riverside
Julio 6, 2009 3:00 pm	Regional Access Project Foundation 75-105 Merle Drive, Suite 800, Palm Desert

¡Esta es una oportunidad para que la comunidad exprese sus opiniones, haga preguntas y provea información!

Para más información o para comodidades especiales, por favor llame a Cynthia Magill al 951-358-4052 o e-mail MAGILL_C@co.riverside.ca.us

Riverside County Department of Mental Health
Mental Health Services Act
Prevention and Early Intervention Plan

30-Day Comment Feedback Form

*Please submit your comments on this form by **June 30, 2009**.*
*Forms can be submitted via **e-mail** to: MHSA@co.riverside.ca.us*
*or **mailed** to: Riverside County Department of Mental Health,*
Attn: MHSA Administration, PO Box 7549, Riverside, CA 92513
*or by **fax** to: 951-358-6924*
You may submit additional comments on a separate sheet.

What do you feel are the strengths of the plan? Please identify the program and age group, if applicable.

What concerns do you have about the plan? Please identify the program and age group, if applicable.

Personal Information (Optional)

What region do you live in?
- ☐ Desert (Banning, Indio, Blythe, etc.)
- ☐ Mid-County (Hemet, Lake Elsinore, Perris, Temecula, etc.)
- ☐ Western (Corona, Riverside, Moreno Valley, etc.)

What group are you most associated with?
- ☐ A consumer of mental health services
- ☐ A family member of a consumer
- ☐ County Employee
- ☐ Law Enforcement
- ☐ Education
- ☐ Human Services
- ☐ General Community
- ☐ Other (Please Specify) _____

Personal Information (Optional)

What is your gender?
- ☐ Female
- ☐ Male

What is your ethnicity?
- ☐ African American/Black
- ☐ American Indian/Native American
- ☐ Asian/Pacific Islander
- ☐ Caucasian/White
- ☐ Hispanic/Latino/Chicano
- ☐ Other.(Please specify):_____

What is your age?
- ☐ 0-17 yrs ☐ 18-24 yrs ☐ 25-59 yrs
- ☐ 60+ yrs

	Very Satisfied	*Somewhat Satisfied*	*Satisfied*	*Unsatisfied*	*Very Unsatisfied*
Overall, how do you feel about the plan?	☐	☐	☐	☐	☐

DEPARTAMENTO DE SALUD MENTAL DEL CONDADO DE RIVERSIDE
Ley de servicios de salud mental
Plan de Prevención e Intervención Temprana (PEI)

Formulario de Retroalimentación y Comentarios de 30 días

Sírvase enviar sus comentarios en este formulario antes del 30 de junio de 2009.
Los formularios se pueden enviar por correo electrónico a: MHSA@co.riverside.ca.us
o por correo convencional a: Riverside County Department of Mental Health,
Attn: MHSA Administration, PO Box 7549, Riverside, CA 92513
o por fax a: 951-358-6924
Usted puede enviar comentarios adicionales en una hoja por separado.

¿Cuáles cree que son las fortalezas del plan? Identifique el programa y el grupo de edad, si corresponde.

¿Qué preocupaciones tiene acerca del plan? Identifique el programa y el grupo de edad, si corresponde.

Información personal (opcional)

¿En qué región vive?
- ☐ Desierto (Banning, Indio, Blythe, etc.)
- ☐ Centro del Condado (Hemet, Lake Elsinore, Perris, Temecula, etc.)
- ☐ Oeste (Corona, Riverside, Moreno Valley, etc.)

¿A qué grupo está más asociado?
- ☐ Un consumidor de servicios de salud mental
- ☐ Un miembro de la familia de un consumidor
- ☐ Empleado del condado
- ☐ Cumplimiento de la Ley
- ☐ Educación
- ☐ Servicios Humanos
- ☐ Comunidad General
- ☐ Otro (Especificar) _____

Información personal (opcional)

Indique su sexo
- ☐ Femenino
- ☐ Masculino

Indique su grupo étnico
- ☐ Afroamericano/Negro
- ☐ Indio americano/Nativo americano
- ☐ Asiático/Pacífico Islandés
- ☐ Caucásico/Blanco
- ☐ Hispano/Latino/Chicano
- ☐ Otro (Especificar):_____

¿Cuál es su edad?
- ☐ 0-17 años ☐ 18-24 años
- ☐ 25-59 años ☐ más de 60 años

	Muy satisfecho	*Algo satisfecho*	*Satisfecho*	*Insatisfecho*	*Muy insatisfecho*
¿En general, cómo se siente con el plan?	☐	☐	☐	☐	☐

Riverside County Department of Mental Health
Mental Health Services Act
Prevention and Early Intervention
Training, Technical Assistance and Capacity Building Funds Request

30-Day Comment Feedback Form

*Please submit your comments on this form by **June 30, 2009**.*
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What is your age?
- ☐ 0-17 yrs ☐ 18-24 yrs ☐ 25-59 yrs
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	Very Satisfied	*Somewhat Satisfied*	*Satisfied*	*Unsatisfied*	*Very Unsatisfied*
Overall, how do you feel about the plan?	☐	☐	☐	☐	☐

DEPARTAMENTO DE SALUD MENTAL DEL CONDADO DE RIVERSIDE
Ley de servicios de salud mental
Plan de Prevención e Intervención Temprana (PEI)
Formulario de solicitud de fondos para capacitación, asistencia técnica y desarrollo de capacidades

Formulario de Retroalimentación y Comentarios de 30 días

Sírvase enviar sus comentarios en este formulario antes del 30 de junio de 2009.
Los formularios se pueden enviar por correo electrónico a: MHSA@co.riverside.ca.us
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	Muy satisfecho	*Algo satisfecho*	*Satisfecho*	*Insatisfecho*	*Muy insatisfecho*
¿En general, cómo se siente con el plan?	☐	☐	☐	☐	☐

ATTACHMENT R-1

County of Riverside
Mental Health Board (MHB)
Executive Committee Review
Friday, July 10, 2009

Prevention and Early Intervention

PEI Comments and Mental Health Board Responses from Public Hearing July 1, 2009

Comment #1: This is probably the most important component of the MHSA. As a retired nurse it took a long time for physical health to realize the importance of catching a problem early. This is truly a quality of life issue. The most important part of the program that I was impressed with was the project 5 having to deal with older adults. You've got to give a lot of credit to the department and to Janine and her staff because there is something in there for everyone, and I don't mean that lightly. If you get a chance to read the program I'm sure there's going to be aspects that you're interested in. There is something in there for everybody. I really think you've done a great job. Thank you!

MHB Response: No action needed.

Comment #2: I think it's a great plan and I am especially pleased and the reason is the elder part of this plan. We have senior specific women's treatment and I just feel that no where near enough has been done for seniors in the field of substance abuse treatment specific to their needs. They are not the same as a 30 yr old person. So, I think they've done an exemplary job. …Thank you!

MHB Response: No action needed.

Comment #3: This is a real privilege to participate in this planning process and the hard work that went into it. I had a couple of comments. This is just the first one: there are person-level outcomes and system-level outcomes. The system-level outcomes for the FAST program include sustainability of the program by the school system. In planning, however, the systems basic outcomes in the evaluations section are different, that is left out and it appears that it was either a mistake or an oversight. The 2 pages are 158 of the evaluation which doesn't match up with page 76 and since those outcomes are very important because FAST seems to be the program selected to report the outcomes to the State this is an important issue. One of the points I'd like to make about it is if there's a partnership of any evidence-based program then it seems to me that the sustainability should not fall on the shoulders of only one of the partners.

