TRI-CITY MENTAL HEALTH SYSTEM'S
PREVENTION AND EARLY INTERVENTION PLAN

A Proposal to the Mental Health Services Oversight and Accountability Commission
in Accordance with the Mental Health Services Act

March 10, 2010

TRI-CITY MENTAL HEALTH SYSTEM'S
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PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN FACE SHEET

MENTAL HEALTH SERVICES ACT (MHSA)
PREVENTION AND EARLY INTERVENTION COMPONENT
OF THE THREE-YEAR
PROGRAM AND EXPENDITURE PLAN
Fiscal Years 2009-10 and 2010-11

County Name: Tri-City	Date: March 10, 2010

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

County Mental Health Director		**Project Lead**	
Name:	Jesse Duff	Name:	Rimmi Hundal
Telephone:	909.623.6131	Telephone:	909.623.6131
Fax:	909.623.4073	Fax:	909.623.4073
Email:	jduff@tricitymhs.org	Email:	rhundal@tricitymhs.org
Mailing Address:	1717 N Indian Hill Blvd • Suite B • Claremont CA 91711		

AUTHORIZING SIGNATURE

I HEREBY CERTIFY that I am the official responsible for the administration of the 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 the passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2007-08, 2008-09, and 2009-10 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: _____ March 10, 2010

County Mental Health Director Date

Executed at Claremont, California

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form 2

PEI COMMUNITY PROGRAM PLANNING PROCESS

County: Tri-City Mental Health Center (TCMHC) **Date:** March 10, 2010

1. Describe which staff positions and/or units assumed the following responsibilities:

1a. Overall Community Program Planning Process

(1) Jesse Duff, Executive Director;
(2) Toni Navarro, LMFT, Director of Clinical Services;
(3) Margaret Harris, Chief Financial Officer;
(4) Rimmi Hundal, MA, MHSA Manager; and
(5) Consultants John Ott, JD and Rose Pinard, PhD.

1b. Coordination and management of the Community Program Planning Process

(1) Rimmi Hundal, MA, MHSA Manager;
(2) Gilbert Saldate, Community Outreach Coordinator;
(3) Randy Nater, MSW, Clinician;
(4) Dana Stein, Community Navigator for La Verne and Coordinator;
(5) Nancy Day, Executive Administrative Assistant; and
(6) Consultants John Ott, JD and Rose Pinard, PhD.

1c. Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process

In addition to the staff members and consultants identified in 1a and 1b, the following staff members also helped to ensure stakeholder participation:

(1) Sonia Fuentes, Community Navigator for Claremont;
(2) Isela Morreno, Community Navigator for Pomona;
(3) Mary Baron, LCSW, Program Manager for Specialized Clinical Services;
(4) Paul Crane, LMFT, Program Manager for Children's Outpatient Services;
(5) Rosalind Watson, Employment Outreach Coordinator; and
(6) Alberta Irons, Adult Education Teacher, Pomona Unified School District.

2. Explain how the county ensured that the stakeholder participation process accomplished the following objectives:

2a. Included representatives of unserved and/or underserved populations and family members of unserved/underserved populations

TCMHC staff and consultants engaged almost 3,000 community members in the PEI community planning effort between June and December 2009, using four inter-related processes: focus groups, surveys, staff presentations, and stakeholder deliberations. The following table briefly describes each of these strategies and the numbers of community members engaged.

PEI Outreach and Engagement Strategy	Brief Description	# of community members
1. Focus Groups	• 40 focus groups convened in community settings engaging specific priority ethnic and other populations • Each focus group lasted between ½ to 1 ½ hours • Attachment A includes a detailed list of these focus groups	**655**
2. Surveys	• Anonymous surveys conducted with community members and providers, including representatives from community-based and faith-based organizations, mental and physical health providers, schools, colleges, and others. • Surveys were completed on-line, in person, and by fax, e-mail, and postal delivery.	**635** including representatives from 34 providers and community organizations
3. Staff Presentations and Media Engagement	• TCMHC staff members conducted a rigorous outreach effort to help build awareness about the PEI planning processes through presentations, radio interview, and community events. • Attachment B includes a partial list of these presentations.	**1,585** community members
4. Stakeholder Constituency - Delegates Process	• Professionally facilitated delegates' meetings to ensure inclusive and collaborative planning. Delegates deliberated to develop consensus recommendations for the draft PEI Plan to be posted for public comment. • 7 public meetings held, each from 5-9 pm with dinner, plus 2 orientation meetings, and 6 subcommittee meetings. Total number of hours: more than 70. • Result: complete consensus among delegates about the projects and budgets for the PEI plan.	**62** delegates **29** observers

TCMHC staff members partnered with trusted community leaders, and staff members from community agencies, to help insure that these processes meaningfully engaged individuals and families from traditionally unserved and under-served communities, including individuals with serious mental illness (SMI) and severe emotional disorders (SED). Sample stories to illustrate these efforts include the following:

- A Native American community leader who was a delegate in both the Community Services and Supports (CSS) and the Prevention and Early Intervention (PEI) planning processes helped TCMHC staff members organize 5 focus groups involving 126 Native Americans from 3 tribes, including 32 transition-aged youths and 21 older adults. These focus groups became natural extensions of established communal activities—e.g., talking circles and purification ceremonies.

- Latinos living in poverty were very reluctant to participate in focus groups or as delegates. Staff members from community-based organizations and schools were very helpful to TCMHC staff members in accommodating these individuals' interests. For example, staff members from Renacimeintos Community Center in Pomona helped to organize a focus group for 20 low-income Latino women. Staff members from elementary schools helped to convene 2 focus groups for 21 parents. Staff members from the Joslyn Senior Center and Washington Park Community Center assisted in forming 5 focus groups for 110 Latino older adults.

- Asian and Pacific Islander (API) community leaders were also very effective partners in this process, once they trusted that TCMHC staff members were committed to developing meaningful and sustained relationships with their communities. According to API community leaders, their members often dismiss mental illness as being too expensive to treat or best addressed through traditional healing practices such as meditation or indigenous healing rituals. TCMHC staff members made multiple visits to engage API community members at places where they typically gather, including community-run grocery stores, a Buddhist temple, an Islamic mosque, offices of API community newspapers, and community health centers. TCMHC staff members attended Buddhist meditation classes, and a range of community events. Eventually, community leaders sponsored 5 focus groups: 1 for transition-aged API youths, 1 for Taiwanese adults, 1 for Islamic adults, and 1 each for Vietnamese transition-aged youths and Vietnamese older adults.

- An African American leader of the consumer group Boredom Is A Cop-Out (BIACO) helped organize a focus group involving 15 African Americans with serious mental health issues. The Youth Activity Center youth staff leader recruited 7 African American transition-aged youths to participate in a focus group, and 6 African American transition-aged youths to serve as delegates. Staff members from the Inland Valley Family Homeless Shelter recruited 5 homeless African Americans, including 4 transition-aged youths for a focus group. Staff members from a provider working with low-income veterans also

recruited 29 African Americans for 2 focus groups, including 8 transition-aged youths.

- Staff members from the Havenly House substance abuse treatment center also helped to engage 18 individuals in a focus group, including 2 transition-aged youths and 3 older adults.

The stories above also demonstrate TCMHC staff members' efforts to reach individuals and families from unserved and under-served populations who do not currently receive services, and who do not belong to known organizations. Several additional stories illustrate this aspect of our outreach and engagement efforts:

- Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community members have a very low profile within the tri-city area. There are no advocacy groups for this population in the tri-city area, and few if any public or private leaders who are publicly identified with this community. There are support organizations on several of the college campuses in the area, and TCMHC staff members made repeated attempts to engage leaders from these organizations. After months of unsuccessful efforts, staff members identified a bar in Pomona with a reputation for serving LGBTQ members, and began to develop relationships with several patrons. These relationships eventually led to an introduction to a community leader who agreed to conduct 2 focus groups for 18 LGBTQ transition-aged youths, many who are HIV positive. Most of these youths were Latino or African American. The community leader explained that these youths do not readily trust outsiders, given their repeated experiences of rejection by employers, family members, faith communities, and friends. TCMHC staff members trained and supported the LGBTQ community leader to conduct the focus groups.

- Individuals with disabilities are also often invisible members of our communities. TCMHC staff members contacted national associations for individuals with disabilities to obtain a list of local referrals. A locally based organization, the White Cane Center, was then contacted and successfully engaged to recruit 21 individuals who are blind to participate in a focus group.

- After several unsuccessful attempts to engage Latino transition-aged youths, TCMHC staff members walked onto a soccer field at the University of La Verne and directly engaged the soccer players there. These conversations eventually resulted in 4 focus groups with 52 transition-aged youths.

2b. Provided opportunities to participate for individuals reflecting the diversity of the demographics of the County, including but not limited to, race/ethnicity and language, age, gender, geographic location

Race, ethnicity, and language

The following table compares the representation of ethnic populations in the tri-city area with the representation of ethnic populations in our engagement strategies:

Ethnic Population	Total # Tri-City Area	% Tri-City Area	% in Focus Groups	% in Surveys	% in PEI Delegates
African American	14,664	6%	13%	12%	35%
Asian Pacific Islander	17,587	8%	8%	8%	21%
Latino	125,458	55%	38%	47%	24%
Native American	884	0.003%	20%	4%	16%
White	66,951	29%	19%	28%	32%
Other	3,929	2%	1%	1%	4%
Totals	229,473	100%	100%	100%	100%
Source for Tri-City Area: United Way 2007 Zip Code Data Book San Gabriel Valley					

As noted by the table, African Americans, Asian Pacific Islanders, and Native Americans participated in the PEI planning processes at rates higher than their rates of demographic representation in the tri-city area.

The representation of Latinos in the delegates' process, however, was lower than in the tri-city area. Given the lower number of Latino delegates, we aggressively pursued Latino participants in both the survey and focus group strategies. Indeed, over 50% of the focus groups were conducted either in Spanish only or Spanish and English. The following table describes the focus groups with a majority representation of Latinos:

Name of Focus Group	# of Latinos	Total # in Focus Group	% of Latinos in Focus Group
Joslyn Senior Center (3 focus groups)	60	82	73%
LGBTQ Community Group (2 focus groups)	16	18	89%
Parent Group, Bueno Vista Elementary	6	10	60%
Parenting Group, Pomona	11	11	100%
Renacimeintos: Low-Income Women	20	20	100%
TCMHC: Bridges Support Group*	8	13	62%
TCMHC: Depression Therapy Group	6	11	55%
TCMHC: Spanish Speaking Therapy Group	2	2	100%
TCMHC: Symptoms Mgt Therapy Group	3	6	50%
TCMHC: Trauma and Recovery Therapy Group	3	3	100%
University of La Verne (2 focus groups)	22	24	92%
Washington Park Older Adults	53	53	100%
* Promotes life skills/linkage to resources for uninsured individuals not enrolled in services			

Age

The following table compares the representation of age groups in the tri-city area with the representation of age groups in our outreach and engagement strategies:

Demographic Representation by Age	Total for Tri-City Area	%	% in Focus Groups	% in Surveys	% in PEI Delegates
16-25	31,471	19%	24%	26%	10%
26-59	101,550	60%	41%	56%	71%
60+	35,827	21%	35%	18%	19%
Totals	168,848	100%	100%	100%	100%
Source for Tri-City Area: United Way 2007 Zip Code Data Book San Gabriel Valley + extrapolation					

We made special efforts to reach older adults, transition-aged youths, and parents of young children. Six focus groups specifically targeted older adults in community settings throughout the three cities, engaging a total of 147 older adults. In addition, older adult representation was significant in the focus groups for Native Americans (17%), family members from the National Alliance on Mental Illness (34%), veterans (18%), Vietnamese (71%), and the White Cane Center for the Blind (76%).

Representation of transition-aged youths in focus groups and surveys was both higher than the representation of transition-aged youth in the tri-city area. Further, while the percentage of transition-aged youth representation in the delegate process was lower than in the overall tri-city population, their involvement as delegates in a stakeholder planning process was unprecedented.

Parents of young children also participated through three focus groups sponsored by an elementary school, mental health provider, and a community provider working with low-income women. A total of 41 parents of young children were engaged through these efforts.

Gender and geography

The gender representation within the tri-city area is equal between men and women. Slightly more women than men participated in the surveys, focus groups, and delegates process.

Regarding geographic representation, the following table compares the population by city in the tri-city area with the representation by city among delegates in the delegates' process:

Demographic Representation by City	Total for Tri-City Area	%	Total for PEI Delegates	%
Claremont	33,998	16%	14	23%
La Verne	31,638	15%	9	15%
Pomona	149,473	69%	32	52%
Other	0	0%	7	11%
Totals	215,109	100%	62	100%
Source for Tri-City Area: 2000 US Census + extrapolation				

TCMHC is a Joint Powers Authority among the cities of Claremont, La Verne, and Pomona. We only reported data from the focus groups and surveys for the whole tri-city area. We did not disaggregate the data by city for the surveys and focus groups because, over the past three years of delegates' processes, we have been working hard to build ownership among participants for the entire region, regardless of the city within which they live or work.

2c. Included outreach to clients with serious mental illness and/or serious emotional disturbance and their family members, to ensure the opportunity to participate

TCMHC staff members and consultants worked to ensure that all aspects of the PEI planning process included the participation and perspective of individuals with SMI/SED and their family members. Evidence of the engagement of these community members in the planning process includes the following:

- Nineteen percent of participants in the focus groups (126 individuals) were people with SMI/SED and/or family members, including: 13 members from Boredom is a Cop-Out, a club for individuals with SMI; 35 individuals from 5 different TCMHC therapy groups; 21 parents of children of all ages, including young children, with SMI; over 40 active members of NAMI; and a number of groups for veterans, individuals who are homeless, older adults, and others likely included many people with SMI/SED. Several of these groups were conducted in Spanish.

- Twenty-three percent of survey respondents (143 individuals) answered affirmatively to the question: Are you currently receiving, or have you received, mental health services? Twenty-seven percent of survey respondents (170 individuals) answered affirmatively to the question: Are you a family member/caregiver of someone with mental health issues? Sixty-seven percent of survey respondents (423 individuals) answered affirmatively to the question: Do you know someone with mental health issues?

- Almost one-half (47%) of PEI delegates were individuals with SMI/SED and/or family members. At least 12 delegates were people with SMI/SED, and at least

17 delegates were family members. Of the 16 delegates who participated on the subcommittee that developed the first draft of recommendations for funding, 3 delegates were people with SMI/SED (19%) and 2 were family members (13%).

Beyond invitations and encouragement to participate, TCMHC staff members and consultants provided individuals with SMI/SED and their family members sustained support to insure their active participation. We conducted focus groups in settings comfortable and familiar to the participants. We conducted many of the in-person surveys in small groups with people who knew one another well. During the delegates' process, 2 delegates (the TCMHC Employment Outreach Coordinator and an Adult Education teacher) provided on-going and active support to the delegates with SMI/SED, including:

- Meeting regularly with delegates who have SMI/SED and their peers to discuss upcoming delegates or subcommittee meetings, and the results of the previous delegates meetings;

- Incorporating the materials distributed at delegates' meetings into the recovery support sessions held with people receiving services, using the materials to advance reading skills, and as the focus of group sessions designed to improve communication and social skills.