MHB Response: The identified outcomes for the Families and Schools Together (FAST) program on pages 76 and 158 will be revised to reflect evaluated outcomes identified by the developers of the model and remove

any appearance of one partner/agency bearing the sole responsibility for system-level changes.

Sustainability will come through ongoing PEI funding. RCDMH will partner with contractors, including schools, and will fund each project with an ongoing budget. Refer to the FAST budget on page 79 of the plan.

Comment #4: I applaud any efforts that go toward Innovation and Prevention Services. I do have some concerns that I would like to express publicly. I have 4 points that I would like to make. Leading that our student body is 36,000 students, one concern is that the SB1802 drop out prevention dollars, tobacco prevention, violence prevention dollars are all issued through the State of California to the local communities in a non-competitive way. It's very frustrating for the district to find that these dollars are being given out in a competitive manner. For us it makes it more difficult to apply for. Also, there has been in our opinion a lack of input by district office staff in fact in our district of 36,000 I don't believe that our administrative staff have ever been involved in any of the input sections, or has been invited to participate in any of the development of the plan. This is a very big concern for us. Moreno Valley and other communities have very localized needs and continue to be frustrated by the fact that many services, state and local, are really only offered by agencies outside the local community, either parents have to go there to receive the services or the services are only ancillary making especially Moreno Valley and localized communities who have been so very frustrated because the services are not comprehensive and are not localized. And finally facing the $63 million deficit, laying off over 22 counselors and other issues and our ability to write comprehensive grants are going to become extremely problematic for us in the next coming days and so I just wanted you to be aware that we are very supportive of the initiatives and would like to have been more involved in the initiatives which we feel we were not and certainly hope that these dollars will be very localized and we are very concerned about the community planning process.

MHB Response: No change to the plan needed. PEI dollars are going to be allocated through a variety of methods which may include, for example, a competitive bid process or memorandums of understanding. The PEI team will work with local school districts in implementation of school based programs. Participants from Moreno Valley Unified School District (MVUSD) were involved in several ways including focus groups and Children's Committee. One of the principles of PEI is to provide services in local community settings and this will be a priority in implementation through identification of partners within the communities in which services will be provided.

Comment #5: I would also like to commend the group. Any help we can get is wonderful. We only have 22,000 students; however we're a little more diverse. I have a 760 square mile district that goes from about Idyllwild, Anza and Aguanga. And so we're very short in services that are provided to us. We also don't have a good grant writer because we can't afford one and so our concern is how is this going to roll out to the schools.

MHB Response: No action needed. Comment refers to implementation.

Comment #6: First of all I just want to thank this community for acknowledging the need for services. Some of the populations in youth suffer severe difficulties because of a lack of services and the inability to access the services. I like the idea of prevention so that you don't have to look at young people developing severe mental illnesses and I also want to put out there around the issue that the prevention dollars will help young people that are dealing with sexual orientation issues and gender identity/expression issues to help them so they can get the services and family support that they need so that they don't end up in the mental health system. Gender identity and sexual orientation are not the issue but that often becomes the issue in their family of origin. Thank you.

MHB Response: No action needed.

Comment #7: I agree with those two on the school districts but, you've got to go beyond that if there's no follow up or no place to go higher, find the success rate or it's all going to collapse. It's like building a house out of sand. I have a personal question for the staff members involved here: how many of you people volunteer your time not writing a check to charity because the government is footing the bill then because you write it down on your taxes. I say maybe a staff meeting or a training course where you just volunteer to go and give some of your own time and not always on the clock and not just asking that everybody else volunteer and many of the people that are asking for volunteers are not willing to volunteer themselves. Thank you!

MHB Response: No action needed.

Comment #8: Programs like Job Corps for kids like at 15-25. I grew up in the system since I was a kid. In the group homes I was in, I've never heard anything of that sort. We didn't talk about Job Corps and other stuff that you can do for pay.

MHB Response: No action needed. Youth transitioning out of foster care is a priority population of focus in the Transition Age Youth Project.

Comment #9: I like how inclusive it was to the Transition Age Youth. I'm in San Bernardino County and most of our youth that we have from San Bernardino are TAY that are LGBTQ and they're suffering a lot of issues that could have been

prevented. It's also good that they do have somewhere that they could go where they are understood and that they are in a safe place where they can go and talk about their problems that they need help with and be able to get referred to places that are also safe places. I know Rainbow Pride Youth Alliance works very closely with San Bernardino TAY and the Jeffrey Owens Community Center (JOCC) is trying to work with Rainbow Pride and they are willing to work with the TAY program out here. And it's all like one big family trying to help each other out. I really like how inclusive it was and that we are included in the TAY program.

MHB Response: No action needed.

Comment #10: Everything that La Vista does is prevention and education for seniors. For over 30 years we have provided all kinds of education anywhere the seniors are that they'll let us in to talk to address substance abuse issues that they may have with out being confrontational. We deal a lot with both in-house and with treatment services that are outreach. I would like very much to see some kind of partnerships with peer counseling and in our nation today where there is no money there are still a great many people who will volunteer with good training, and I stress good training, to go into the homes of the elderly because they are not going to come out and tell their business. I would really like to see partnerships to create peer counseling as a part of whatever older adult services are in the plan.

MHB Response: No change to the plan needed. The Board would like the PEI team to work with the Department's Older Adult Manager as implementation of the older adult PEI programs occurs to look for opportunities to include older adults in service delivery and to work with community providers who are working with older adults.

Comment #11: I commend the QPR (Question, Persuade, and Refer) program for suicide prevention as a way to build in screening and even potential for brief intervention for the senior population. My recommendation is that it work very closely with the existing screening and brief intervention services that are already within the Department of Mental Health that are offered to the substance abuse prevention services currently. There are prevention providers in 6 clinics across this county doing screening and brief intervention that is focused around risk and is available to anyone. You don't have to qualify for it and it has reengineered the services into a continuum of services in the way that's sought in the Mental Health Services Act. So if they work together, the potential for sustainability is higher and we'll get to more of the elders. And basically I would like to make a strong recommendation that any of the prevention efforts that get rolled out work very closely with those people with 20 years experience who have been doing substance abuse prevention and violence abuse prevention not only within the Department but the partnerships out in the community. There's a lot of capacity

already built that you can build upon, however, there has to be some infrastructure in ways so that the networking can take place and be sustained.

MHB Response: No change to the plan needed. This comment relates to implementation partners. The PEI team will work with the RCDMH substance abuse prevention providers to train as appropriate.

Comment #12: I would like to continue with prevention. Having things hung up on bulletin boards at some of our senior centers, retirement homes, and elder apartments and senior apartment complexes as alternates for kids and family members and those who have contact with that age level. That would be a very effective means of spreading the word.

MHB Response: No change to the plan needed. Project #1 will include outreach and community education as well as maintain current resources through Riverside County's 211 telephone referral source. Partners will be expected to inform the community of services offered in multiple locations. The ideas about locations to provide information will be explored upon implementation and can be provided to the outreach staff for follow through.

Comment #13: I have to admit that I've not read the plan extensively at this point but I know when working with DPSS, one of the biggest hurdles in working with foster youth and in group homes is the cross agency difficulties. That's common when working with the schools and with agencies. Agreements are one of the biggest hurdles in getting cooperative efforts and leads back to my comment about grant writing and not having localized services. If an individual misses 2 meetings and they are dropped from mental health services they didn't stop needing mental health services and so the need is to have those mental health services and have those services very localized which means agencies coming up with agreements and ways of understanding each other's terminology. Ways to work with agencies so that we can more cooperatively provide services. In our school district we do not have mental health services. We have educational counselors who have been given training in counseling and other skills in prevention but they are not therapists. We do not have a model for allowing therapists to come onto our campuses and yet there are other funding avenues such as Medi-Cal billing that would provide revenue to expand and to continue to sustain services. Without that interagency cooperation and agreements of how to bring these services on and how to make these services more localized we can not have places for people to go. We must bring those services to those localized areas. We have created a collaborative in Moreno Valley with over 50 localized agencies that now work together by learning each other's languages, how to negotiate education, how to negotiate Mental Health, how to negotiate CPS, how to negotiate the police department. Those are going to be critical in the start up of any systems planning that is going to go on between cities.

MHB Response: No action needed. Through implementation PEI programs will be localized within communities and collaboration and partnership will be essential.

Comment #14: A lot of agencies that were spoken of have been providing clinical services and with this plan I'm most encouraged by the fact that a lot of these services are going to be provided in community settings, in what I would call alternative settings. What I have found through out the years in working with individuals and also in my clinical practice is that although the services we offer, the mental health treatment services, are excellent services, it's the location that is important. Providing the brief intervention programs in the schools, if we can get in there and in other areas will definitely go in line in reducing stigma. Sustaining services and looking at things in the long term. It's very encouraging and I'm really very, very, pleased to see this in the plan.

MHB Response: No action needed.

Comment #15: Those of us that have been around the Mental Health Services Act realize that the act itself is kind of limited and is subject to change so over the last 3 ½ years we didn't know what MHSA was and I'm still not totally sure. I'm still not quite sure how it will work, but I know that many of us have been at these public meetings and I'm totally impressed today. This is the best turnout we've ever had. So, it's great that you took time out of your busy schedule to come. We all know that this is probably the most important component. It's going to affect so many people in the community and your comments are very crucial.

MHB Response: No action needed.

Comment #16: On a personal note, I remember the day when I was 6 years old and I told a counselor that my dad was hitting me and I was told that it wasn't abuse. I hope everybody in here realizes that even though we might not have it all perfect right away, we have something that is really amazing before us that we put together and that we've come together and put little pieces of ourselves in it. Thank you everyone.

MHB Response: No action needed.

Comment #17: I like to thank PEI for putting the transgender into the plan. Thank you.

MHB Response: No action needed.

PEI Comments and Mental Health Board Responses from Public Hearing Held on Monday, July 6, 2009

Comment #18: I've sat in on a great many of these focus groups and the four day steering committee and I'm a little bit concerned about the lack of the LGBT mentioned in the Executive Summary. It's mentioned quite clearly on project 4 the TAY project yet it's no where mentioned in project 5 - First Onset for Older Adults. The LGBTQ elder was mentioned approximately 22 times through out this 220 page document. So, I'm a little perplexed and confused why it's not mentioned under the older adults when it's mentioned under Transition Age Youth. The way I was raised is that if it's not in black and white it's not black and white, and if it's not in the Executive Summary, it's not in the Executive Summary. And my 2nd comment that I would like answered is referring to page 106 where despite a couple of times where I have asked for my organization's name to be changed, it remains incorrect. It's on page 106 and it is referred to as the Rainbow Pride Senior Center and the correct title is the Golden Rainbow Senior Center. I've asked for that to be changed and I'm asking again in the public space. It's only my concern and not to be critical it's because I pointed this out before but, in answer to my first question is, you clearly spell in project 4 the LGBT youth where as in project 5 it's left to interpretation and I'm a little bit uncomfortable with that.

Response: You shared with me on the phone that the name of your senior center is incorrect in the draft plan and I explained that it will be corrected in the final plan. This is our draft plan. There's going to be one revision and in the final plan it will be corrected.

MHB Response: Action needed: The following sentence will be added to Project 5 – First Onset for Older Adults in the Executive summary: "Targeted outreach will occur to identify and provide services for underserved cultural populations, specifically LGBTQ older adults." The references to Golden Rainbow Senior Center were corrected to accurately reflect the organization's correct name.

Comment #19: I'm concerned about the older adult project. There is a great emphasis on suicide prevention but no mention of alcohol or substance abuse. Alcohol and prescription drugs appear to be a precipitating factor with suicide and a higher percentage, much higher, 60 to 70 % depression and alcoholism and suicide are very closely linked and there is no mention of including anything related to that because all three of them are so closely linked. There is an excellent program that has been developed by the Department of Health and Human Services called "Get Connected" that deals with these three issues. I have written something out and done research on this. Can I just hand this to you after this?

MHB Response: No change to the plan required. The PEI Coordinator explained to the Board members that "Get Connected" is a toolkit that is free of charge and could be a great resource for providers. MHB requests that the Department's Older Adult Services manager work with partners during the implementation of PEI programs to include the "Get Connected" toolkit as a curriculum for training.

Comment #20: My comment is regarding the reference on the LGBT community. You mentioned that the reason why it's not mentioned in project 7 is because it's going to be across all projects. I would recommend that if that's the case and it's not stated somewhere in the plan that you want to find a place within the plan and make sure that that's inclusive and that it is very clear that when we look at all projects that the intent is to include the LGBT community in all the projects rather than leaving it up to assumption and to make sure that it's somewhere in the plan. And if that's going to be the case, my second recommendation is a follow up to that one is that in each project that you dedicate some space to describe exactly how the needs of the LGBT community specifically will be addressed with each of the projects because when reading through the projects it makes reference of LGBT communities as a matter of fact. Kind of like not really describing what that really means or what that really entails within the project itself because throughout the project I did read very specific recommendations and narrative about what each project will be doing and then when it talks about the LGBTQ community it mentions it in the last paragraph in the last sentence also to include LGBT. That would be my recommendation as well.

MHB Response: No action needed. The LGBTQ population is well referenced throughout the plan. The Department has a commitment to include underserved cultural populations and the needs of the LGBTQ are identified in the plan and remain a priority. RCDMH will ensure that inclusion of underserved populations will occur during the implementation.

Comment #21: I'm wondering, I'm guessing the homeless treatment and outreach will be under project 6 is that right? Do you have homeless outreach? What about people who are falling through the cracks?

MHB Response: No change to the plan required. Homeless runaway youth are identified as a targeted population in the Transition Age Youth Project. The Board members requested that RCDMH ensure that information about programs is provided to service providers and recipients of services for the homeless, including but not limited to homeless shelters as implementation occurs.

Comment #22: On page 71 where you show the graphs of the school districts because I couldn't find a reference as to some of those like DHS do you mean Desert Hot Springs? Because that's not a school district that's a city so, that

needs to be corrected unless it stands for another school district that I'm not aware of. Unfortunately I have some concerns about it. I understand that low performing schools have these indicators and as low performing schools they have a very strong administrative staff that focuses in on strategies meant for low performing students which can break many of the barriers that our schools have ….and we (Desert Sands Unified School District) are not named in this application which is shameful because we too have many deserving students and higher percentages of free and reduced lunches and English language learners.