- Encouraging participation and providing support as needed during meetings; and

- Providing transportation to and from meetings as necessary.

At the end of each delegates' meeting, participants were provided a feedback form to self-assess how well they understood the key concepts covered and actions taken during the meeting, and to share their reflections about what worked well during the meeting and what could be improved in subsequent meetings. Identification of the participant's name was optional. At the end of the last delegates' meeting, when the delegates reached consensus on the recommendations to be included in the draft PEI plan, one of the delegates with SMI/SED provided the following feedback:

I love being a part of this process. It was very interesting to be involved in planning and my input on the subject was fantastic. I am on top of the world. I am on a high.

3. Explain how the county ensured that the Community Program Planning Process included:

3a. Participation by required stakeholders

In early June 2009, TCMHC began an aggressive effort to recruit delegates to participate in the PEI delegates' process. Ultimately 62 people were chosen as delegates. The following table details the required constituencies represented by the

PEI delegates. Note: Some delegates represented more than one constituency, so the numbers in the table total more than 62, and the percentages more than 100%.

Required and Recommended Community Constituencies (CA DMH Notice 07-17)		# of delegates	% of delegates (#/62)
Underserved Communities			
1	African American	22	35%
2	Asian/Pacific Islander	13	21%
3	Latino	15	24%
4	Lesbian/Gay/Bisexual/Transgender/Questioning	2	3%
5	Native American	10	16%
6	Refugee/Immigrant	4	6%
7	Other: transition-aged youth	6	9%
8	Other: older adult	12	19%
9	Other: physically disabled	1	2%
Education			
10	School Districts	8	13%
11	Colleges and Universities	3	5%
12	Adult Education	1	2%
Individuals w/ SMI/SED and their families			
13	Individuals w/ SMI/SED	12	19%
14	Family members, including NAMI members	17	27%
Providers of mental and physical health services			
15	Provider: mental health services, including substance abuse	9	15%
16	Provider: physical health care services	2	3%
Providers of social services			
17	City social service providers	3	5%
18	Community social service providers, including homeless, rape crisis, and domestic violence services	7	11%
Law enforcement			
19	City law enforcement	2	3%
20	County law enforcement: probation department	1	2%
Other			
21	City government	3	5%
22	Los Angeles County, Department of Mental Health, including programs for transition-aged youth	4	6%
23	TCMHC Governing Board/Mental Health Commission	5	8%
24	TCMHC staff members	3	5%

3b. Training for county staff and stakeholders

The PEI delegates' process was the third such process TCMHC has sponsored in the last three years. The first process, concluded in October 2007, engaged over 40 delegates in a one-year intensive community visioning process. This process helped TCMHC emerge from bankruptcy as a system of care organized around the core values of the Mental Health Services Act. The second process engaged almost 50 delegates to develop the Community Services and Supports (CSS) plan, and was concluded in May 2009.

In all three of these processes, delegates have not been passive responders to recommendations developed by staff or others. Instead, they have actively participated in the creation and refinement of the substantive recommendations for each of the three proposed plans.

For delegates to play such an integral role requires a substantial and sustained investment in training and capacity-building skills, both for stakeholders and for staff. Some of the dimensions of the training and capacity-building efforts that supported the PEI planning process included:

- The fundamental concepts of wellbeing, resiliency, and recovery, prevention (both universal and selective), risk and preventive factors, and early intervention;
- The distinction between treatment efforts, prevention and early intervention efforts, and other differences between the CSS and PEI plans;
- The essentials related to MHSA funding, including current and projected funding levels based on consultant Mike Geiss' financial analysis performed on behalf of the California Mental Health Directors' Association (CHMDA);
- The data that emerged from the focus groups and the surveys;
- Distinctions in levels of evidence among evidence-based practices, promising practices, and practices supported by community-defined evidence;
- Principles and concepts related to community capacity-building that emerged through the Learning Collaborative sponsored by the California Institute of Mental Health and facilitated by consultants John Ott and Rose Pinard, the lead consultants for the TCMHC PEI planning processes;
- An introduction to the core concepts of Results-based Accountability; and
- Principles, frameworks, and skill sets related to group consensus decision-making developed by John Ott and Rose Pinard.

The consultants used multiple structures to offer this training to stakeholders and staff members, including:

- Specialized trainings for staff and members of the TCMHC Board of Directors and Commission members;

- Two intensive orientation sessions for delegates who had not participated in either of the two previous delegates processes (about 50% of the PEI delegates); and

- Integrated training sessions into the 7 delegates' meetings (that totaled almost 30 hours) and 6 sub-committee meetings (that totaled over 40 hours).

Consultants also developed trainings for staff members who organized and conducted the focus groups, surveys, and community presentations, and for subcommittee members to introduce them to the broad array of PEI programs researched by CA DMH and a number of counties whose plans had been approved by the California Oversight and Accountability Commission (CaOAC).

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

4a. The lessons learned from the CSS process and how these were applied in the PEI process.

As noted in the discussion under question 3 above, the PEI planning process emerged and benefited from the experience of two prior delegates' processes: a community visioning process completed in October 2007 and the CSS planning process completed in May 2009. We applied many lessons learned through these first two planning processes to improve the PEI planning process. Some of these lessons learned included:

- Being more strategic and persistent in establishing relationships with trusted community leaders from unserved and under-served communities to increase the likelihood of meaningful participation from these communities. TCMHC staff members began a systematic relationship-building effort during the CSS planning process, and stepped it up significantly for the PEI effort. The result: we had extensive participation in the focus groups, surveys, and community presentations, and an even more representative delegates' group.

- Being more creative in reaching people from unserved and under-represented communities, particularly those who do not participate in organizations or other typical community structures to increase the likelihood of meaningful participation from these community members. Staff members' persistence in exploring multiple strategies to engage LGBTQ youth is a demonstration of this lesson.

- Conducting outreach on an on-going basis through different channels to significantly increase participation and community awareness. TCMHC staff members, as well as delegates and other participants, learned to seize opportunities to talk about the PEI planning efforts, regardless of the official meeting or event topic. Three brief examples illustrate how this lesson was applied: (1) The CSS Plan created four new Community Navigator positions to provide linkages to community resources for full service partnership (FSP) participants and others served by the plan. When Community Navigators made presentations across the three cities about FSPs and available community resources, they also informed and engaged key constituencies about the PEI planning process; (2) When the Community Outreach Coordinator organized Project Homeless Connect involving over 500 participants and 30 agencies, he made a special public announcement about the PEI planning efforts and invited the MHSA Manager and the Community Navigators to host a booth; and (3) as noted earlier, staff members used PEI materials as the focus for some of their group recovery sessions to help support reading, communication, and social skills among people with SMI/SED.

- Insuring meaningful participation by people with SMI/SED requires a number of formal and informal support structures. Some of the structures we created for the PEI planning efforts to support the active participation of people with SMI/SED are described in response to question 2.

4b. Measures of success that outreach efforts produced an inclusive and effective community planning process with participation by individuals who are part of the PEI priority populations, including Transition Age Youth.

Some of the measures of success we tracked through the PEI planning process included the following.

Participation measures

One obvious measure we tracked was the number of people from unserved and under-represented communities who participated through the outreach and engagement strategies. As noted in response to questions 2 and 3 above, we had significant success engaging members from multiple unserved and under-represented communities through focus groups, surveys, community presentations, and the delegates' process.

In particular, transition-aged youths participated in the focus groups and surveys at rates higher than their representation within the tri-city area. Six focus groups with a total of 28 participants included only transition-aged youths. Focus groups for API, Native American, and Vietnamese communities had significant percentages of transition-aged youth. Six transition-aged youths also served as delegates.

In addition to these two populations, the question asks specifically about our success in engaging individuals who are part of other PEI priority populations. CA DMH information notice 07-17 and others identified six priority populations: under-served cultural populations, individuals experiencing the onset of serious psychiatric illness, trauma-exposed individuals, and children and youth who are living in stressed families, at risk for school failure, and at risk of experiencing juvenile justice involvement.

Beyond the descriptions about the numbers of unserved and under-served populations, including transition-aged youths we already cited for the previous questions, we did not collect information to count the numbers of people who participated in our outreach strategies to more precisely fit the categories of priority populations. Anecdotal evidence (written and oral comments made during surveys, focus groups, community presentations, and delegates meetings), however, suggests that significant numbers of the participants were members of one or more of these groups, and/or knew individuals who were. For example, during the focus group for Latino parents, mothers described their constant worry about their children becoming involved in the juvenile justice system through gang activity. In addition, war veterans described how they typically avoid asking for help to address symptoms of Post Traumatic Stress Disorder due to their military training that emphasizes performing one's duties despite hardships. The veterans further explained that it is often difficult to meaningfully share personal experiences with someone who hasn't served in the military. Finally, a delegate with SMI who participated in the subcommittee's deliberations described the debilitating, negative effects of psychotropic medication prescribed in response to an initial onset of serious psychiatric illness while this person was attending college.

Convergence of data

The data collected from the different types of engagement such as focus groups, on-line surveys, in-person surveys, and the delegates' deliberations all identified the same three priority populations and the same three priority community mental health issues. The three priority populations that emerged (from among the six candidates identified by CA DMH) were: (1) individuals experiencing onset of serious psychiatric illness; (2) children and youth in stressed families; and (3) trauma-exposed individuals. The three priority community mental health issues that emerged (from among the five candidates identified by CA DMH) were: (1) prevention efforts and responses to early signs of emotional and behavioral health problems among specific at-risk populations of 0-25, (2) disparities in access to early mental health interventions, and (3) suicide risk.

This convergence of data collected through distinct and independent engagement strategies (focus groups, surveys, and delegates' deliberations) from large numbers of people across a wide range of communities gave the delegates a high degree of confidence about the directions suggested by the data.

Participation in and feedback to the delegates' meetings

The delegates' process was consistently well attended with an average attendance of more than 50 delegates and observers. As noted earlier, at the end of each delegates' meeting, the consultants distributed feedback forms to all participants asking them to self-assess how well they understood the key concepts covered and the actions taken during the meeting, and to share their reflections about what worked well during the meeting and what could be improved in subsequent meetings. Across the seven delegates' meetings, ratings to measure understanding of meeting content, satisfaction with the meetings, and support for the direction of the overall process, averaged 4.61 on a scale of 1-5, with 5 being most favorable.

Typical written feedback to these meetings included the following:

- *It's great to know my opinion means something.*
- *Facilitator presented complex information in a digestible form for a diverse group.*
- *Meetings were very well organized with Power Point slides and handouts.*
- *There was open sharing of divergent ideas.*
- *These meetings are friendly and respectful about others' views.*
- *The questions and answers are most educational. I really enjoy the diversity of this group.*
- *Community capacity building just keeps getting more and more inspiring of a concept and vehicle for change.*
- *There's great collaboration and group knowledge. I'm excited about the possibilities, especially the school wellbeing program. Very promising plan.*

Consensus among delegates about the draft PEI plan

The TCMHC Governing Board has authorized the delegates' process to generate the draft recommendations for the PEI plan (just as it did with the CSS plan). Throughout their deliberations, delegates were introduced to practices and principles that promote the emergence of collective wisdom. Rather than debate and compromise, delegates were introduced to the skills of dialogue and discernment. Delegates were encouraged to welcome divergent perspectives, treating such perspectives as neutral data rather than as opposing views that people had to choose between.

For all major decisions taken by the group, no voting took place. Instead, each delegate was polled using a tool called the Gradients of Agreement (see Attachment C). Delegates faced no pressure to agree with each other, or to develop convergent recommendations for the TCMHC Governing Board. Had the deliberations ultimately resulted in irreconcilable differences, the areas of convergence and divergence would have been fully documented and shared with the TCMHC Governing Board in the final report. In this case, however, every delegate fully endorsed the draft structure and budget of the PEI plan. The plan posted for community comment represents *a complete consensus* among the delegates.

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

5a. The date of the public hearing: January 27, 2010

5b. 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.

Beginning on December 22, 2009 and continuing throughout January 2010, we pursued an expansive effort to distribute the draft PEI plan and solicit feedback, including:

- Posting the plan on the TCMHC website;
- Emailing the link to the posted plan to hundreds of stakeholders and interested parties;
- Placing physical copies of the plan in community gathering places, including public libraries, community centers, post offices, and others; and
- Making over 90 presentations to community organizations and meetings, reaching almost 2,000 people.

Community members were encouraged to participate in the public hearing at the end of January, and to offer feedback prior to the public hearing by posting comments on the website and/or emailing, faxing, or mailing comments to staff. Attachment D includes the articles that appeared in the Inland Valley Daily Bulletin in advance of, and following, the public hearing.

5c. A summary and analysis of any substantive recommendations for revisions.

Participants in the various meetings that occurred during the public comment period, and participants during the public hearing, had a range of questions about the plan, including questions about how various programs funded by the plan would interact with each other, questions about funding, questions about sustainability, and questions about how we would know if the plan was effective over time. We responded to these and other inquiries through the meetings, indicating the sections in the plan that address these questions and offering further clarifications.

Three substantive recommendations for revisions emerged through these comment and feedback processes. One recommendation was to insure that K-12 students in *private schools* in the tri-city area benefit from the K-12 Student Wellbeing Program. A related recommendation was to insure that the College Student Wellbeing Program seek to involve as many of the local colleges as possible. We agree with these recommendations. The relevant program descriptions now reflect these intentions.

A final recommendation was to consider a different name for the Mental Health First Aid Program. The concern was that this name might create expectations that were not realistic (an expectation of professional clinical response), and that the name focused

on responding to incidences of distress rather than on promoting wellness. We agreed to revisit this issue when we begin implementation of the program, but are continuing to use the name Mental Health First Aid Program throughout this document.

5d. The estimated number of participants

We had over 200 participants at the public hearing for the PEI plan, doubling the turnout from our CSS public hearing. Some particulars of note from the hearing include:

- About one-third of the participants were engaging in the process for the first time.

- Participants included a number of monolingual Spanish- and Vietnamese-speaking people. All documents were translated into both languages, and translation was available for both groups. We also had sign language translators.

- The Tri-City area is home to many Costanoan tribal members. Several tribal leaders have been active participants in our efforts since the CSS planning process. At the public hearing, a tribal leader brought eight dancers of all ages to the gathering as one illustration of how a particular community promotes its mental health and wellbeing. They performed in the middle of the event, invoking the ancestors, Mother Earth, the power of women, and the power of bear in support of the gathering.

- Attachment E contains a summary of the feedback and comments we received during the public hearing. We offer one example here. One of the most vocal critics of Tri-City came to the hearing. He is co-chair of the Pomona Youth Family Master Plan Committee. During the large group dialogue (following small table discussions about the particulars of the plan), he offered the following comments:

  > *Over the years, I have been a vocal critic of Tri-City. I am a Vietnam veteran and have a son with mental illness. I am just so excited by what I'm hearing and experiencing tonight. I read every page of the plan and I wanted to see if it was really real. What you're doing here is the most engaging of community that I've seen any organization attempt to do. Your plan is truly humble so I also want to be humble and say that I'm wrong to continue being a critic. The delegates here have done an incredible job. This plan shows they want to connect to this community at a real level. All I can say is thank you. I just want to say thank you, thank you—to all of you.*

- The hearing ended with a rousing endorsement of the plan by all present. The Mental Health Commission then voted unanimously to recommend the plan to the Governing Board, and the Board voted unanimously to recommend the plan to the Mental Heath Services Oversight and Accountability Commission (MHSOAC).