MHB Response: A substantive change to the plan will be made. The tables on pages 71 and 72 of the draft plan are the result of an evaluation of several data sources by the Research unit to identify those districts throughout the County with children at highest risk based upon the risk factors listed in the tables. Three changes will be made to the tables: (1) Indicate that the enrollment is for elementary schools only; (2) Replace the reference to Desert Hot Springs (DHS) with the actual school district, which is Palm Springs Unified School District (PSUSD), and add a footnote that the elementary schools from PSUSD that are included are the three from DHS as they are identified as a high need area based upon the data. (3) As a result of an additional data review conducted by the Research Department, four specific elementary schools within Desert Sands Unified School District (DSUSD) were identified as having similar high risk factors as the other identified school districts. These schools will be added to the initial target communities in Project 3.

The Mental Health Board members expressed concern about additional locations within the County with high rates of poverty, dense populations of ethnic minorities (primarily Hispanic), and many risk factors associated with the development of mental health problems. Through implementation, providers will need to deliver PEI services to the initial target communities, though not exclusively. If a provider is aware of additional locations within the County that meet the criteria for highest at-risk population, they can demonstrate their ability to provide PEI services to the target communities as well as additional communities and PEI services can be more broadly implemented.

Comment #23: I'm just going to comment that it appears that the bulk of the youth in the comprehensive school system are not really served by this plan or this program. Where a family could go to a parenting program in order to receive services, it doesn't seem that there is a way that if a student came in with a need to talk to somebody about what's going on, and that's the vast majority of the students in the school system so, they don't have access to that. The seniors have that kind of availability with the QPR program; they can go into a centralized place and get a referral out but that kind of system doesn't exist for the youth throughout Riverside County. The Department of Mental Health has worked very

closely with Desert Sands Unified School District with the Safe Schools Student Assistance Program as a way of getting the students referred to appropriate services. Right now in the Department of Mental Health the substance abuse program uses a screening type program like this at all the County clinics for kids that are coming in for prevention services for substance abuse and making referrals available. Maybe something like this would be something that you guys can consider. It would be cost effective because it would be across systems and just something to think about.

MHB Response: No change to the plan required. The draft plan follows the PEI guidelines and the guiding principles that were approved at the beginning of the community planning process which state the need to provide PEI services to those at highest risk. Also see response to Comment #11.

Comment #24: My comment is that on page 111 you have a PEI project summary budget. When I first heard about this project I understood that there was only 1 and like 1 and 1 ½ of a behavioral health person or therapist that was for this and now I see on the sheet there are 6 FTE's for Behavioral Health Specialist II and .47 for clinical therapist. Are those the same basic qualifications? I was wondering what you mean by behavioral health specialist? Could that be a therapist?

Response: In our system a clinical therapist is a master's level clinician usually licensed or licensed eligible, such as an LCSW or LMFT. A Behavioral Health Specialist is someone with less education. A bachelor's degree often in a social service, sociology, or psychology degree.

Continues Comment #24: So, other than the psychiatrist which is .15 of an FTE and .47 for clinical therapist is that all for the entire project?

Response: We were not asked to specify particular positions on the budget form for subcontracts and professional services. Our anticipation is that we will be contracting out. If you look at # 3, subcontracts, there is a dollar amount there that is inclusive of a variety of positions designed to implement the programs listed in the project.

Continued Comment #24: Alright. Thank you. I was also wondering if there were other experts other than Dr. Renda Dionne when you talk about the Native American part. When you address the Native American as one of the culturally underserved areas, she's the only one that you list here and I was wondering were there other people that were included? Because, I know Dr. Dionne and I respect her work but I was wondering had anybody else been asked to participate in this regarding Native Americans?

Response: Can we talk afterwards?

MHB Response: No action needed. Specific focus groups were held with the Native American population. RCDMH recognizes the need to continue to build relationships with the Native American community and plans to address this through Project #1 with the use of the Ethnic and Cultural Community Leaders in a Collaborative Effort. The PEI team will identify and work with potential partners within the Native American community for the delivery of PEI services.

Comment #25: I wanted to see about the Call to Care program which is a training program for non-professional caregivers and the program is centered on the person in need and then secondly focusing on the caregivers themselves. It's really helping them learn the skills, knowledge, and boundaries that caregivers need to know in order to be effective. Its recovery focused and it really focuses on hope. It deals with issues like skills, cultural issues, mental health issues, loss and grief, suicide risk, psychosocial impact of trauma and dealing with at risk populations. Most of the participants that come to the program are volunteers in different service agencies. They need the training for the skills, and when they do that it is very productive. They can make referrals and such. They are really important skills for volunteers and people who are care giving to have and because they are non-professionals, they really need to learn the basic information. They also need to know that they can't do a lot of things that a professional person can do. We're basically partnering with faith-based organizations for outreach purposes. Although there are other places and other sources that are looking for help with their programming and it seems that it's been so helpful for the participants and for the community. Going back to Project number one, the question I had after I read the write up about the Call to Care program is it going to be implemented Countywide?

MHB Response: A substantive change to the plan will be made. Call to Care will be implemented Countywide and as a result of this change the budget for this program will increase. Please see the Project Summary Budget form for Project #1 for more details.

Comment #26: Today's Desert Sun front page news was about gay seniors and by coincidence it's today when the public hearing is. Just as a point of reference, Riverside County has the 3rd highest concentration of senior same sex couples of which 10% live below poverty. The suicide rate is 3 times, the alcoholism rate is much higher where the gay senior is isolated and depressed and the way I understood the PEI money was to break into the underserved population where we could reduce isolation, reduce depression before full onset of mental illness occurs. 25% of all new HIV cases in Riverside County are gay seniors they are acting out because of depression and isolation. I strongly suggest that the gay senior be listed in the Executive Summary.

MHB Response: See response to comment #18.

Comment #27: I would like to suggest putting some kind of reference to the homeless and low income population of any age and outreach to the shelters and outlets that serve them. The number of people that need some mental help is growing. The rescue mission at Martha's Village in the North Desert and all of us could use some education and training to help identify it because of the cut backs in mental health services.

MHB Response: No change to the plan required. See response to comment #21.

Feedback Form Comments and Mental Health Board Responses

Of the _35_ Feedback Forms submitted: _4_ were "Very Satisfied", _10_ were "Somewhat Satisfied", _9_ were "Satisfied", _2__ were "Unsatisfied", _1_were "Very Unsatisfied", and _9_ did not indicate a Response

1. What do you feel are the strengths of the plan? Please identify the program and age group if applicable:

- Used evidence-based programs/practices.
- Use of evidence-based programs.
- Teamwork in FAST seems appropriate. A staff rate of 1-3 is impressive. Only 8 months to implement – ambitious.
- Length of program & facilitator ratio. Focus on children & family.
- PEI project (Strengthening Families Program, Children 3-16). Addresses children during high risk ages. Uses a whole family approach in the various realms of family interaction. Culturally based, family & community feed back, utilizes community resources including faith based organizations, portable.
- CBITS ages 10-15 plan strengths is implemented at school and two parent education sessions CBITS goal Safe Dates involves family members (middle & high school students).
- Stakeholder input & data used to develop the plan is impressive.
- PEI Project: Trauma Exposed services – Attempts to impact the various factors associated with individuals exposed to pervasive trauma experiences. Intervention well based on detailed stakeholder research process. The use of the school environment which has the intended client readily available will assist with outreaching more full participation.
- PCIT component of Parent Ed. & Support.
    - Program to address & rates of maltreatment
    - Mobile Instruction to reach parents who have difficulty
    - Collaboration with Riverside County Office of Education to assist children before 3rd grade.
- The Triple P program would be effective in that it separates out intensity of parenting issues/problems – not a general/one size fits all, which is not effective.
- Addresses a wide variety of cultures.
- Community involvement in program development.
- Address all major groups.
- Expanded parenting classes, Parent Child Interaction Therapy, trauma Services.
- I'm pleased that it strives to be inclusive, particularly of the Lesbian, Gay, Bisexual and Transgender communities. With this population of young people

(ages 13-25), I see a great deficit of mental health resources. Thank you for taking on this task.

- I like how inclusive project 4 is with LGBTQ issues. Many TAY peers are of the LGBTQ community, and I like how there will be specified treatment for them.
- TAG – Working very strong at JTP 16-60's. I have seen great work with this ongoing program.
- Providing services to all ages groups in alternative settings. Often being sent to mental health clinics or scheduled appointments & during school hours for school represents significant stigma therein reducing help seeking.
- All of it 25- 65.
- I'm extremely pleased with Senior QPR. Elder needs are well represented.
- Well thought out plan with evidence that a lot of work went into its development – Good job!
- Covers many needs of broad segments of the populations.

2. What Concerns do you have about the plan? Please identify the program and age group, if applicable.

- No homeless services for anyone who is indigent. NO police sensitivity training. No interest in the growing number of individuals who are falling through the cracks of our society. We need some sort of safety net.

MHB Response: No change to the plan needed. See response to comment #21. Law enforcement training is addressed in the Training, Technical Assistance, and Capacity Building plan.

- PEI has not used school sites for simple screening for prevention and referrals to link services. DSUSD has many students in Indio who could benefit.

MHB Response: No change to the plan is needed for the first comment. Communities in which PEI programs are implemented will be provided with education and referral information for those programs. With regard to the second comment, see response to Comment #22 for a substantive change to the draft plan.

- PEI project – I have heard complaints Coachella Valley National Alliance for the Mentally Ill (NAMI) is not consistent with some of their activities. In Our Own Voice (IOOV) program not available at this time.

MHB response: No action needed.

- Families and Schools Together (FAST) program: My concern is that the plan is too complicated to understand, let alone implement. And with such a start-up date (July 1), I'm unclear as to how FAST could happen.

Response: No action needed. The timeline for implementation as stated on page 74 is that program implementation is targeted for Feb-June 2010.

- Families and Schools Together (FAST) – requires a detailed Memorandum of Understanding (MOU) – to make sure districts are well informed and cooperative. Clinical trainers with treatment experience may not be the right infrastructure match. If FAST is prevention - why aren't prevention experienced trainers used?

MHB Response: No action needed. Comment relates to implementation.

- Plan is too long & complicated the number of sessions required don't allow for school vacations. Why must a mental health clinician be the lead in a prevention program?

MHB Response: No action needed. Planning for implementation included an understanding of school breaks so the program will not run year round, but the 30 weeks that schools are in session. A mental health clinician is not the lead in the prevention programs.

- Lofty goal in a 14 week period.

MHB Response: No action needed. This comment related specifically to The Strengthening Families program. This program is a 14 week Evidence-Based Program (EBP) that has been found to be effective.

- Concerns are parents attending sessions (Cognitive-Behavioral Intervention for Trauma in Schools -CBITS).

MHB Response: No action needed. The goal is to include outreach and engagement activities to increase the likelihood of parent participation in the CBITS program.

- Some projected service #'s are high. Will enough people be able/willing to participate to reach goals by June 2010?

MHB Response: No action needed.

- For Triple P program: would like to see community–wide education level included. With MHSA funding use we are better prepared to meet service demands than ever before. This would be a cost effective means of providing prevention service, county-wide.

MHB Response: No action needed. The developers of the Triple P program do not recommend implementing the community wide education level of Triple P until the other levels (explained in the Parent Education and

Support Project) are implemented otherwise there will be a demand for services that are not yet established. This is something that can be reviewed in future years.

- The time frames are quite ambitious. These may not be ample time to secure and train the appropriate staff in the execution of the identified Evidence-Based Program (EBP). However, this plan will reach a greatly underserved population in need of any service that can be implemented.

MHB Response: No action needed.

- Collaboration between RCDMH, local school districts, and Special Education Local Plan Areas (SELPA)'s will be critical.

MHB Response: No action needed.

- Larger demand for services than availability of services. Pg. 57 Possible typo check mark #2 should read 50,712 referrals.

MHB Response: A substantive change to the plan will be made. Data was provided by the MH Research and Evaluation Unit. On 6/24/09 The Department of Public Social Services provided a fact sheet that clarified the number of child abuse/abuse neglect referrals as well as the number of substantiated cases in 2007. The plan will reflect the accurate numbers (on page 57), which are 48,391 children referred with 9,393 substantiated.

- How to augment the services/link family to (especially highest level group) with other services necessary.

MHB Response: No action needed. Each project addresses the issue of linkage to other needed services. Providers will be made aware of available referral sources both in and out of the County system because there is awareness that there will be individuals identified with additional needs.

- Not one program that touches the lives of LGBTQ population. Not even outreach/engagement to connect with TAY centers.

MHB Response: The LGBTQ population is well referenced throughout the draft PEI plan. The Department has a commitment to include underserved cultural populations and the needs of the LGBTQ are identified in the plan and remain a priority. A recommended change, in order to provide clarification in Project #7, is the addition of the following sentence on page 136: "Although there is not a specific LGBTQ evidenced based practice, there was recognition throughout the community planning process that LGBTQ individuals, from adolescents to older adults, are an underserved population. Several of the PEI projects clearly state the needs of the

LGBTQ community and that engagement and participation of individuals and families from that population in the PEI programs will be a priority. Those projects are the Mental Health Outreach, Awareness, and Stigma Reduction Project; the Transition Age Youth Project; the First Onset for Older Adults Project; and the Trauma-Exposed Services for All Ages Project."

- Pg. 140 of the plan – Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) – it is unclear whether CBITS is specifically targeting African American youth. Was the program adapted? No program description for LBGTQ.

MHB Response: The MHB recommends that a sentence be added to the page referenced in the comment stating that CBITS has been shown effective with the African American population. In regards to the comment regarding the LGBTQ population, see response above.

- Please expand Parent-Child Interaction Therapy (PCIT) to our Spanish speakers! Sustainability in the school districts – utilizing school personnel that are already trained in Student Assistance Programs (SAP) & parenting classes, training. School people to implement all programs. I'm concerned about the underserved in untargeted districts.

MHB Response: No action needed. As with any PEI program there will be targeted outreach to underserved populations, including the Spanish speaking population. Service providers of any PEI program will demonstrate cultural competence. RCDMH will look to community providers who are from and know the community they serve and will provide all accommodations as needed to program participants.

- I have concerns about which evidence–based practices will be used and if they have been adequately tested with LGBTQ population. What specific tailoring is planned? My hope is that the community will be intimately involved in this tailoring.

MHB Response: No changes to the plan needed. This will need to be a discussion during implementation. Providers of the programs with the LGBTQ populations will need to have demonstrated the ability to effectively work with that population.

- Older Adult program – Not enough resources at Jefferson Transitional Program for paranoid 60+.

MHB Response: No action needed.

- I do not see much in the older adult program that is very helpful to an individual.