PEI PROJECT 01:
COMMUNITY CAPACITY-BUILDING

Forms 3 and 4

PEI PROJECT SUMMARY

County: Tri-City
PEI Project Name: Community Capacity-Building **Date:** March 10, 2010

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition Age Youth	Adults	Older Adults
Select as many as apply to this PEI Project				
1. Disparities in Access to Mental Health Services	●	●	●	●
2. Psycho-Social Impact of Trauma				
3. (Prevention and Early Intervention for) At-Risk Children, Youth, and Young Adults				
4. Stigma and Discrimination				
5. Suicide Risk				

2. PEI Priority Population(s)	Age Group			
	Children and Youth	Transition Age Youth	Adults	Older Adults
2a. Select as many as apply to this PEI Project				
1. Trauma Exposed Individuals				
2. Individuals Experiencing Onset of Serious Psychiatric Illness	●	●	●	●
3. Children and Youth in Stressed Families				
4. Children and Youth at Risk for School Failure				
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement				
6. Underserved Cultural Populations	●	●	●	●

2b. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

TCMHC staff and consultants engaged almost 3,000 community members in the PEI community planning effort between June and December 2009, using four inter-related

processes: focus groups, surveys, staff presentations, and stakeholder deliberations. The data that emerged from these multiple conversations and engagement efforts revealed remarkable convergence among community members and leaders across the tri-city area on a range of questions, including the question of priority populations.

The detailed descriptions for the six priority populations include the following:

- Individuals experiencing onset of serious psychiatric illness as identified by providers, including but not limited to primary health care, as presenting signs of mental illness or experiencing a first break, including those who are unlikely to seek help from any traditional mental health services;

- Children and youth in stressed families, including children and youth placed out-of-home or 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 a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems;

- Trauma-exposed individuals—i.e., individuals who are exposed to traumatic events or prolonged traumatic conditions such as grief, loss or isolation, including those who are unlikely to seek help from any traditional mental health service;

- Children and youth at risk of or experiencing juvenile justice involvement, including children and youth exhibiting signs of behavioral/emotional problems who are at risk of having contact with, or have had any contact with, any part of the juvenile justice system, and who cannot be appropriately served through the Community Services and Supports plan;

- Children and youth at risk for school failure, including children at risk due to unaddressed emotional and behavioral problems; and

- Underserved cultural populations: those populations unlikely to seek help from any traditional mental health services whether due to stigma, lack of knowledge, or other barriers.

For the on-line survey, we asked respondents to identify their top 3 priority populations. Of the 635 survey respondents:

- 19.29% chose individuals experiencing onset of serious psychiatric illness;
- 22.88% chose children and youth in stressed families;
- 17.05% chose trauma-exposed individuals;
- 13.59% chose children and youth at risk of or experiencing juvenile justice involvement;
- 14.23% chose children and youth at risk for school failure; and
- 12.95% chose underserved cultural populations.

Delegates reviewed this survey data. They also understood data for the past year that indicate discernible, and in many cases significant increases in domestic violence calls, violent crime, suicide attempts, and other indicators of mental and emotional distress within families and communities across the three cities. Delegates understood that these and other indicators of mental and emotional distress are increasing at precisely the time when local governments, schools, foundations, and service providers are suffering escalating and devastating budget cuts. Indeed, the funding streams that support this plan under the Mental Health Services Act have declined significantly, and will likely continue to do so over the next several fiscal years.

All of this data impacted the delegates' decisions about priority populations (and their choice of projects as well). When the delegates went through their own exercise of prioritizing the top three populations, their percentages differed slightly from the online survey respondents. Specifically:

- 29.90% of delegates chose individuals experiencing the onset of serious psychiatric illness;
- 23.04% of delegates chose children and youth in stressed families;
- 20.59% chose trauma-exposed individuals;
- 9.80% chose children and youth at risk of or experiencing juvenile justice involvement;
- 8.83% chose children and youth at risk for school failure; and
- 7.84% chose underserved cultural populations.

Ultimately, however, delegates concluded that many of the root causes affecting the mental wellbeing of these different populations are the same, and many of the strategies that could promote the mental wellbeing of these populations would also be similar. While we indicate that this project will support underserved cultural communities and individuals experiencing the onset of serious mental illness, we believe that this project will actually impact most if not all of the priority populations.

The project includes two programs: the Community Wellbeing Program and the Mental Health First Aid Program. The Community Wellbeing Program will support initiatives by unserved and underserved communities across the three cities to promote the wellbeing of their members. While it is unlikely that any one community will address the needs of all six priority populations within their community, we are confident that the work of all the communities who participate in this program, when taken together, will address the needs of people in all of the priority populations. The Mental Health First Aid Program will train over one thousand First Aiders across the three cities who will be prepared to offer support to anyone they encounter who is experiencing mental or emotional distress (much like someone trained in the Heimlich maneuver can provide support to someone who is choking on food). While we expect that many of the people supported by the First Aiders will be people experiencing the onset of mental illness, we also expect that many people who receive support through this program will include members of the other priority populations as well.

3. PEI Project Description

3a. 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 data that emerged from the different types of engagement—focus groups, on-line surveys, in-person surveys, and the delegates' deliberations—showed remarkable convergence not only on the priority populations, but also on the priority issues to be addressed by the PEI plan.

CADMH guidelines identified six priority issues for counties to choose among when constructing their PEI plans, including:

- Disparities in access to early mental health services and interventions;
- Negative impact of trauma for all ages;
- Prevention efforts and responses to early signs of mental health problems among at-risk populations by age;
- Stigma and discrimination; and
- Suicide risk.

Of the 635 on-line survey respondents:

- 30.16% prioritized prevention efforts and responses to early signs of mental health problems among at-risk populations 0-25;
- 20.21% prioritized disparities in access to early mental health services and interventions;
- 19.10% prioritized suicide risk;
- 15.00% prioritized negative impact of trauma for all ages; and
- 14.44% prioritized stigma and discrimination.

After reviewing the on-line survey data, delegates completed their own priority issue exercise. Ultimately, delegates' percentages for the top three issues differed only slightly from the on-line survey data. Specifically:

- 34.31% of delegates prioritized prevention efforts and responses to early signs of mental health problems among at-risk populations 0-25;
- 20.59% of delegates prioritized disparities in access to early mental health services and interventions;
- 19.12% prioritized suicide risk;
- 18.63% prioritized negative impact of trauma for all ages; and
- 4.41% prioritized stigma and discrimination.

In addition to questions about priority issues and populations, we also asked survey participants, focus group participants, and delegates a series of questions about *wellness*, including:

- What does mental wellbeing mean for you and the people closest to you?
- What helps you maintain mental and emotional wellbeing?
- What helps people in your community meet challenges in their lives?

Regardless of the characteristics of the group—income level, race and ethnicity, geography, gender identity, immigrant status, and others—responses to these questions were extraordinarily consistent: the top responses to each of these open-ended questions remained consistent across virtually all sub-groups.

- What does mental wellbeing mean for me and the people who are closest to me?
  - Healthy relationships with family and friends;
  - A sense of greater purpose and meaning through religion, church, spirituality, and/or nature; and
  - An ability to create and maintain supportive relationships with others.

- What helps me maintain mental wellbeing?
  - Support from family and friends;
  - A meaningful connection to church, religion, spirituality, and/or nature;
  - Exercise, recreation, and music; and
  - A sense of purpose through employment, volunteering, and/or school.

- What helps people in these communities meet these challenges?
  - Healthy relationships with family and friends;
  - A sense of greater purpose and meaning through religion, church, spirituality, and/or nature;
  - Meaningful work, employment, school and/or volunteer opportunities.

We also asked focus group and survey participants who some of the people were that they considered to be trusted leaders and healers in their communities, and some of the places they and others in their communities frequented for worship, health, recreation, shopping, and other purposes. What became clear from the responses to these questions was that while the *categories* of wellbeing and support were consistent across groups and communities, the actual *experience* of wellbeing and support is highly contextual: where people go and who they trust for support and care varies dramatically within and among families and communities.

As delegates reflected on the purposes of the PEI plan, and on the data that emerged from the surveys, focus groups, and their own deliberations, several guiding values began to emerge:

- A focus on *communities*, defined as a groups of people who have sufficiently strong relationships that they provide tangible support to each other and can act together. Communities have strengths and assets that *already* support their members' health and wellbeing. With culturally appropriate support and encouragement, communities can leverage and extend these strengths and assets to improve and sustain the wellbeing of their members over time.

- A commitment to *strengthen the capacities of communities* to promote the mental and emotional wellbeing of their members. This commitment reflects an understanding that communities have the primary responsibility for promoting and sustaining the mental and emotional wellbeing of their members. No service system, no matter how efficient and effective, can ever be a complete and permanent substitute for the care and nurturing that becomes available to individuals and families through their natural communities of support.[1]

- A commitment to *sustainability*. Given the volatile and highly unstable economic environment, and the resulting uncertainty around MHSA funding, delegates committed to invest in strategies that would strengthen community capacity for caring and action that could continue regardless of future funding realities.

- A commitment to community-defined *results.* Too often data about effectiveness is unavailable, incomprehensible to anyone but program experts, or irrelevant to communities and families striving to decide on courses of action culturally appropriate to their contexts. Transformative action within communities will more likely emerge when community leaders can design their own rigorous assessment plan, and access data they care about in a timely manner, to help them assess whether actions they are taking are having a positive impact.

- A commitment to *learning.* Too often within complex systems, data is used to enforce compliance with static and predetermined program guidelines, and/or to affix blame if something goes wrong. These two values—compliance and blame—profoundly diminish the capacity of communities to adapt to complex and shifting realities. Many of the challenges confronting local communities, including those that undermine their health and wellbeing, defy simple analyses and responses. What is needed are structures of support and learning that help communities learn from each other, even cross-culturally, to expand their respective repertoires of effective action.

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[1] This value reflects emerging research documenting the importance of communities and families to the resiliency and wellbeing of children, families, members of unserved and under-served communities, and others. See e.g., www.search-institute.org/developmental-assets-tools and other research on the 40 developmental assets for children, TAY, and families; "Native American Children and Adolescents: Cultural Distinctiveness and Mental Health Needs," Journal of Child and Adolescent Psychiatric Nursing, Volume 6 Issue 4, August 13, 2007, pp. 18–23. The abstract from this article reads in part: "Native American families have powerful reservoirs for resilience. Many families experience oppression, exploitation, and poverty that contribute to mental health disturbances. Cultural traditions associated with harmony can promote positive mental health for Native American children and adolescents. Health care providers will benefit from knowing risks, cultural expressions of coping, and a framework for contextual assessment and intervention. http://www3.interscience.wiley.com/journal/119981664/abstract?CRETRY=1&SRETRY=0

Given these values, we have designed the Community Capacity-Building Project to strengthen the capacity of communities across the three cities—focusing particularly on unserved and under-served communities—to promote the mental and emotional wellbeing of their members. The project will also strengthen communities' ability to offer support when someone is experiencing the mental and emotional distress quickly, effectively, and in ways that are culturally appropriate. This project also addresses one of the top three issues identified through the on-line surveys and the delegates deliberations: namely, the disparities in access to mental health services.

3b. 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.

The Community Capacity-Building Project will engage partners in communities across the three cities, particularly unserved and under-served ethnic and other communities. These partners will include schools, colleges, health clinics and other primary care providers, faith-based organizations, community organizations and collaboratives, community businesses, and other non-traditional partners.

3c. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

The Community Capacity-Building Project includes two programs: the Community Wellbeing Program and the Mental Health First Aid program. The Community Wellbeing Program will focus on unserved and under-served communities across the three cities—e.g., Native American communities, Vietnamese and other Asian and Pacific Islander communities, and Latino communities, including immigrant communities and communities of predominantly monolingual Spanish speakers.

The Mental Health First Aid program will provide training and support to leaders from the unserved and under-served communities who participate in the Community Wellbeing Program, as well as to leaders and others from schools, colleges, health clinics and other primary care providers, faith-based organizations, community organizations, community businesses, and others.

3d. Highlights of new or expanded programs
3e. Actions to be performed to carry out the PEI project, including frequency or duration of activities.
3f. Key milestones and anticipated timeline for each milestone

The Community Wellbeing Program

Highlights: The Community Wellbeing Program is a new program designed to help communities develop and implement community-driven plans to improve and sustain the mental and emotional wellbeing of their members, particularly unserved and under-

served communities who often struggle to access appropriate mental health and other services. Building on the principles and approaches of the CADMH recommended *Asset Based Community Development (ABCD),* the Community Wellbeing Program reflects several foundational premises:

- Families and communities have primary responsibility for promoting and sustaining the mental and emotional wellbeing of their members;
- Families and communities have strengths and assets that already support their members' health and wellbeing; and
- With culturally appropriate support and training, communities can leverage their strengths and assets to improve and sustain the wellbeing of their members.

TCMHC staff, with support from consultants in the first year, will identify a number of communities with strong community leadership and a commitment to improving the mental and emotional wellbeing of their members. The unserved and under-served communities who partnered with us in the community planning process are obvious candidates for this effort.

Once identified, staff (and consultants in the first year) will work with community leaders to master the skills and frameworks needed to support their communities' actions to promote the mental health and wellbeing of their members. Examples of actions communities may take to promote the mental and emotional wellbeing of their members include organizing:

- Community wellness fairs;
- Cultural events to promote deeper understanding and connection to culture, language, and healing traditions;
- Community mentoring efforts to provide support to young people experiencing emotional or mental distress;
- Peer support circles for veterans returning from Afghanistan or Iraq;
- Volunteers to be trained as Mental Health First Aider Trainers, and as Mental Health First Aiders (see below); and
- Other community-driven activities to promote the mental and emotional wellbeing of their members.

Community leaders and partners will receive several forms of on-going support to support their actions. First, communities can apply for funding for up to three years from a community grants fund to support their actions focused on results of emotional wellbeing. Second, communities will receive support so that they are able to generate and analyze reliable and timely data to assess the effectiveness of their efforts. Third, communities will be able to participate in various learning circles and other structures that help them share and receive lessons learned with other communities who are also participating in this program.

Actions and activities: TCMHC staff (with consultants in the first year) will provide support to the communities chosen to participate in the first round of this process, to

help them finalize and implement the actions and activities devoted to improving results of emotional and mental wellbeing for their members.