MHB Response: No action needed. The Board members recognized that the programs identified in the Older Adult Project address individuals.

- I would like to see all people to get help. I feel that I was heard. People will get help and what they need.

MHB Response: No action needed.

- Age specific, drug & alcohol services addressing partnerships to include – mental health services, in full with substance abuse services for the elders - blend peer counseling with residential and outpatient elder substance abuse services. Partner with substance abuse providers – build service continuum.

MHB Response: No change to the plan needed. The PEI team will work with the Department's Older Adult manager as implementation of the older adult PEI programs occurs to look for opportunities to include partnering with substance abuse providers as appropriate.

- Of course, it doesn't meet all needs of the community, but it's a "good start".

MHB Response: No action needed.

- I think that younger and older adults should come together about education program.

MHB Response: No action needed.

Letters given to Prevention and Early Intervention staff at Public Hearing held 7/1/09:

(A.) To: Mental Health Board
RE: Prevention and Early Intervention Plan Public Hearing.

I am writing this statement in support of the LGBTQ youth in the community and their inclusion of PEI services. So many times I have heard about youth across the county committing suicide because of the stigma of being gay especially among young men of Color. They are being bullied in schools and sometimes out in the streets because of what they wear or how they walk or even talk. I can only imagine the mental stability of these young people and being able to cope and survive. What message are we sending them if we aren't doing anything to support their mental health issues? Groups like Rainbow Pride Youth Alliance, PFLAG are important agencies to fill in the gaps where schools, faith community and families fall short.

Respectfully,
Community Member

MHB Response: No action needed.

(B.) 7-2009
Gentlemen/Women:

This is to voice my support for the inclusion of the LGBT community in the Prevention and Early Intervention Plan.

Whether it is youth services or senior services, I support your decision for inclusion. This decision has been a long awaited plan for the LGBT community.

MHB Response: No action needed.

(C.) 7-1-09
To Whom It May Concern:

As a citizen, I support the inclusion of the LGBT community in the Prevention and Early Intervention (PEI) Plan.

The trauma and stigma of aging is especially difficult for LGBT seniors as they struggle with health issues, loss of partners and community.

Programs in the Western Region that serve LGBT seniors are especially needed. We are in need of more space to gather for support that is smoke free, alcohol free and safe.

I would like to “Thank you” in advance for any consideration you can give to this issue.

MHB Response: No action needed.

Email received at the Prevention and Early Intervention Unit on 7/5/09

I'm age 64 and live in Palm Desert with my partner of 20 years, who is 74. I'm unable to attend tomorrow's hearing, and decided to share my thoughts with you. We moved here 8 years ago in large part because we wanted to be in an area with a sizeable gay-lesbian population. Our circle of friends includes many men in our age bracket dealing with chronic or terminal illness and the loss of life partners-typically after 25-40 years together. As LGBT-friendly as this area is-and it is far better than many other places I've lived-we have been troubled by an apparent "tone-deafness" to issues of grief, loss, and depression among our gay friends.
The negative experiences include gay widowers being turned away from or treated disparagingly within bereavement support groups because a same sex relationship isn't a "real marriage." Friends of mine fighting depression over loss of mobility, loss of friends, loss of income have been told by professionals not to be "drama queens," and to "stop being so sensitive." And don't even get me started on how many times I've confronted a questionnaire in a health professional's office asking me whether I'm Married, Single, Widowed, or Divorced. Hello: can't they at least pretend to be interested in the domestic partnerships of their gay/lesbian clients? I believe it's important to know if an older adult lives alone or has a companion, and those maddeningly closed-ended questions don't reveal that information.
The need for gay/lesbian-sensitive mental health services is real and growing in this area. Thank you so much for this opportunity to share my limited but real exposure to this topic within my circle of friends and acquaintances.

MHB Response: No action needed.

ATTACHMENT R-2

County of Riverside
Mental Health Board (MHB)
Executive Committee Review
Friday, July 10, 2009

Training, Technical Assistance and Capacity Building (TTACB) funds Request

TTACB Comments and Suggested Responses from Public Hearing
July 1, 2009

Comment #1: I think it is exemplary and I am especially pleased about the law enforcement piece because we deal with that on a regular basis.

MHB Response: No action needed.

Comment #2: I would like to see that every police officer or law enforcement officer that goes through that training would actually get something that they could wear on their collar or on their shirt so that it is recognizable to consumers and family members that this is an officer that understands and has been through training.

MHB Response: No action needed. The Board members requested that the suggestion be given to the Workforce, Education, and Training Coordinator for the law enforcement collaborative.

Comment #3: My concern is about the Training, Technical Assistance, and Capacity Building plan. My concern centers around the fact that it appears that in the plan the training on the evidence-based practices and preparation is going to be provided to those who the Department of Mental Health contracts with. My concern is that we have a lot of underserved communities and it will probably preclude newcomers from learning evidence-based practices. It will not position them to be able to help to team with Mental Health to spread these services out into those underserved communities. My hope is that training will be offered to those who are interested as well as those who receive these contracts.

MHB Response: No action needed. Trainings for evidence-based practices through PEI will be provided to all contractors and it is expected additional space in many of the trainings will be available and offered to community service providers who may be interested.

Comment #4: I would like to speak to the Training, Technical Assistance, and Capacity Building plan and commend the three components. The California Institute for Mental Health organization has shown capacity in Riverside and the law enforcement is great as well as working with consumers. I think I would like to make the recommendation that a fourth group be included. Riverside County

has a long tradition of successful Student Assistance Programs (SAP) and training. The Student Assistance Programs are the most basic allies to mental health because they work closely with their school counselors. The school counseling population in Riverside and across California has been cut significantly. Student Assistance Programs have proven their cost effectiveness. Gathering them together in the same way that law enforcement is gathering together and the consumers are gathering together was a specific request of this group and since the schools are the site of where the single evaluated program is going to take place leaving this group out of the Technical Assistance plan is a serious overlook because it is potentially the bridge between many of these programs succeeding or failing. In addition to succeeding and sustaining they are the coaches for mental health inside the whole school system and they are true allies to this process. Please add a fourth area of the plan to include SAP training that would increase skills in screening, brief intervention and referrals to PEI programs. This will help implement and sustain programs in the non-traditional setting of schools. Adding SAP training would improve FAST outcomes which is the program chosen to be evaluated.

MHB Response: A substantive change to the plan will be made. A fourth component will be added to address the feedback from several people regarding the request to provide Student Assistance Program training for school personnel and training for other County and contract, including substance abuse, providers. This will dove-tail with programs described in Project #1 of the PEI draft plan: Mental Health Outreach, Awareness and Stigma Reduction Project.

Comment #5: I see schools suggested over and over again but do not see them identified as one of the training components. I'm not sure how your programs are going to get into the schools. How are you going to get the school district to work with you, to open their doors, to say come on in? And you mention that school people are going to be trained to present the FAST programs specifically but, that's not the only program that is reaching out to the schools. It looks like almost every component will be offered in schools. I don't know if you have ever tried getting into schools but it is not always easy and the Student Assistance Programs are an easy way. Parents call our Student Assistance Program in Desert Sands to find out where the parenting classes are. So, I agree and I'm sad that Desert Sands is not one of the identified areas, but I still want to see that happen where ever the need is that people are trained in the schools to offer services.

MHB Response: See response to Comment #4.