Milestones

Apr-Jun 2010	Finalize job descriptions and hire Community Wellbeing Specialists
	Finalize job description for and hire Community Data Specialist
	Create infrastructure to administer community grants, including a staff-delegates' panel to review community grant proposals
Jul-Sept 2010	Complete design of leadership + community action support structures
	Choose first cohort of communities
Oct-Dec 2010	First PEI community summit
	Communities begin wellbeing efforts
	Finalize data infrastructure to support community efforts
Jan-Jun 2011	Communities submit requests for community grants
	Grant proposals reviewed and approved by a staff-delegates committee
	Data infrastructure completed and data collection begins for first cohort
	Selection process begins for second cohort of communities

Mental Health First Aid Program

Highlights: The Mental Health First Aid (MHFA) is a program to train scores of people in community-based settings to intervene quickly and effectively to offer support when someone is experiencing mental and emotional distress. This evidence-based program begins with a premise that just as people can master basic first aid for physical injuries—e.g., the Heimlich maneuver, CPR—without being doctors, people can also master basic *mental health first aid* without being clinicians.

The components of this program are straightforward. An initial group of people successfully completes a five-day course to become certified MHFA instructors. We estimate that 25 people from the tri-city area will complete this instructor course in the first year: two will be new staff members from TCMHC; the others will come from the communities who participate in the Community Wellbeing Program, and a range of other partners, including schools, colleges, health clinics and other primary care providers, faith-based organizations, community organizations and collaboratives, community businesses, and other non-traditional partners.

Each of these 25 people will then be certified to offer the 12-hour MHFA course to members of their community. The course provides knowledge and skills to people to help them learn how to help someone struggling with mental or emotional distress, or developing a mental health problem or crisis. Specifically, First Aiders will learn:

- The potential risk factors and early warning signs for a range of mental health problems, including: depression, anxiety, post-traumatic stress disorder, eating

disorders, substance use disorders, self-injury, psychosis and psychotic disorders;
- An understanding of the prevalence of various mental health disorders in the U.S. and the need for reduced stigma in their communities;
- A 5-step action plan encompassing the skills, resources and knowledge to assess the situation, to select and implement appropriate interventions, and to help the individual in crisis connect with appropriate supports; and
- The self-help, social, peer, and professional resources available to help someone with a mental health problem.

The budget includes non-recurring funds to support the wide-ranging delivery of these 12-hour programs, including funds to purchase people's time—e.g., funds for substitutes so teachers can take the 12-hour first aid training—and stipends for food, space, childcare, and other support.

The intention is to train over 1,000 Mental Health First Aiders within the first several years of the program. These First Aiders will know how to appropriately respond to a person they encounter who is struggling with a mental health issue, and how to help the person connect to their natural communities of support, and to other support structures and resources such as peer counseling, wellness activities, self-help programs, school-based supports, and others (see Projects 2, 3, 4, and 5 below).

The two TCMHC staff members who are trained as MHFA instructors will have additional responsibilities beyond delivering the basic MHFA course. One of their responsibilities will be to develop curriculum to augment the basic 12-hour first-aid training. We therefore expect these staff members to have expertise in curriculum and training design. The first two issues they will develop specialized training for will be: (1) recovering from trauma in response to violence (e.g., community violence, domestic violence, war); and (2) suicide awareness and prevention. They will deliver this training sometimes as an adjunct to the MHFA basic training, and sometimes as standalone training for high priority communities.

We also expect these two staff members to develop relationships with key community partners—e.g., primary care physicians and clergy. The focus of this work will be to understand these partners' needs to become more effective first responders for people having a mental health crisis, and identifying and securing experts or others who can provide specialized information, training, and support for these partners—e.g., training related to prescribing psychotropic medications for primary care physicians.

Actions and activities: TCMHC staff will recruit the first cohort of 25 instructors to take the five-day instruction course, and then offer support to these instructors as they train mental health First Aiders across the three cities. Staff members will also develop and deliver specialized curriculum and training, and develop strategic learning partnerships with key community partners. Staff will also organize periodic learning and support sessions among the 25 instructors to allow them to share and receive lessons learned, and to make plans for improving the first aid training over time.

Milestones

Apr-Sep 2010	Finalize job descriptions for Mental Health First Aid Trainer/Facilitators
	Hire two Mental Health First Aid Trainer/Facilitators
	Recruit first cohort of 25 MHFA instructors
	Instructors complete 5-day training
	Build support processes for the instructors
	First aid trainings begin
Oct-Dec 2010	First aid trainings continue
	Begin building relationships with primary care physicians and clergy
	Begin work on curriculum for priority issues—e.g., trauma from violence and suicide curriculum
Jan-Jun 2011	First aid trainings continue
	Building relationships with physicians and clergy continues
	Support/training sessions developed for physicians and/or clergy begin
	Trainings focused on trauma and suicide begin

4. Programs

Program Title	**Proposed # of individuals** or families through PEI expansion **to be served through June 2011** by type		**# of months in operation thru June 2011**
	Prevention	**Early Intervention**	
Program: Community Well-Being	Individuals: 260 Families:	Individuals: 20 Families:	# of months: 15
Program: Mental Health First Aid	Individuals: 325 Families:	Individuals: 100 Families:	# of months: 15
Total Project Estimate of **Unduplicated Count** of Individuals to be Served	**560**	**120**	

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

5a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

These linkages will happen in at least two ways. First, the Community Wellbeing Specialists and the Mental Health First Aid Trainer/Facilitators will meet regularly with TCMHC clinical staff and the CSS community navigators to share resources and referrals, and to develop protocols for connecting traditional mental health services to these project efforts where appropriate. Second, the CSS community navigators will meet with the Mental Health First Aid instructors to develop part of the regular 12-hour first aid training that will focus on how to connect with the Navigators or other emergency staff in the case of a mental health crisis.

5b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

These linkages will happen in myriad ways. First, the Community Wellbeing Program will support communities in promoting the mental and emotional wellbeing of their members using community assets and resources, including community-based organizations and other community support structures.

Second, many Mental Health First Aiders will be people who are staff or volunteers in non-traditional mental health community agencies—e.g., domestic violence prevention programs, substance abuse prevention programs, soup kitchens, homeless shelters. Moreover the First Aiders will be trained on how to connect people to a variety of community supports and resources, and will have access to the expertise of the CSS Community Navigators.

5c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

The Community Wellbeing Program will leverage myriad resources to support the efforts of communities to promote the wellbeing of their members. The Community Wellbeing Specialists and Community Data Specialist, along with consultants when needed, will provide on-going support to the multiple community efforts.

The Mental Health First Aid Trainer/Facilitators will organize periodic support for the scores of trained First Aiders. The TCMHC PEI coordinator, together with support from other staff and consultants, will also provide the needed coordination and support to sustain the PEI plan.

In addition, the budget also includes funds to support PEI summits, learning circles, a website, and other structures to facilitate cross-community learning and support to strengthen the communities' efforts to promote the wellbeing of their members.

6. Collaboration and System Enhancements

6a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

Communities who participate in the Community Wellbeing Program will engage myriad community-based organizations in support of their efforts to promote the emotional and mental wellbeing of their members. We expect schools to have many of their teachers and staff trained as mental health First Aiders (see Project 5 below), along with the staff of health clinics and many other community organizations and providers.

The two TCMHC Mental Health First Aid Trainer/Facilitators will work to establish close working relationships with primary health care physicians and clergy, and organize the support they need to become more effective partners in the mental health system of care across the tri-city area. Myriad studies indicate that members of many unserved and under-served populations seek out help from primary care physicians and clergy members rather than seeking out help from mental health clinicians.[2] Indeed primary care providers issue most prescriptions for psychotropic medications (67%) and antidepressants (80%).[3]

6b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

Primary care: Again, communities who participate in the Community Wellbeing Program will engage myriad community-based organizations in support of their efforts to promote the mental and emotional wellbeing of their members. We expect many staff members of health clinics, along with many other community organizations and providers, to be trained as Mental Health First Aiders. The two TCMHC Mental Health First Aid Trainer/Facilitators will work to establish close working relationships with primary health care physicians, and organize the support they need to become more effective partners in the mental health system of care across the tri-city area.

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[2] See, e.g., Busko, Marlene. "Asian Americans' Reluctance to Seek or Use Mental Health Services Explored," Medscape Medical News, August 31, 2007, www.medscape.com/viewarticle/562290; "Critical Disparities in Latino Mental Health: Transforming Research into Action," National Council of La Raza Institute for Hispanic Health, 2005, pp. 6-7; Gone, Joseph P., "Mental Health Services for Native Americans in the 21st Century United States," Professional Psychology: Research and Practice, 2004, Vol. 35, No. 1, pp. 10–18; "Cultural Beliefs Affect New Immigrants' Use of Mental Health Services," September 6, 2007, pp. 1-2, http://www.medindia.net/news/Cultural-Beliefs-Affect-New-Immigrants-Use-of-Mental-Health-Services-25984-1.htm

[3] See, e.g., Chapa, T., "Mental Health Services in Primary Care Settings for Racial and Ethnic Minority Populations," Draft Issue Brief, Office of Minority Health, September 2004; Snowden, L., "Bias in Mental Health Assessment and Intervention: Theory and Evidence," American Journal of Public Health, 93, 2003: pp. 239-243.

Mental health: Community Wellbeing Specialists and the Mental Health First Aid Trainer/Facilitators will meet regularly with TCMHC clinical staff and the CSS Community Navigators to share resources and referrals, and to develop protocols for connecting formal mental health services to these project efforts where appropriate. Second, the CSS community navigators will meet with the Mental Health First Aid instructors to develop part of the regular 12-hour first aid training that will be focused on how to connect with the Navigators or other emergency staff in the case of a mental health crisis.

6c. Describe how resources will be leveraged and sustained.

The heart of this project is to build capacity across communities throughout the tri-city area that, once developed, will continue to be present regardless of ongoing funding. Many of the resources identified and engaged by participating communities in the Community Wellbeing Program will be within the community already, and therefore not dependent on PEI funding. Moreover, within the Mental Health First Aid Program, once the Instructors and the First Aiders are trained, that knowledge and capacity cannot be taken away from communities, regardless of what happens to MHSA or other funding in subsequent fiscal years.

7. Intended Outcomes

7a. Describe intended system and program outcomes.

Community Wellbeing Program

In the first phase of the Community Wellbeing Program, TCMHC staff and consultants will engage in discussions with community leaders across the three cities, focusing particularly on unserved and under-served communities, to assess their readiness and capacity to engage in the Community Wellbeing Program. Ultimately a first cohort of communities, currently estimated at four, will be chosen to participate in the first year. (We will continue to add communities in subsequent years of the project.)

Leaders from these communities will receive leadership development and facilitation support to engage in sustained, community-driven efforts, integrating Asset Based Community Development and Results-based Accountability, to promote the mental and emotional wellbeing of community members. Through this process, each community will:

- Develop broad agreement about conditions of mental and emotional wellbeing that each community wants to achieve for its members (results);
- Develop broad agreement about the measures the community will track to assess progress toward these results (community indicators);
- Develop a plan for what community members will do to promote these conditions of wellbeing, including leveraging existing community resources, pursuing new community-based strategies, and other efforts;

- Report progress on their community-defined results of mental and emotional wellbeing over time; and
- Participate in learning structures to share and receive lessons learned and support with other participating communities.

Over time, each community will be able to document outcomes of mental and emotional wellbeing for their members who participate in and benefit from the various initiatives undertaken by the community. While each community will ultimately decide on what indicators they will track to assess the effectiveness of their efforts, we anticipate that these indicators will include self-reports of wellbeing, and decreased incidences of behaviors that indicate mental and emotional distress.

Please see Form 7, a Local Evaluation of a PEI Project, for a more detailed discussion of outcomes for this program.

Mental Health First Aid Program

Through the Mental Health First Aid Program we will train two cohorts of 25 instructors each (50 total; 25 by the end of Year 1), and more than 1,000 First Aiders. Over time, we expect these instructors and First Aiders to report and demonstrate:

- Greater awareness about mental health issues particular to their community;
- Increased confidence about responding appropriately to individuals who are experiencing mental health issues;
- Increased awareness and ability to connect people in mental distress to their natural communities of support, and to other needed community resources; and
- Diminished stigma and fear toward people who struggle with mental and emotional health issues in their communities.

As trained First Aiders begin to be available in their communities, we expect them to offer mental health first aid and support to perhaps thousands of people over time. For the people who *receive* mental health first aid, we anticipate that these individuals and families will report:

- Positive experiences with the First Aiders;
- Progress in responding to and resolving the immediate experience of mental and emotional distress;
- Increased access to supports that can help them maintain their mental and emotional wellbeing going forward (including the supports described in Projects 2-5 below); and
- Increased confidence that they will be able to maintain their mental and emotional wellbeing going forward.

At the program/system level, we expect that the presence of the more than 1,000 First Aiders will have a positive impact on stigma and discrimination experienced by people who struggle with issues of mental and emotional distress, including those people who

suffer from mental illness. Please see Form 7, a Local Evaluation of a PEI Project, for a more detailed discussion of outcomes for this program.

7b. Describe other proposed methods to measure success.

We will use simple feedback forms to assess the First Aiders' satisfaction with the training, as well as their mastery of particular content. We will use similar feedback forms to assess the effectiveness of the community initiatives. Finally, we will explore opportunities to engage undergraduate and graduate research students from one or more of the local colleges to document the scope and impact of this effort.

7c. What will be different as a result of the PEI project and how will you know?

To us, the outcomes outlined in 7a are very exciting, and hopeful. For the Community Wellbeing Program, communities across the three cities will commit—publicly—to improving outcomes of mental and emotional well-being for their members. They will develop plans that focus on community-driven strategies to improve these outcomes of well-being, and will track their progress over time. They will have multiple opportunities to share their learning and progress with other communities, and to get support to address challenges they are encountering. Over time, we will have community-defined data that we fully expect will document improved measures of wellbeing across multiple communities. Please see Form 7, a Local Evaluation of a PEI Project.

For the Mental Health First Aid Program, we expect that trained First Aiders will come to the aid of hundreds of people annually who may be experiencing mental or emotional distress, and will help connect these individuals to natural communities of support, peer support groups if appropriate (see the next two projects), and other community resources (including the supports detailed in projects 4 and 5). We will create a simple system to invite First Aiders to report on their experience, and will follow-up with people who have received first aid to assess their experience and whether they were helped. Please see Form 7, a Local Evaluation of a PEI Project.

8. Coordination with Other MHSA Components

8a. Describe coordination with CSS, if applicable.

The Community Wellbeing Specialists and the Mental Health First Aid Trainer/Facilitators will meet regularly with the CSS Community Navigators to insure effective communication and coordination of referrals. Many of the trained First Aiders will likely make referrals to programs available through the CSS Wellness Center.

8b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

TCMHC has planned uses for the *PEI training and technical assistance funds*, but has not yet assessed how it will use its Workforce Education and Training funds to support the PEI plan.

8c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

TCMHC has not yet assessed how it will use its Capital Facilities and Technology funds to support the PEI plan.

PEI Revenue and Expenditure Budget Worksheet

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

County Name: **Tri-City** Date: March 10, 2010

PEI Project Name: **Community Capacity-Building Project**

Provider Name (if known): Tri-City Mental Health System; Others TBD

Intended Provider Category: County agency; others TBD

Proposed Total Number of Individuals to be served:	FY 09-10: 0	FY 10-11: 680
Total # of Individuals currently being served:	FY 09-10: 0	FY 10-11: 0
Total # of Individuals to be served through PEI expansion:	FY 09-10: 0	FY 10-11: 680
Months of operation:	FY 09-10: 3	FY 10-11: 12

		Total PEI Project/Program Budget		
Proposed Expenses and Revenues		**FY 09-10**	**FY 10-11**	**Total**
A. Expenses				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
(1) Community Wellbeing Specialists	2.0 FTE	7,700	92,400	100,100
(2) Community Data Specialist	1.0 FTE	3,846	46,154	50,000
(3) Mental Health First Aid Trainer/Facilitators	2.0 FTE	25,000	100,000	125,000
(4) Community Capacity-Building Coordinator	1.0 FTE	9,625	38,500	48,125
b. Benefits and taxes @ 30%		13,851	83,116	96,967
c. **Total personnel expenses**		**60,022**	**360,170**	**420,192**
2. Operating expenditures				
a. Facility costs		1,920	38,400	40,320
b. Other operating expenses		15,429	283,792	299,221
c. **Total operating expenses**		**17,349**	**322,192**	**339,541**
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
a. Community grants		0	200,000	200,000
b. Consultant for Community Wellbeing Program		2,500	47,500	50,000
c. **Total Subcontracts/Professional Services**		**2,500**	**247,500**	**250,000**
4. Total proposed PEI project budget		$79,871	$929,862	$1,009,733
B. Revenues (list/itemize by fund source)				
1. Total revenue (other than PEI)		0	0	0
2. **Total Funding Requested for PEI Project**		**$79,871**	**$929,862**	**$1,009,733**
3. **Total In-Kind Contributions**		0	**$36,000**	**$36,000**

BUDGET NARRATIVE

County Name: **Tri-City** Date: March 10, 2010
PEI Project Name: **Community Capacity-Building**

Note: Budgets for each project show a three-month period for FY 2009-10 and a twelve-month period for FY 2010-11. These budgets include ongoing program costs as well as non-recurring costs needed to establish and implement the programs.

Brief Program Description
The Community Capacity-Building Project will strengthen the capacity of communities across the three cities, including unserved and under-served communities, to promote the mental and emotional wellbeing of their members. The project will also strengthen communities' ability to intervene quickly and effectively to offer support when someone is experiencing mental and emotional distress.

Budget Year 2009-10

The costs included in the 2009-10 budget cover the initial three-month period of the project.

A. Expenditures

1. Personnel Expenditures—$60,022
    a) Salaries of $46,171 were determined based on Tri-City's job classifications and compensation ranges.
    Positions include:
        - Community Well Being Specialists—2.0 FTE
        - Community Data Specialist—1.0 FTE
        - Mental Health First Aid Trainers and Facilitators—2.0 FTE
        - Community Capacity-Building Coordinator—1.0 FTE
    b) Benefits of $13,851 were based on Tri-City's average benefit rate of 30% and include all payroll taxes, retirement costs, health insurance and worker's compensation insurance.

2. Operating Expenditures—$17,349
    a) Facility costs of $1,920 include a one month allocation of rental and utilities costs expected to be incurred during the first three months of implementation.
    b) Other operating expenses of $15,429 include $3,850 for office supplies, training costs and on-going learning support costs expected to be incurred over the initial three-month period of the project. In addition, operating costs include "one-time" costs of $5,000 for MHFA training and an operating reserve of $6,579 representing 10% (ten percent) of on-going project costs.

3. Subcontracts/Professional Services—$2,500
    a) Community Grants—It is anticipated that these grants will be made to participating communities beginning in fiscal year 2010-11.
    b) Consultant fees represent the costs to be incurred for design, development and initial implementation of community training programs. It is expected that this process will begin during the last month of 2009-10, and therefore, only $2,500 has been budgeted in this fiscal period.

4. Total Proposed PEI Project Budget—$79,871

B. **Revenues**
1. Total revenue (other than PEI)—None
2. Total Funding Requested for PEI Project—$79,871
3. Total In-Kind Contributions—None

Budget Year 2010-11

The costs in the 2010-11 budget cover the first full year of the project.

A. Expenditures

1. Personnel Expenditures—$360,170
    a) Salaries of $277,054 were determined based on Tri-City's job classifications and compensation ranges.
    Positions include:
        - Community Well Being Specialists—2.0 FTE
        - Community Data Specialist—1.0 FTE
        - Mental Health First Aid Trainers and Facilitators—2.0 FTE
        - Community Capacity-Building Coordinator—1.0 FTE
    b) Benefits of $83,116 were based on Tri-City's average benefit rate of 30% and include all payroll taxes, retirement costs, health insurance and worker's compensation insurance.

2. Operating Expenditures—$322,192
    a) Facility costs of $38,400 include rental, utility and telephone costs.
    b) Other operating expenses of $283,792 include $80,850 for office supplies, training costs and on-going learning support costs expected to be incurred the first full year of the project. In addition, operating costs include "one-time" costs of $135,000 for MHFA training and Community Web-Site development and training. In addition, operating expenditures include an operating reserve of $67,942 representing 10% (ten percent) of the budgeted on-going project costs.

3. Subcontracts/Professional Services—$247,500
    a) Community Grants of $200,000 will be provided to community organizations to support the Community Wellbeing Program.
    b) Consultant fees of $47,500 represent "one-time" costs to be incurred for design, development and initial implementation of community training programs.

4. Total Proposed PEI Project Budget—$929,862

B. Revenues

1. Total revenue (other than PEI)—None
2. **Total Funding Requested for PEI Project—$929,862**
3. Total In-Kind Contributions—$36,600
   The in-kind contributions represent community contributions for meeting space and outreach efforts.

PEI PROJECT 02:
OLDER ADULT WELLBEING

Forms 3 and 4

PEI PROJECT SUMMARY

County: Tri-City
PEI Project Name: Older Adult Wellbeing **Date:** March 10, 2010

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition Age Youth	Adults	Older Adults
Select as many as apply to this PEI Project				
1. Disparities in Access to Mental Health Services				●
2. Psycho-Social Impact of Trauma				
3. (Prevention and Early Intervention for) At-Risk Children, Youth, and Young Adults				
4. Stigma and Discrimination				
5. Suicide Risk				●

2. PEI Priority Population(s)	Age Group			
	Children and Youth	Transition Age Youth	Adults	Older Adults
2a. Select as many as apply to this PEI Project				
1. Trauma Exposed Individuals				
2. Individuals Experiencing Onset of Serious Psychiatric Illness				●
3. Children and Youth in Stressed Families				
4. Children and Youth at Risk for School Failure				
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement				
6. Underserved Cultural Populations				●

2b. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

As noted in the Community Capacity-Building project description above, TCMHC staff and consultants engaged almost 3,000 community members in the PEI community

planning effort between June and December 2009, using four inter-related processes: focus groups, surveys, staff presentations, and stakeholder deliberations. The data that emerged from these multiple conversations and engagement efforts revealed remarkable convergence among community members and leaders across the tri-city area on a range of questions, including the question of priority populations.

For the on-line survey, we asked respondents to identify their top 3 priority populations. Of the 635 survey respondents:

- 19.29% chose individuals experiencing onset of serious psychiatric illness;
- 22.88% chose children and youth in stressed families;
- 17.05% chose trauma-exposed individuals;
- 13.59% chose children and youth at risk of or experiencing juvenile justice involvement;
- 14.23% chose children and youth at risk for school failure; and
- 12.95% chose underserved cultural populations.

When the delegates went through their own exercise of prioritizing the top three populations, their percentages differed slightly from the online survey respondents. Specifically:

- 29.90% of delegates chose individuals experiencing the onset of serious psychiatric illness;
- 23.04% of delegates chose children and youth in stressed families;
- 20.59% chose trauma-exposed individuals;
- 9.80% chose children and youth at risk of or experiencing juvenile justice involvement;
- 8.83% chose children and youth at risk for school failure; and
- 7.84% chose underserved cultural populations.

Delegates also noted that the imperative to serve underserved cultural populations was a priority for all other priority populations.

For this project, delegates chose to focus on older adults, including older adults from underserved cultural populations and/or at risk of serious psychiatric illness. The response to question 3a below further delineates the rationale for the focus on this age group.

3. PEI Project Description

3a. 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.

This project focuses on older adults, and in particular, the disparities in access to mental health services experienced by older adults, as well as the high risk of suicide for this

age group. During the planning process for the Community Services and Supports Plan (CSS), delegates documented a large gap in mental health services for older adults. Older adults 60 years and older comprise almost 16% of the total population in the tri-city area.

TOTAL POPULATION BY AGE GROUP					
City: / Age group:	La Verne	Claremont	Pomona	Tri-City area	% by age
0-15	7,524	6,191	46,910	60,625	26.42%
16-25	4,734	4,854	21,884	31,472	13.71%
26-59	16,124	17,341	68,084	101,549	44.25%
60+	7,232	8,175	20,420	35,827	15.61%
Totals	**35,614**	**36,561**	**157,298**	**229,473**	**100.00%**
Source: United Way 2007 Zip Code Data Book San Gabriel Valley + extrapolation					

While gaps in services are high for all age groups, the gap is particularly high for older adults. Our data indicated that over 90% of older adults living below 200% of the federal poverty threshold who suffer from severe and persistent mental illness are receiving *no* mental health services. We sought to respond to this gap in services through our CSS plan with Full Service Partnerships and Field-Capable Services targeted for older adults. When work began on the PEI plan, this gap in services for older adults was very much in delegates' awareness. Cognizant of the focus of the PEI plan on *prevention and early intervention supports* rather than treatment, delegates sought to create PEI supports appropriate for this age group.

Data from the focus groups reinforced the need for PEI supports for older adults, and was corroborated by subsequent research. Research indicates that individuals over age 75 have the highest suicide rate of any age group.[4] We repeatedly heard from advocates and seniors themselves about the reluctance among older adults to seek out formal mental health services, and about how much more comfortable seniors are connecting with peers, and their primary health care physicians.[5, 6] Through this project, we will train volunteer older adult peer counselors to provide 1-1 counseling and peer

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[4] Bartels, Stephen J. and Michael A. Smyer, "Mental Disorders of Aging: An Emerging Public Health Crisis." Generations, Volume XXVI, Number 1, Spring 2002, p.1.

[5] For research corroborating this perspective, see, e,g., "Mental Health Needs of Older Adults and Primary Care: Opportunity for Interdisciplinary Geriatric Team Practice," *Clinical Psychology: Science and Practice*, Volume 10, Issue 1, May 11, 2006, pp. 85-101. The abstract for this article states in part: "Elders shun mental health services, instead turning to their personal physicians when troubled." www3.interscience.wiley.com/journal/ 118891543/abstract?CRETRY=1&SRETRY=0

[6] See, e.g., "Forum on Self-Advocacy Among Older Adults with Mental Health Needs," US Department of Health and Human Services, Final Report, August 17, 1998, p. 4. "The top three priorities were: [e]ducating the public in order to debunk myths about older adults with mental health needs; [e]ducating older adult mental health consumers about how they can help both themselves and their peers; and [e[ncouraging peer support groups with mental health needs."

support groups for older adults who are struggling with issues of mental and emotional wellbeing. A number of research studies document the effectiveness of peer support groups and counseling in improving mental health outcomes for older adults affected by a range of mental and emotional challenges.[7] We will also train Mental Health First Aiders in community centers, assisted living centers, and other settings frequented by older adults in the tri-city area.

3b. 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.

The Older Adult Wellbeing Project will engage partners in communities across the three cities, including unserved and under-served ethnic and other communities, to identify older adults who could benefit from the programs under this project. These partners will include health clinics and other primary care providers, faith-based organizations, community organizations, community businesses, and other non-traditional partners.

3c. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

The Older Adult Wellbeing Project includes two programs: the Peer Support Program and the Mental Health First Aid Program. The Peer Support Program will provide peer counseling and peer support groups for older adults, including older adults from unserved and under-served communities. Potential recipients of these supports will be identified by, among others:

- Community leaders from unserved and under-served communities (e.g., Native American communities, Vietnamese and other Asian and Pacific Islander communities, Latino communities) participating in the Community Wellbeing Program (detailed under the Community Capacity-Building Project above);
- Mental Health First Aiders trained under the Mental Health First Aid Program (see below) who will be located in non-traditional mental health settings across the three cities, particularly in settings frequented by older adults;
- CSS Community Navigators;
- TCMHC staff funded through the CSS Field Capable Services for Older Adults program; and
- TCMHC staff funded through the CSS Wellness Center program, particularly staff members providing support and programming for older adults.

[7] See, e.g., "Community Integration for Older Adults with Mental Illnesses: Overcoming Barriers and Seizing Opportunities," US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2005; Schneider, R.L. and N.P. Kropf. "Gerontological Social Work, Knowledge Service Settings, and Special Populations." Chicago:Nelson-Hall, 1992; and Lieberman, M.A. and L. Videka-Sherman, "The Impact of Self-Help Groups on the Mental Health of Widows and Widowers." American Journal of Orthopsychiatry, 56(3), 1986, pp. 435-439.

The Mental Health First Aid program will provide training and support to older adults, and to people who work in organizations that serve older adults, particularly older adults in unserved and under-served communities and older adults at risk of mental and emotional distress.

3d. Highlights of new or expanded programs
3e. Actions to be performed to carry out the PEI project, including frequency or duration of activities.
3f. Key milestones and anticipated timeline for each milestone

The Peer Support Program

Highlights: Building on the success of the acclaimed senior peer counseling model from the Center for Healthy Aging in Santa Monica, California, the Peer Support Program will recruit and train volunteer peer counselors for older adults. These volunteers will be trained to assess the mental health and well-being of older adults, to provide 1-1 peer counseling, and to lead age- and issue-based peer support groups. Groups organized under this program will focus on providing support *and* creating opportunities for members to engage in projects that serve their communities and other wellness activities.

Communities who have implemented the peer counseling program have implemented ratios of counselors to group members as low as 1-4 (Contra Costa county) and as high as 1-75 (Marin County). Our target is to recruit up to 30 volunteers for older adults (15 in the first 15 months), and for each volunteer to support up to 25 peers each (10 each in the first 15 months) through a combination of groups and 1-1 counseling. We expect that supports offered through this program will include both targeted prevention and early intervention supports.

Volunteer counselors (who we expect will also be trained as Mental Health First Aiders) will receive part-time supervision from TCMHC clinical staff, and will meet regularly to receive support and share lessons learned. They will be recruited from communities across the three cities, including unserved and under-served communities; some will be fluent in languages other than English, and will conduct groups and 1-1 counseling sessions in these languages.

As noted above, potential recipients of these peer supports will be identified by, among others:

- Community leaders from unserved and under-served communities (e.g., Native American communities, Vietnamese and other Asian and Pacific Islander communities, Latino communities) participating in the Community Wellbeing Program (detailed under the Community Capacity-Building Project above);
- Mental Health First Aiders trained under the Mental Health First Aid Program (see below) who will be located in non-traditional mental health settings across the three cities;

- CSS Community Navigators;
- TCMHC staff funded through the CSS Field Capable Services for Older Adults program; and
- TCMHC staff funded through the CSS Wellness Center program, particularly staff members providing support and programming for older adults.