Comment #6: I do have to say that I've talked about the law enforcement training for years and I'm so pleased that it was written into the plan. There are so many police departments out there that need their officers trained and when our consumers are in crisis we need those officers to be trained in mental health

and how to approach and how to deal with it and I'm exceptionally pleased that this was written into the plan and that we're doing it at last.

MHB Response: No action needed.

TTA Comments and Mental Health Board Responses from Public Hearing July 6, 2009

Comment #7: The plan talks about offering pre-employment training to consumers and family members to prepare them with recovery and wellness principals and to show how they learn through life experiences. Through the stimulus package Workforce Development is receiving significant funding to expand their services to reach and help train individuals as well. Has there been any cross referencing regarding those new services or expanding services through the stimulus funding for Workforce Development to what you're offering here with this funding?

MHB Response: No change to the plan is needed. The Board requests that RCDMH make contact with Workforce Development regarding this matter prior to implementation.

Comment #8: Regarding the police department receiving education on the overview on mental illness and mental health and mental health laws. My family went through an experience in dealing with the police department and behavioral health services. One of the things that was really difficult in dealing with both entities was the fact that unless the patient is expressing verbally that he is going to hurt himself or harm others the family is caught in the middle. Behavioral health did not want to intervene even though all the signs and symptoms were there and the police department did not want to intervene because they said that it was a behavioral health issue. We had to go through hell, and it got to the point that the administrator had to intervene. But, one of the first things that came into my mind is, where's the education for police officers? Or for providers as well, helping families that are dealing through distress when they're dealing with a loved one. I would like to see that there is an opportunity to provide training to police officers.

MHB Response: No action needed. This comment substantiates the need for law enforcement training as listed in the plan.

Feedback Form Comments and Mental Health Board Responses

Of the _10_ Feedback Forms submitted: _2_ were "Very Satisfied", _2_ were "Somewhat Satisfied", _1_ was "Satisfied", _4__ were "Unsatisfied", _0_were "Very Unsatisfied", and _1_ did not indicate a Response

3. What do you feel are the strengths of the plan? Please identify the program and age group if applicable:

- The strength in the plan clearly lies in its attention to provide training to law enforcement. Thank you.
- #3 is sorely needed in the Desert communities – lack of Psychiatric facilities in the Coachella Valley make the job of law enforcement more difficult – therefore many needing Psychiatric help are not provided these services because law enforcement does not have the knowledge or resources to provide such and do not.
- Particularly interested in #3 of plan – acute need for law enforcement training.
- The law enforcement training.
- Focus on key setting. California Institute for Mental Health (CIMH) is respected in Riverside for its past Technical Assistance.
- Law enforcement training is very important – I'm so pleased as a provider of services.

4. What Concerns do you have about the plan? Please identify the program and age group, if applicable.

- 1.) Why does the department believe California Institute for Mental Health (CIMH) to be the right provider? The Department needs a fresh, new perspective on mental health outside of California with updated, creative perspectives on programs and budget. 2.) Where is the dual diagnosis training on intellectual disabilities?

MHB Response: No action needed. 1.) CIMH has the infrastructure and experience to bring together development teams which both reduces the cost of training and ensures fidelity to the models. In addition, with the implementation of the vast number of evidence-based practices through PEI across the State. CIMH has knowledge of other Counties' training needs and can assist us in collaboration regarding trainings adding to cost effectiveness. 2.) Not PEI related.

- Does not address needs of LGBT community.

MHB Response: No action needed.

- Training designed to increase community capacity should be offered to "providers" and potential partner providers (schools, Community-Based Organization's, Public Health, and other public agencies). Trainings should be more inclusive.

MHB Response: No action needed. Trainings for evidence-based practices in the PEI plan will be coordinated and offered by RCDMH to all contract partners and trainings will be available to additional community providers who may be interested. The trainings in TTACB will be offered to contracts and additional non-contracted community agencies as appropriate, including schools. In addition, as stated above, adding a fourth component to the plan also addresses this concern.

REFERENCES

Adler, N. E., Boyce, T., Chesney, M. A., Cohen, S., Folkman, S., Kahn, R. L., and. Syme, S. L. "Socioeconomic status and health: *The challenge of the gradient. American Psychologist (1994): 49, 15-24.*

"Adverse Child Experiences Study." ACE Study - Major Findings - Adverse Childhood Experiences. 12 Dec. 2005. 17 Mar. 2009 <www.cdc.gov/nccdphp/ACE/findings.htm>.

Brennan, P. A., Hammen, C., Anderson, M. J., Bor, W., Najman, J. M., &.Williams, G. M. "Chronicity, severity, and timing of maternal depressive symptoms: relationships with child outcomes at age 5." *Developmental Psychology 36 (2000): 759 -766.*

Clark, D. B., Lesnick, L. and Hegedus, A.M.. "Traumas and other adverse life events in adolescents with alcohol abuse and dependence." J AM Acad Child Psychiatry 36.12 (1997): 1744-51.

Cochran, S. "An epidemiologist in the University of California." *Los Angeles School of Public Health*

Conwell, Y., and Brent D. "Suicide and Aging I: Patterns of Psychiatric Diagnosis." INTERNATIONAL PSYCHOGERIATRICS 7.2 (1995): 149-64.

Conwell, Y. "Suicide in later life: a review and recommendations for prevention." Suicide and Life Threatening Behavior 31 (2001): 32-47.

Costello, E.J., Erkanli, A., Fairbank, J.A. and Angold, A. "Trauma Stress." *The prevalence of potentially traumatic events in childhood and adolescence.* 15.2 (2002): 99-112.

Deykin, E. Y., and Buka, S.L. "Prevalence and risk factors for posttraumatic stress disorder among chemically dependent adolescents." *Am J Psychiatry 154.6 (1997): 752-7.*

Dienemann, J., Boyle, E., Baker, D., Resnick, W., Wiederhorn, N. & Campbell, J. (2000). Intimate partner abuse among women diagnosed with depression. *Issues in Mental Health Nursing, 21*, 499-513.

Kilpatrick, D. G., Saunders B.E., & Smith D.W. "Youth Victimization: Prevalence and Implications*." Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice. 16 Apr. 2008* <http://www.ncjrs.gov /pdffiles1nij/194972.pdf>.

REFERENCES

Dube, S.R., Anda, R.F., Felitti, V.J., Chapman, D.P., Williamson, D.F., and Giles, W.H. "Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the adverse childhood experiences study." *JAMA 286.24 (2001): 3089-3096.*

Eaton, W.W., & Mantaner, C. Socioeconomic stratification and mental disorder. In A. Horwitz, A. V., and T. K. Scheid. (Eds.), "*A handbook for the study of mental health." New York: Cambridge University Press 1 Jan. 1999: 259-283.*

"Facts About California's Elderly/Demographics/Aging in California - California Department of Aging." *California Department of Aging - State of California. 19 May 2009 <http://www.aging.ca.gov/stats/fact_about_elderly.asp>.*

Garmezy, N., & Neuchterlein, K. "Invulnerable children: The fact and fiction of competence and disadvantage." *American Journal of Orthopsychiatry 42 (1972): 328 - 329.*

Giaconia, R.M., Reinherz, H.Z., Hauf, A. C., Paradis, A.D., Wasserman, M.S, and Langhammer, D.M. "Co-morbidity of substance use and post-traumatic stress disorder in a community sample of adolescents." *Am J Orthopsychiatry 70.2 (2000): 253-62.*