Actions and activities: TCMHC staff members will recruit volunteer counselors for older adults who will then receive up to 50 hours of training. The Community Support Coordinator (who oversees the work of the Community Navigators, Community Wellbeing Specialists, and the Mental Health First Aid Trainer/Facilitators) will help coordinate the process of identifying community members to participate in the peer support structures. TCMHC clinical staff members will regularly convene the volunteer counselors for supervision, support, and sharing lessons learned.

Milestones

Apr-Jun 2010	Begin recruiting volunteer counselors (Target: 15 older adult counselors in the first year)
	Identify and hire clinical staff to train and supervise volunteer counselors
	Begin publicizing program through Community Navigators, etc.
Jul-Sept 2010	Training provided to first cohort of volunteer counselors
	Publicity and outreach continue
	Supervision and support begin
Oct-Dec 2010	First groups formed
	Publicity and outreach continue for program participants
	Supervision and support continue for volunteer counselors
Jan-Jun 2011	Training of second cohort of counselors
	Groups continue to form; publicity and outreach continue
	Supervision and support of counselors continue

Mental Health First Aid Program

Highlights: See description under Community Capacity Building Project.

Actions and activities: See description under Community Capacity Building Project. TCMHC staff will recruit several older adults, and people who work with older adults, to be among the first cohort of 25 instructors to take the five-day instruction course. These instructors will train a number of older adults as Mental Health First Aiders.

Milestones

See description under Community Capacity Building Project.

4. Programs

Program Title	**Proposed number of individuals** or families through PEI expansion **to be served through June 2011** by type		**# of months in operation thru June 2011**
	Prevention	**Early Intervention**	
Program: Peer Support Program	Individuals: 90 Families:	Individuals: 75 Families:	# of months: 15
Program: Mental Health First Aid [8]	Individuals: 65 Families:	Individuals: 20 Families:	# of months: 15
Total Project Estimate of **Unduplicated Count** of Individuals to be Served	**150**	**85**	

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

5a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

These linkages will happen in several ways. First, the supervisors for the volunteer peer counselors will be clinical staff, and so will be able to make immediate and direct connections to available supports for longer-term treatment. Second, the clinical supervisors and the volunteer counselors will meet regularly with the Community Navigators, Community Wellbeing Specialists and the Mental Health First Aid Trainer/Facilitators to share resources and referrals, and to develop protocols for connecting traditional mental health services to these project efforts where appropriate. Finally, the CSS community navigators will meet with the Mental Health First Aid instructors to develop part of the regular 12-hour first aid training that will focus on how to connect with the Navigators or other emergency staff in the case of a mental health crisis, insuring that the older adult First Aiders will have access to this information.

5b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

[8] The numbers listed under the Mental Health First Aid Program are a subset of the numbers listed under the Mental Health First Program in the Community Capacity-Building Project above.

These linkages will happen in myriad ways. First, as noted above, this will be an essential element of the training for Mental Health First Aiders, including the First Aiders who are older adults. Second, the clinical supervisors and the volunteer counselors will meet regularly with the Community Navigators and Community Wellbeing Specialists to learn about non-traditional mental health support services. Third, we expect that many participants in the older adult peer support groups will be referred by organizations and community groups from unserved and under-served communities, and therefore will themselves know about community-based resources that they will share with their peer counselors and other group members.

5c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

The Older Adult Wellbeing Project will leverage myriad community resources to support the programs within this project, including volunteers who work as peer counselors and Mental Health First Aiders. The volunteer peer counselors and Mental Health First Aiders will leverage resources and other supports from community partners based on the needs and interests of the older adults they engage.

Clinical supervisors will support the volunteer counselors. In addition, the TCMHC PEI coordinator will provide the needed coordination and support to sustain this part of the PEI plan.

6. Collaboration and System Enhancements

6a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

Volunteer counselors for the Peer Support Program, and the Mental Health First Aiders who engage older adults, will leverage resources and other support from community partners based on the needs and interests of older adults they engage.

6b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

We expect many staff members of health clinics, along with many other community organizations and providers, to be trained as Mental Health First Aiders. The two TCMHC Mental Health First Aid Trainer/Facilitators will work to establish close working relationships with primary health care physicians, and organize the support they need to become more effective partners in the mental health system of care across the tri-city area. These relationships will facilitate reciprocal referrals between the programs in this

project and the local community-based mental health and primary care system. Moreover, the clinical supervisors for the volunteer counselors will meet regularly with the Community Navigators, further facilitating reciprocal referrals between the programs in this project and the local community-based mental health and primary care system.

6c. Describe how resources will be leveraged and sustained.

The Older Adult Wellbeing Project will leverage myriad community resources to support the programs within this project. Indeed, we are recommending this project specifically because its primary focus is on developing volunteer counselors and leveraging existing community resources on behalf of project participants.

7. Intended Outcomes

7a. Describe intended system and program outcomes.

Peer Support Program

- Up to 15 volunteer counselors trained to provide 1-1 peer counseling and lead peer support groups older adults.
- When fully operational (at the end of two years), over 600 older adults will participate in peer support structures, and:
    - Report positive experiences in the peer support structures;
    - Report progress in recovering from the episode or conditions that inspired them to seek peer support; and
    - Demonstrate sustained wellness behaviors.

Mental Health First Aid Program

Through the Mental Health First Aid Program[9] we will train 10 instructors for older adults (5 by the end of Year 1), and more than 80 First Aiders for older adults (40 by the end of year one). Over time, we expect these instructors and First Aiders to report and demonstrate:

- Greater awareness about mental health issues particular to their community;
- Increased confidence about responding appropriately to individuals who are experiencing mental health issues;
- Increased awareness and ability to connect people in mental distress to their natural communities of support, and to other needed community resources; and
- Diminished stigma and fear toward people who struggle with mental and emotional health issues in their communities.

[9] These outcomes are a subset of the outcomes listed under the Mental Health First Aid Program in the Community Capacity-Building Project.

As trained First Aiders begin to be available in their communities, we expect them to offer mental health first aid and support to hundreds of older adults over time. For the people who *receive* mental health first aid, we anticipate that these individuals and families will report:

- Positive experiences with the First Aiders;
- Progress in responding to and resolving the immediate experience of mental and emotional distress;
- Increased access to supports that can help them maintain their mental and emotional wellbeing going forward (including the supports described in Projects 2-5); and
- Increased confidence that they will be able to maintain their mental and emotional wellbeing going forward.

7b. Describe other proposed methods to measure success.

Beyond the measures indicated above, we will use simple feedback forms to assess participant satisfaction with the peer counselor training, the peer support groups, and the Mental Health First Aiders. We will also explore opportunities to engage undergraduate or graduate research students from one or more of the local colleges to document the scope and impact of this effort.

7c. What will be different as a result of the PEI project and how will you know?

Just as with the Community Capacity-Building Project, the outcomes outlined in 7a above are exciting and hopeful to us. For the Peer Support program, we will regularly invite the people participating in the peer support structures to offer both written and oral feedback about their experiences in the support structures, and the difference they believe the support has made in their lives.

For the Mental Health First Aid Program, we expect that trained First Aiders will come to the aid of hundreds of older adults who may be experiencing mental or emotional distress, and will help connect these individuals to natural communities of support, peer support groups if appropriate, and other community resources. We will create a simple system to invite First Aiders to report on their experience, and will follow-up with people who have received first aid to assess their experience and whether they were helped.

8. Coordination with Other MHSA Components

8a. Describe coordination with CSS, if applicable.

The clinical supervisors for the peer support program and volunteer counselors will meet regularly with the CSS Community Navigators to insure effective communication and coordination of referrals. The clinical supervisors for the peer support program will

also meet as appropriate with Full Service Partnership staff members, and staff members who are providing CSS field-capable services for older adults.

8b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

TCMHC has planned uses for the *PEI training and technical assistance funds*, but has not yet assessed how it will use its Workforce Education and Training funds to support the PEI plan.

8c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

TCMHC has not yet assessed how it will use its Capital Facilities and Technology funds to support the PEI plan.

PEI Revenue and Expenditure Budget Worksheet

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

County Name: **Tri-City** Date: March 10, 2010

PEI Project Name: **Older Adult Wellbeing Project**

Provider Name (if known): Tri-City Mental Health System; Others TBD

Intended Provider Category: County agency; others TBD

Proposed Total Number of Individuals to be served:	FY 09-10: 0	FY 10-11: 165
Total # of Individuals currently being served:	FY 09-10: 0	FY 10-11: 0
Total # of Individuals to be served through PEI expansion:	FY 09-10: 0	FY 10-11: 165 [10]
Months of operation:	FY 09-10: 3	FY 10-11: 12

		Total PEI Project/Program Budget		
Proposed Expenses and Revenues		**FY 09-10**	**FY 10-11**	**Total**
A. Expenses				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
(1) Clinical Supervisor(s) for peer counselors	.5 FTE	4,600	27,600	32,200
b. Benefits and taxes @ 30%		1,380	8,280	9,660
c. **Total personnel expenses**		**5,980**	**35,880**	**41,860**
2. Operating expenditures				
a. Facility costs		320	6,400	6,720
b. Other operating expenses		1,180	12,313	13,493
c. **Total operating expenses**		**1,500**	**18,713**	**20,213**
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
a.		0	0	0
b.		0	0	0
c. **Total Subcontracts/Professional Services**		**0**	**0**	**0**
4. Total proposed PEI project budget		**$7,480**	**$54,593**	**$62,073**
B. Revenues (list/itemize by fund source)				
1. Total revenue (other than PEI)		0	0	0
2. **Total Funding Requested for PEI Project**		**$7,480**	**$54,593**	**$62,073**
3. **Total In-Kind Contributions**		0	**$30,250**	**$30,250**

[10] The numbers listed to be served under this program are for the Peer Counselor Program only. The numbers for the Mental Health First Aid Program are listed under Project 01, the Community Capacity-Building Project.

BUDGET NARRATIVE

County Name: **Tri-City** Date: March 10, 2010
PEI Project Name: **Older Adult Wellbeing**

Note: Budgets for each project show a three-month period for FY 2009-10 and a twelve-month period for FY 2010-11. These budgets include ongoing program costs as well as "one-time" costs expected to be incurred to establish and implement the programs.

Brief Program Description
The Older Adult Wellbeing Project will create a peer counseling program for older adults, and train older adult Mental Health First Aiders to provide community-based support for older adults who may be experiencing mental and emotional distress, including the onset of mental illness.

Budget Year 2009-10

The costs in the 2009-10 budget cover the initial three-month period of the project.

A. Expenditures

1. Personnel Expenditures—$5,980
   a) Salaries of $4,600 were determined based on Tri-City's job classifications and compensation ranges and reflect the initial two months of salaries for the clinical supervisor(s).
      Positions include:
      - Clinical Supervisors for peer counselors—.5 FTE
   b) Benefits of $1,380 were based on Tri-City's average benefit rate of 30% and include all payroll taxes, retirement costs, health insurance and worker's compensation insurance.

2. Operating Expenditures—$1,500
   a) Facility costs of $320 include a one month allocation of rental and utilities costs expected to be incurred during the first three months of implementation.
   b) Other operating expenses of $1,180 include $500 for office supplies, training costs and on-going learning support costs expected to be incurred over the initial three-month period of the project. In addition, operating costs include an operating reserve of $680 representing 10% (ten percent) of on-going project costs.

3. Subcontracts/Professional Services—None

4. Total Proposed PEI Project Budget—$7,480

B. Revenues

1. Total Revenue (Other than PEI)—None
2. **Total Funding Requested for PEI Project—$7,480**
3. Total In-Kind Contributions—None

Budget Year 2010-11

The costs in the 2010-11 budget cover the first full year of the project.

A. Expenditures

1. Personnel Expenditures—$35,880
   a) Salaries of $27,600 were determined based on Tri-City's job classifications and compensation ranges. Positions include:
      - Clinical Supervisors for peer counselors—.5 FTE

   b) Benefits of $8,280 were based on Tri-City's average benefit rate of 30% and include all payroll taxes, retirement costs, health insurance and worker's compensation insurance.

2. Operating Expenditures—$18,713
   a) Facility costs of $6,400 include rental, utility and telephone costs.
   b) Other operating expenses of $12,313 include $7,350 for office supplies, training costs and on-going learning support costs expected to be incurred the first full year of the project. In addition, operating costs include an operating reserve of $4,963 representing 10% (ten percent) of the budgeted on-going project costs.

3. Subcontracts/Professional Services—None

4. Total Proposed PEI Project Budget—$54,593

B. Revenues

1. Total Revenue (Other than PEI)—None
2. **Total Funding Requested for PEI Project—$54,593**
3. Total In-Kind Contributions—$30,250
   The in-kind contributions represent community contributions for meeting space and volunteer time.

PEI PROJECT 03:
TRANSITION-AGED YOUNG ADULTS WELLBEING

Forms 3 and 4

PEI PROJECT SUMMARY

County: Tri-City
PEI Project Name: Transition-Aged Young Adults Wellbeing **Date:** March 10, 2010

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition Age Youth	Adults	Older Adults
Select as many as apply to this PEI Project				
1. Disparities in Access to Mental Health Services		●		
2. Psycho-Social Impact of Trauma				
3. (Prevention and Early Intervention for) At-Risk Children, Youth, and Young Adults		●		
4. Stigma and Discrimination				
5. Suicide Risk		●		

2. PEI Priority Population(s)	Age Group			
	Children and Youth	Transition Age Youth	Adults	Older Adults
2a. Select as many as apply to this PEI Project				
1. Trauma Exposed Individuals		●		
2. Individuals Experiencing Onset of Serious Psychiatric Illness		●		
3. Children and Youth in Stressed Families		●		
4. Children and Youth at Risk for School Failure				
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement				
6. Underserved Cultural Populations		●		

2b. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

As noted previously, the on-line survey data and the delegates' deliberations converged on three priority populations:

- Individuals experiencing onset of serious psychiatric illness;
- Children and youth in stressed families; and
- Trauma-exposed individuals.

Delegates also assumed that the imperative to serve underserved cultural populations was a priority for all other priority populations.

For this project, delegates chose to focus on older transition-aged youth (transition-aged young adults, or TAYA), including young adults from underserved cultural populations, young adults at risk of serious psychiatric illness, young adults exposed to trauma (e.g., gang violence), young adults in stressed families, and others. The response to question 3a below further delineates the rationale for the focus on this age group.

3. PEI Project Description

3a. 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 top three issues, identified both by the on-line survey data and the delegates in their deliberations, included:

- Prevention efforts and responses to early signs of mental health problems among at-risk populations 0-25;
- Disparities in access to early mental health services and interventions; and
- Suicide risk.

This project focuses on all three of these issues for transition-aged young adults (TAYA).