Goodenow, C. "2003 Youth Risk Behavior Survey Results." *Massachusetts Department of Education (2004).*

Harvey, A. R. "Group work with African-American youth in the criminal justice system: A culturally competent model. In G. L. Greif & P. H. Ephross (Eds.)." New York: Oxford University Press 1 Jan. 1997, sec. *Group work with populations at risk: 160 - 174.*

Hill, H.M., & Madhere, S. "Exposure to community violence and African American children: A multidimensional model of risks and resources." *Journal of Community Psychology 24, (1996): 26 - 43.*

Holzer, C., Shea, B., Swanson, J.,. Leaf, P., Myers, J., George, L., Weissman, M., & Bednarski, P. "The increased risk for specific psychiatric disorders among persons of low socioeconomic status*." American Journal of Social Psychiatry 6 (1986): 259 - 271.*

Johnson, Hans. "Birth Rates in California." *PPIC 9.2 (2007): 1 - 24.*

Krieger N. "Epidemiologic theory and societal patterns of disease "*Epidemiology (1993): 4, 276 278.*

REFERENCES

Delgado, M., & Humm-Delgado, D. "Hispanics and group work: A review of the literature." *Social Work with Groups* *7* (1984): 85- 96.

Lynberg MC, and Eaton D. "Prevalence and Associated Health Risk Behaviors of Physical Dating Violence Victimization among High School Students." *United States, 2003 Morbidity & Mortality Weekly Report. 2006. 2 Mar. 2009 <www.chooserespect.org.>.*

Lynberg, MC, and Eaton D. "Prevalence and Associated Health Risk Behaviors of Physical Dating Violence Victimization among High School Students. *United States, 2003." Morbidity & Mortality Weekly Report 2006 (2003)*

Molino, A.C. "Characteristics of Help-Seeking Street Youth and Non-Street Youth." *National Symposium on Homelessness Research. (2007): 4.*

Muntaner, C., Eaton, W. W., Diala, C., Kessler, R. C., &. Sorlie, P. D. "Social class, assets, organizational control and the prevalence of common groups of psychiatric disorders*." Social Science and Medicine 47, (1998): 2043 - 2053.*

Munoz, Ricardo F. "Prevention of Postpartum Depression in Low-Income Women: Development of the Mamás y Bebés/Mothers and Babies." *ScienceDirect: Cognitive and Behavioral Practice 14, (2007): 70-83.*

"C. Stigma And Discrimination Defined." *Mental Health Services Oversight And Accountability Commission: (2007): 1 - 62.*

"Eliminating Stigma And Discrimination Against Persons With Mental Health Disabilities." Mental Health Services Oversight And Accountability Commission: (2007): 62.

"Executive Summary: Understanding the Goal." *The President's New Freedom Commission On Mental Health (2003): 1- 98.*

"Executive Summary: Recommendations." UC Davis Center for Reducing Health Disparities 1.1 (2008): 1 - 67.

"MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL." U.S. Department *of and Human Services (2001): 1 - 203.*

"MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY." *U.S. Department of Health and Human Services (2001): 1 - 203.*

"MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL." Message from Tommy G. Thompson., Secretary of Health and Human Services., *U.S. Department of and Human Services (2001): 1 - 203.*

REFERENCES

"National Evaluation of Runaway and Homeless Youth." *U.S. Department of Health and Human Services (c) (1997).*

"National School Climate Survey." *Gay, Lesbian & Straight Education Network (2001).*

"Outreach to Underserved Communities: History of Discrimination, Marginalization, and Mistrust." UC Davis Center for Reducing Health Disparities 2.2: 1 - 32.

"Part 1: The Problem And The Challenge." California Strategic Plan On Suicide Prevention: Every Californian Is Part of the Solution (2008): 12.

"Report to the Congress on the Runaway and Homeless Youth Program of the Family and Youth Services Bureau for Fiscal Year 1995." U.S. Department of Health and Human Services (b). (1995) (1996).

"School-Based Mental Health Services. American Academy of Pediatrics: Committee on School Health 113.6 (2004): 1839 - 1845.

"Self reported frequent mental distress among adults - United States, 1993 - 1996." *Morbidity and Morality Weekly Report 47,* (1998): 326-331.

"The Goal of a Transformed System: Recovery." *The President's New Freedom Commission On Mental Health (2003): 1 - 98.*

"Understanding the Goal: Many People with Mental Illnesses Go Untreated." *The President's New Freedom Commission On Mental Health (2003): 1- 98.*

"Understanding the Goal: Stigma Impedes People from Getting the Care They Need." *The President's New Freedom Commission On Mental Health (2003): 1 - 98.*

"Youth with Runaway, Throwaway, and Homeless Experiences... Prevalence Drug Use, and Other At-Risk Behaviors." *U.S. Department of Health and Human Services (a) I (1995).*

"Youth." *National Alliance to End Homelessness. 2 Apr. 2009 <http://www.endhomelessness.org/section/policy/focusareas/youth>.*

Washington, DC: "Statistical Abstract of the United States: The National Data Book". *U.S. Census Bureau (1999).*

O'Hara, M. W., & Swain., A. M. "Rates and risk of postpartum depression: A meta-analysis." *International Review of Psychiatry 8 (1996): 37 -54.*

REFERENCES

Pecora, P.J et al., "Improving family foster care: Findings from the Northwest Foster Care Alumni Study," Casey Family Programs provides and improves—and ultimately prevents the need for—foster care. - Casey Family Programs. 26 Mar. 2009 <http://www.casey.org>.

Perkonigg, A., R. C. Kessler, S. Storz, and H. U. Wittchen. "Traumatic events and post-traumatic stress disorder in the community: Prevalence, risk factors and co morbidity.." Acta Psychiatr Scand, 101.1 (2000): 46-59.

Pescosolido, B., Martin, J.K., Link, B.G., Kikuzawa, S., Burgos G., Swindle R., & Phelan J.. "Public Report on the MacArthur Mental Health Module, 1996 General Social Survey. Bloomington, IN: Indiana Consortium of Mental Health Services Research, Indiana University and the Joseph P. Mailman School of Public Health, Columbia University." *Americans' views of mental health and illness at century's end: Continuity and Change. (2000).*

"QPR For Suicide Prevention." QPR Self-Study Course. 11 Mar. 2009 <www.qprinstitute.com>.

Ray, Nicholas. "An Epidemic of Homelessness." *National, Gay and Lesbian Task Force Policy Institute, National Coalition for the Homeless*

Regier, D. A., Narrow, W.E., Rae, D.S., Manderscheid, R.W., Locke, B.Z., and Goodwin, F.K. "The de facto U.S. mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services." Archives of General Psychiatry 50.2 (1993): 85 - 94.

Roman, Nan P., and Phyllis B. Wolfe. "Web of Failure: The Relationship Between Foster Care and Homelessness." *National Alliance to End Homelessness, 1995).*

Shute, Nancy. "On Parenting: How to Protect Your Child's Mental Health." Health News Articles - US News Health. 13 Feb. 2009. 12 Mar. 2009 <http://health.usnews.com>.

Smith, P.H., White, J.W. and Holland, L.J. "A longitudinal perspective on dating violence among adolescent and college-age women." *American Journal of Public Health 93.7 (2003): 1104-1109.*

Wilchins, R., Lombardi, E., Priesing, D., and Malouf, D., "First National Survey of Transgender Violence." *Gender Public Advocacy Coalition (1997).*