Transition-aged youth and young adults ages 16-25 comprise almost 14% of the total population in the tri-city area. Data gathered during our CSS planning suggested that, in the tri-city area, 71% of young people ages 16-25 who live below 200% of the federal poverty threshold and suffer from severe emotional disturbances or serious and persistent mental illness are receiving no mental health services. While not as high as the gaps in services for older adults, this is still a staggering figure, and one that is undoubtedly increasing as schools and colleges struggle with dramatic budget cuts. Moreover, suicide is a significant risk for this population.[11]

Our focus groups also taught us a great deal about this population. In reaching out to young adults who are LGBTQ, we ultimately had to train leaders from this community to

[11] According to National Institute of Mental Health data, in 2006, suicide was the third leading cause of death among young people ages 15-24. "Suicide in the US: Statistics and Prevention," 2009, www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml#children

conduct their own focus groups. Their leaders shared with us that members of this community do not readily trust outsiders, given their repeated experiences of rejection by employers, school officials, family members, and others.

This message was reinforced by the TAY delegates to the PEI planning process. These delegates are very enthusiastic about the PEI plan, but stressed the need to involve young adults as peer counselors and as Mental Health First Aiders. Research further corroborated the need for specific focus on young adults, who often are left out of efforts targeting high school students and younger children and youth, and who are often reluctant to participate in programs focused on adults of all ages. Given this data, we will train young adult volunteers as volunteer peer counselors to provide 1-1 counseling and peer support groups for transition aged youth who are struggling with issues of mental and emotional wellbeing, and as Mental Health First Aiders.

3b. 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.

The Transition-Aged Young Adult Wellbeing Project will engage partners in communities across the three cities, including unserved and under-served ethnic and other communities, to identify young adults who could benefit from the programs under this project. These partners will include health clinics and other primary care providers, faith-based organizations, community organizations and collaboratives, community businesses, and other non-traditional partners.

3c. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

The Transition-Aged Young Adult Wellbeing Project includes two programs: the Peer Support Program and the Mental Health First Aid Program. The Peer Support Program will provide peer counseling and peer support groups for transition-aged young adults, including young adults from unserved and under-served communities. Potential recipients of these supports will be identified by, among others:

- Community leaders from unserved and under-served communities (e.g., Native American communities, Vietnamese and other Asian and Pacific Islander communities, Latino communities) participating in the Community Wellbeing Program (detailed under the Community Capacity-Building Project above);
- Mental Health First Aiders trained under the Mental Health First Aid Program who will be located in non-traditional mental health settings across the three cities, particularly in settings frequented by TAYA;
- CSS Community Navigators; and
- TCMHC staff funded through the CSS Wellness Center program, particularly staff members providing support and programming for transition-aged youth.

3d. Highlights of new or expanded programs
3e. Actions to be performed to carry out the PEI project, including frequency or duration of activities.
3f. Key milestones and anticipated timeline for each milestone

The Peer Support Program

Highlights: See program description under Older Adult Wellbeing Project above.

The Peer Support Program will recruit and train transition-aged young adult volunteers as peer counselors for this age group. These volunteers will be trained to assess the mental health and well-being of transition-aged young adults, to provide 1-1 peer counseling, and to lead age- and issue-based peer support groups. Groups organized under this program will focus on providing support *and* creating opportunities for members to engage in projects that serve their communities and other wellness activities.

Communities who have implemented the peer counseling program have implemented ratios of counselors to group members as low as 1-4 (Contra Costa county) and as high as 1-75 (Marin County). Our target is to recruit up to 20 volunteers for transition-aged young adults (10 in the first 15 months), and for each volunteer to support up to 25 peers each (10 each in the first 15 months) through a combination of groups and 1-1 counseling. We expect that supports offered through this program will include both targeted prevention and early intervention supports.

Volunteer counselors (who we expect will also be trained as Mental Health First Aiders) will receive part-time supervision from TCMHC clinical staff, and will meet regularly to receive support and share lessons learned. They will be recruited from communities across the three cities, including unserved and under-served communities; some will be fluent in languages other than English, and will conduct groups and 1-1 counseling sessions in these languages.

As noted above, potential recipients of these peer supports will be identified by, among others:

- Community leaders from unserved and under-served communities (e.g., Native American communities, Vietnamese and other Asian and Pacific Islander communities, Latino communities) participating in the Community Wellbeing Program (detailed under the Community Capacity-Building Project above);
- Mental Health First Aiders trained under the Mental Health First Aid Program who will be located in non-traditional mental health settings across the three cities, particularly in settings frequented by TAYA;
- CSS Community Navigators; and
- TCMHC staff funded through the CSS Wellness Center program, particularly staff members providing support and programming for transition-aged youth.

Actions and activities: TCMHC staff members will recruit volunteer counselors for transition-aged young adults who will then receive up to 50 hours of training. The Community Support Coordinator (who oversees the work of the Community Navigators, Community Wellbeing Specialists, and the Mental Health First Aid Trainer/Facilitators) will help coordinate the process of identifying community members to participate in the peer support structures. TCMHC clinical staff members will regularly convene the volunteer counselors for supervision, support, and sharing lessons learned.

Milestones

Apr-Dec 2010	Identify and hire clinical staff to train and supervise volunteer counselors
	Refine the design of the Peer Support Program to serve transition-aged young adults
	Begin recruitment of peer counselors
Jan-Jun 2011	Train transition-aged young adult peer counselors
	Publicity and outreach for program participants
	Groups begin to form
	Supervision and support of counselors begin

Mental Health First Aid Program

Highlights: See description under Community Capacity Building Project.

Actions and activities: See description under Community Capacity Building Project. TCMHC staff will recruit several transition-aged young adults to be among the first cohort of 25 instructors to take the five-day instruction course. These instructors will train a number of people, including transition-aged young adults, as Mental Health First Aiders.

Milestones

See description under Community Capacity Building Project.

4. **Programs**

Program Title	**Proposed number of individuals** or families through PEI expansion **to be served through June 2011** by type		**# of months in operation thru June 2011**
	Prevention	**Early Intervention**	
Program: Peer Support Program	Individuals: 60 Families:	Individuals: 50 Families:	# of months: 15

Program: Mental Health First Aid [12]	Individuals: 104 Families:	Individuals: 32 Families:	# of months: 15
Total Project Estimate of **Unduplicated Count** of Individuals to be Served	**157**	**70**	

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

5a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

These linkages will happen in several ways. First, the supervisors for the volunteer peer counselors will be clinical staff, and so will be able to make immediate and direct connections to available supports for longer-term treatment. Second, the clinical supervisors and the volunteer counselors will meet regularly with the Community Navigators, Community Wellbeing Specialists and the Mental Health First Aid Trainer/Facilitators to share resources and referrals, and to develop protocols for connecting traditional mental health services to these project efforts where appropriate. Finally, the CSS community navigators will meet with the Mental Health First Aid instructors to develop part of the regular 12-hour first aid training that will focus on how to connect with the Navigators or other emergency staff in the case of a mental health crisis, insuring that the transition-aged young adult First Aiders will have access to this information.

5b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

These linkages will happen in myriad ways. First, as noted above, this will be an essential element of the training for Mental Health First Aiders, including the First Aiders who are transition-aged young adults. Second, the clinical supervisors and the volunteer counselors will meet regularly with the Community Navigators and Community Wellbeing Specialists to learn about non-traditional mental health support services. Third, we expect that many participants in the transition-aged young adult peer support groups will be referred by organizations and community groups from unserved and under-served communities, and therefore will themselves know about community-based resources that they will share with their peer counselors and other group members.

[12] The numbers listed under the Mental Health First Aid Program are a subset of the numbers listed under the Mental Health First Program in the Community Capacity-Building Project above.

5c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

The Transition-Aged Young Adults Wellbeing Project will leverage myriad community resources to support the programs within this project, including volunteers who work as peer counselors and Mental Health First Aiders. The peer counselors and Mental Health First Aiders will leverage resources and other supports from community partners based on the needs and interests of the transition-aged young adults they engage. Clinical supervisors will support the volunteer counselors. In addition, the TCMHC PEI coordinator will provide coordination and support to sustain this part of the PEI plan.

6. Collaboration and System Enhancements

6a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

Volunteer counselors for the Peer Support Program, and the Mental Health First Aiders who engage transition-aged young adults, will leverage resources and other support from community partners based on the needs and interests of TAYA they engage.

6b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

We expect many staff members of health clinics, along with many other community organizations and providers, will be trained as Mental Health First Aiders. The two TCMHC Mental Health First Aid Trainer/Facilitators will work to establish close working relationships with primary health care physicians, and organize the support they need to become more effective partners in the mental health system of care across the tri-city area. These relationships will facilitate reciprocal referrals between the programs in this project and the local community-based mental health and primary care system. Moreover, the clinical supervisors for the volunteer counselors will meet regularly with the Community Navigators, further facilitating reciprocal referrals between the programs in this project and the local community-based mental health and primary care system.

6c. Describe how resources will be leveraged and sustained.

The Transition-Aged Young Adults Wellbeing Project will leverage myriad community resources to support the programs within this project. Indeed, we are recommending this project specifically because its primary focus is on developing volunteer counselors, volunteer Mental Health First Aiders, and leveraging existing community resources on behalf of project participants.

7. Intended Outcomes

7a. Describe intended system and program outcomes.

Peer Support Program

- Up to 10 volunteer counselors trained to provide 1-1 peer counseling and lead peer support groups for transition-aged young adults.
- When fully operational (at the end of two years), over 250 transition-aged young adults will participate in peer support structures, and:
  - Report positive experiences in the peer support structures;
  - Report progress in recovering from the episode or conditions that inspired them to seek peer support; and
  - Demonstrate sustained wellness behaviors.

Mental Health First Aid Program

Through the Mental Health First Aid Program[13] we will train 16 instructors for transition-aged young adults (8 by the end of Year 1), and more than 120 First Aiders for transition-aged young adults. Over time, we expect these instructors and First Aiders to report and demonstrate:

- Greater awareness about mental health issues particular to their community;
- Increased confidence about responding appropriately to individuals who are experiencing mental health issues;
- Increased awareness and ability to connect people in mental distress to their natural communities of support, and to other needed community resources; and
- Diminished stigma and fear toward people who struggle with mental and emotional health issues in their communities.

As trained First Aiders begin to be available in their communities, we expect them to offer mental health first aid and support to hundreds of transition-aged young adults over time. For the people who *receive* mental health first aid, we anticipate that these individuals and families will report:

- Positive experiences with the First Aiders;
- Progress in responding to and resolving the immediate experience of mental and emotional distress;
- Increased access to supports that can help them maintain their mental and emotional wellbeing going forward (including the supports described in Projects 2-5); and
- Increased confidence that they will be able to maintain their mental and emotional wellbeing going forward.

[13] These outcomes are a subset of the outcomes listed under the Mental Health First Aid Program in the Community Capacity-Building Project.

7b. Describe other proposed methods to measure success.

Beyond the measures indicated above, we will use simple feedback forms to assess participant satisfaction with the peer counselor training, the peer support groups, and the Mental Health First Aiders. We will also explore opportunities to engage undergraduate or graduate research students from one or more of the local colleges to document the scope and impact of this effort.

7c. What will be different as a result of the PEI project and how will you know?

For the Peer Support program, we will regularly invite the people participating in the peer support structures to offer both written and oral feedback about their experiences in the support structures, and the difference they believe the support has made in their lives. For the Mental Health First Aid Program, we expect that trained First Aiders will come to the aid of hundreds of transition-aged young adults who may be experiencing mental or emotional distress, and will help connect these individuals to natural communities of support, peer support groups if appropriate, and other community resources. We will create a simple system to invite First Aiders to report on their experience, and will follow-up with people who have received first aid to assess their experience and whether they were helped.

8. Coordination with Other MHSA Components

8a. Describe coordination with CSS, if applicable.

The clinical supervisors for the peer support program and volunteer counselors will meet regularly with the CSS Community Navigators to insure effective communication and coordination of referrals. The clinical supervisors for the peer support program will also meet as appropriate with Full Service Partnership staff members.

8b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

TCMHC has planned uses for the *PEI training and technical assistance funds*, but has not yet assessed how it will use its Workforce Education and Training funds to support the PEI plan.

8c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

TCMHC has not yet assessed how it will use its Capital Facilities and Technology funds to support the PEI plan.

PEI Revenue and Expenditure Budget Worksheet

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

County Name: **Tri-City** Date: March 10, 2010

PEI Project Name: **Transition-Aged Young Adults**

Provider Name (if known): Tri-City Mental Health System; Others TBD

Intended Provider Category: County agency; others TBD

Proposed Total Number of Individuals to be served: FY 09-10: 0 FY 10-11: 110 [14]

Total # of Individuals currently being served: FY 09-10: 0 FY 10-11: 0

Total # of Individuals to be served through PEI expansion: FY 09-10: 0 FY 10-11: 110

Months of operation: FY 09-10: 3 FY 10-11: 12

		Total PEI Project/Program Budget		
Proposed Expenses and Revenues		**FY 09-10**	**FY 10-11**	**Total**
A. Expenses				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
(1) Clinical Supervisor(s) for peer counselors	.5 FTE	4,600	27,600	32,200
b. Benefits and taxes @ 30%		1,380	8,280	9,660
c. **Total personnel expenses**		**5,980**	**35,880**	**41,860**
2. Operating expenditures				
a. Facility costs		320	6,400	6,720
b. Other operating expenses		1,180	12,313	13,493
c. **Total operating expenses**		**1,500**	**18,713**	**20,213**
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
a.		0	0	0
b.		0	0	0
c. **Total Subcontracts/Professional Services**		**0**	**0**	**0**
4. Total proposed PEI project budget		**$7,480**	**$54,593**	**$62,073**
B. Revenues (list/itemize by fund source)				
1. Total revenue (other than PEI)		0	0	0
2. **Total Funding Requested for PEI Project**		**$7,480**	**$54,593**	**$62,073**
3. **Total In-Kind Contributions**		0	**$22,250**	**$22,250**

[14] The numbers listed to be served under this program are for the Peer Counselor Program only. The numbers for the Mental Health First Aid Program are listed under Project 01, the Community Capacity-Building Project.

BUDGET NARRATIVE

County Name: **Tri-City** Date: March 10, 2010
PEI Project Name: **Transition-Aged Young Adults Wellbeing**

Note: Budgets for each project show a three-month period for FY 2009-10 and a twelve-month period for FY 2010-11. These budgets include ongoing program costs as well as non-recurring costs needed to establish and implement the programs.

Brief Program Description
The Transition-Aged Young Adults Wellbeing Project will create a peer counseling program for transition-aged young adults (TAYA), and train transition-aged young adult Mental Health First Aiders to provide community-based support for TAYA who may be experiencing mental and emotional distress, including the onset of mental illness.

Budget Year 2009-10

The costs in the 2009-10 budget cover the initial three-month period of the project.

A. Expenditures

1. Personnel Expenditures—$5,980
   a) Salaries of $4,600 were determined based on Tri-City's job classifications and compensation ranges and reflect the initial two months of salaries for the clinical supervisor(s).
      Positions include:
      - Clinical Supervisors for peer counselors—.5 FTE

   b) Benefits of $1,380 were based on Tri-City's average benefit rate of 30% and include all payroll taxes, retirement costs, health insurance and worker's compensation insurance.

2. Operating Expenditures—$1,500
   a) Facility costs of $320 include a one-month allocation of rental and utilities costs expected to be incurred during the first three months of implementation.
   b) Other operating expenses of $1,180 include $500 for office supplies, training costs and on-going learning support costs expected to be incurred over the initial three-month period of the project. In addition, operating costs include an operating reserve of $680 representing 10% (ten percent) of on-going project costs.

3. Subcontracts/Professional Services—None

4. Total Proposed PEI Project Budget—$7,480

B. Revenues

1. Total Revenue (Other than PEI)—None
2. **Total Funding Requested for PEI Project—$7,480**
3. Total In-Kind Contributions—None

Budget Year 2010-11

The costs in the 2010-11 budget cover the first full year of the project.

A. Expenditures

1. Personnel Expenditures—$35,880
   a) Salaries of $27,600 were determined based on Tri-City's job classifications and compensation ranges. Positions include:
      - Clinical Supervisors for peer counselors—.5 FTE
   b) Benefits of $8,280 were based on Tri-City's average benefit rate of 30% and include all payroll taxes, retirement costs, health insurance and worker's compensation insurance.

2. Operating Expenditures—$18,713
   a) Facility costs of $6,400 include rental, utility and telephone costs.
   b) Other operating expenses of $12,313 include $7,350 for office supplies, training costs and on-going learning support costs expected to be incurred the first full year of the project. In addition, operating costs include an operating reserve of $4,963 representing 10% (ten percent) of the budgeted on-going project costs.

3. Subcontracts/Professional Services—None

4. Total Proposed PEI Project Budget—$54,593

B. Revenues

1. Total Revenue (Other than PEI)—None
2. **Total Funding Requested for PEI Project—$54,593**
3. Total In-Kind Contributions—$22,250
   The in-kind contributions represent community contributions for meeting space and volunteer time.

PEI PROJECT 04:
FAMILY WELLBEING

Forms 3 and 4

PEI PROJECT SUMMARY

County: Tri-City
PEI Project Name: Family Wellbeing **Date:** March 10, 2010

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition Age Youth	Adults	Older Adults
Select as many as apply to this PEI Project				
1. Disparities in Access to Mental Health Services		●	●	●
2. Psycho-Social Impact of Trauma				
3. (Prevention and Early Intervention for) At-Risk Children, Youth, and Young Adults				
4. Stigma and Discrimination				
5. Suicide Risk				

2. PEI Priority Population(s)	Age Group			
	Children and Youth	Transition Age Youth	Adults	Older Adults
2a. Select as many as apply to this PEI Project				
1. Trauma Exposed Individuals				
2. Individuals Experiencing Onset of Serious Psychiatric Illness				
3. Children and Youth in Stressed Families	●	●		
4. Children and Youth at Risk for School Failure				
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement				
6. Underserved Cultural Populations	●	●	●	●

2b. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

As noted previously, the on-line survey data and the delegates' deliberations converged on three priority populations:

- Individuals experiencing onset of serious psychiatric illness;
- Children and youth in stressed families; and
- Trauma-exposed individuals.

Delegates also assumed that the imperative to serve underserved cultural populations was a priority for all other priority populations.

For this project, delegates chose to focus on family members and caregivers, particularly of young children, as a way of providing support to children and youth in stressed families. Delegates understood data for the past year that indicate discernible, and in many cases significant increases in domestic violence calls, violent crime, suicide attempts, and other indicators of mental and emotional distress within families and communities across the three cities. Delegates understood that these and other indicators of mental and emotional distress are increasing at precisely the time when local governments, schools, foundations, and service providers are suffering escalating and devastating budget cuts.

3. PEI Project Description

3a. 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 top three issues, identified both by the on-line survey data and the delegates in their deliberations, included:

- Prevention efforts and responses to early signs of mental health problems among at-risk populations 0-25;
- Disparities in access to early mental health services and interventions; and
- Suicide risk.

Most mental health services are designed to support individuals struggling with mental health issues, and provide little if any support for family members of the people receiving mental health supports. This disparity in access to support can make it more difficult for family members to provide support for their loved one(s), and can increase the likelihood that the family members themselves will suffer mental and emotional distress.

The tri-city area is home to a very strong chapter of the National Alliance on Mental Illness (NAMI). NAMI has been active for decades in this area, and has been expanding its peer support programs, including Family to Family, Parents and Teachers as Allies, Care and Share, Understanding Children Displaying Emotional and Behavioral Difficulties, and others. As vital as these programs are, we heard through a number of our focus groups that many parents and caregivers, particularly in immigrant and ethnic communities, are reluctant even to admit that their child or other family member struggles with mental or emotional challenges, much less to seek help *for themselves* in

providing support to the child or other family member. Research corroborated this focus group data.[15]

Staff and volunteers in the Family Wellbeing Program will build trusting relationships and provide supports to family members and caregivers of people who participate in the Mental Health First Aid Program, the Peer Support Programs, the Community Wellbeing Program, and the Student Wellbeing Program, focusing particularly on family members from unserved and under-served communities. In the first year, supports will include culturally-appropriate programming focused on wellness interests—e.g., exercise, cooking, other interests—that can attract family members and other caregivers from vulnerable communities into peer support groups.

As we develop better understanding of family members' interests and needs, as well as better understanding of what future MHSA budget realities will be, we will explore additional programs to support family members in future years, including, e.g., Incredible Years, Nurturing Parenting Program, and others.

3b. 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.

The Family Wellbeing Project will engage partners in communities across the three cities, including unserved and under-served ethnic and other communities, to identify people who could benefit from the supports under this project. These partners will include schools, colleges, health clinics and other primary care providers, faith-based organizations, community organizations and collaboratives, community businesses, and other non-traditional partners.

3c. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

In the first year, recipients of these supports will be identified by, among others:

- Mental Health First Aiders trained under the Mental Health First Aid Program under the Community Capacity-Building Project, who will be located in non-traditional mental health settings across the three cities;
- Community leaders from unserved and under-served communities (e.g., Native American communities, Vietnamese and other Asian and Pacific Islander communities, Latino communities) participating in the Community Wellbeing Program (under the Community Capacity-Building Project);

[15] See, e.g., Busko, Marlene. "Asian Americans' Reluctance to Seek or Use Mental Health Services Explored," *op.cit.*; "Critical Disparities in Latino Mental Health: Transforming Research into Action," *op.cit.*; "Family Ties Provide Protection Against Young Adult Suicidal Behavior," April 14, 2009, pp. 1-2, www.medicalnewstoday.com/articles/145941.php.

- CSS Community Navigators; and
- TCMHC staff providing services through the Full Service Partnership programs and the Field-Capable Services for Older Adults program under the CSS plan.

3d. Highlights of new or expanded programs
3e. Actions to be performed to carry out the PEI project, including frequency or duration of activities.
3f. Key milestones and anticipated timeline for each milestone

Highlights: The Family Wellbeing Project will include only one staff member in the first year. This staff person will be located at the CSS-funded Wellness Center, and will identify existing community resources—e.g., NAMI programs, parent and family support groups, and others—and develop new programming to support family members and/or caregivers of people receiving supports through the other PEI projects. The new programming will reflect the culture and traditions of families who seek support through the project, and as with the Peer Support Program, will include a range of wellness activities—e.g., exercise, music, cultural awareness activities, and others. Some of this programming will occur in the Wellness Center; much of it, we expect, will be delivered in appropriate community locations for the families who are participating.

In subsequent years, as we develop better understanding of family members' interests and needs, as well as better understanding of what future MHSA budget realities will be, we will explore additional programs to support family members in future years, including, e.g., Incredible Years, Nurturing Parenting Program, and others.

Actions and activities: Once the Family Wellbeing Specialist is hired, s/he will meet regularly with Community Navigators, Community Wellbeing specialists, and leaders of communities and community organizations across the tri-city area to identify what resources are already available to support families of children and young transition-aged youth who struggle with mental distress, and to identify potential opportunities for new programming.

Milestones

Apr-Jun 2010	Finalize job description for Family Wellbeing Specialist
	Community Navigators begin to map existing community resources for families of children and young transition-aged youth
	Begin publicizing the program through Community Navigators, etc.
Jul-Sept 2010	Hire Family Wellbeing Specialist
	Begin recruiting existing programs and identifying new program needs
	Publicity and outreach continue
Oct 2010 – Jun 2011	Programming begins
	Publicity and outreach continue

4. Programs

Program Title	**Proposed number of individuals** or families through PEI expansion **to be served through June 2011** by type		**# of months in operation through June 2011**
	Prevention	**Early Intervention**	
Program: Family Wellbeing	Individuals: Families: 80	Individuals: Families: 40	# of months: 15
Total Project Estimate of **Unduplicated Count** of Individuals to be Served	**180**	**60**	

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

5a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

The Family Wellbeing Specialist will be located at the Wellness Center (funded under the CSS plan), and will interact regularly with TCMHC clinical staff. Additionally, the Family Wellbeing Specialist will meet regularly with the Community Navigators, Community Wellbeing Specialists and the Mental Health First Aid Trainer/Facilitators to share resources and referrals, and to develop protocols for connecting traditional mental health services to these project efforts where appropriate.

5b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

These linkages will happen in myriad ways. First, the Family Wellbeing Specialist will be mapping available community resources to support families with children and young transition-aged youth, primarily focusing on non-traditional mental health services. Second, the Family Wellbeing Specialist will meet regularly with the Community Navigators and Community Wellbeing Specialists to learn about non-traditional mental health services. Third, many participants in the Family Wellbeing Project will be referred by organizations and community groups from unserved and under-served communities, and therefore will themselves know about community-based resources that we expect them to share with the Family Wellbeing Specialist.

5c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

The Family Wellbeing Project will leverage myriad community resources to support the programs within this project. Indeed, we are recommending this project specifically because its primary focus is on leveraging existing community resources on behalf of project participants.

Beyond the work of the Family Wellbeing Specialist, the TCMHC PEI coordinator will provide the needed coordination and support to sustain this part of the PEI plan.

6. Collaboration and System Enhancements

6a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

The Family Wellbeing Specialist will engage myriad community-based organizations that provide support and programs for family members and/or caregivers of people receiving supports through the other PEI projects.

6b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

We expect many staff members of health clinics, along with many other community organizations and providers, to be trained as Mental Health First Aiders. The two TCMHC Mental Health First Aid Trainer/Facilitators will work to establish close working relationships with primary health care physicians, and organize the support they need to become more effective partners in the mental health system of care across the tri-city area. We expect these relationships to facilitate referrals to the Family Wellbeing Project, and to provide needed support for project participants.

And again, the Family Wellbeing Specialist will meet regularly with the Community Navigators, further facilitating reciprocal referrals between project participants and the local community-based mental health and primary care system.

6c. Describe how resources will be leveraged and sustained.

The Family Wellbeing Project will leverage myriad community resources to support the programs within this project. Indeed, we are recommending this project specifically because its primary focus is on leveraging existing community resources on behalf of project participants.

7. Intended Outcomes

7a. Describe intended system and program outcomes.

- Existing community resources for family members and/or caregivers of people receiving supports through the other PEI projects. are linked to the Wellness Center and made available to families seeking support or referred by other PEI programs.
- Culturally-appropriate programming is developed for family members and/or caregivers of people receiving supports through the other PEI projects.
- When fully operational, hundreds of families will participate annually in programs sponsored by the Family Wellbeing Program, and
    - Report positive experiences with the programs;
    - Report progress in providing support to their children or other family members struggling with mental health issues; and
    - Demonstrate sustained wellness behaviors.

7b. Describe other proposed methods to measure success.

Beyond the measures indicated above, we will use simple feedback forms to assess participant satisfaction with the family wellbeing programming. We will also explore opportunities to engage undergraduate or graduate research students from one or more of the local colleges to document the scope and impact of this effort.

7c. What will be different as a result of the PEI project and how will you know?

Beyond documenting the outcomes listed in 7a, we will regularly invite participants in the project to offer both written and oral feedback about their experiences, and the difference they believe the support has made in their lives.

8. Coordination with Other MHSA Components

8a. Describe coordination with CSS, if applicable.

The Family Wellbeing Specialist, clinical supervisors for the peer support program, and volunteer counselors will meet regularly with the CSS Community Navigators to insure effective communication and coordination of referrals. The clinical supervisors for the peer support program will also meet as appropriate with Full Service Partnership staff members, and staff members who are providing CSS field-capable services for older adults. Finally the Family Wellbeing Specialist will be stationed at the CSS Wellness Center and will regularly explore program linkage opportunities.

8b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

TCMHC has planned uses for the *PEI training and technical assistance funds*, but has not yet assessed how it will use its Workforce Education and Training funds to support the PEI plan.

8c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

TCMHC has not yet assessed how it will use its Capital Facilities and Technology funds to support the PEI plan.

PEI Revenue and Expenditure Budget Worksheet

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

County Name: **Tri-City** Date: March 10, 2010

PEI Project Name: **Family Wellbeing**

Provider Name (if known): Tri-City Mental Health System; Others TBD

Intended Provider Category: County agency; others TBD

Proposed Total Number of Individuals to be served: FY 09-10: 0 FY 10-11: 240

Total # of Individuals currently being served: FY 09-10: 0 FY 10-11: 0 [16]

Total # of Individuals to be served through PEI expansion: FY 09-10: 0 FY 10-11: 240

Months of operation: FY 09-10: 3 FY 10-11: 12

		Total PEI Project/Program Budget		
Proposed Expenses and Revenues		**FY 09-10**	**FY 10-11**	**Total**
A. Expenses				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
(1) Family Wellbeing Specialist	1.0 FTE	0	55,000	55,000
b. Benefits and taxes @ 30%		0	16,500	16,500
c. **Total personnel expenses**		**0**	**71,500**	**71,500**
2. Operating expenditures				
a. Facility costs		0	0	0
b. Other operating expenses		0	14,080	14,080
c. **Total operating expenses**		**0**	**14,080**	**14,080**
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
a.		0	0	0
b.		0	0	0
c. **Total Subcontracts/Professional Services**		**0**	**0**	**0**
4. Total proposed PEI project budget		**$0**	**$85,580**	**$85,580**
B. Revenues (list/itemize by fund source)				
1. Total revenue (other than PEI)		0	0	0
2. **Total Funding Requested for PEI Project**		**$0**	**$85,580**	**$85,580**
3. **Total In-Kind Contributions**		0	0	0

[16] While we expect that many of the resources made available to families through the Family Wellbeing Program already have participants, there's no way for us to know exactly which programs will be made available to program participants or how many people they are currently serving.

BUDGET NARRATIVE

County Name: **Tri-City** Date: March 10, 2010
PEI Project Name: **Family Wellbeing**

Note: Budgets for each project show a three-month period for FY 2009-10 and a twelve-month period for fiscal year 2010-11. These budgets include ongoing program costs as well as non-recurring costs to establish and implement the programs.

Brief Program Description
The Family Wellbeing Project will create a range of tailored structures of support and programming for family members of participants in other PEI projects.

Budget Year 2009-10

The costs of this project will begin accruing in July 2010. There are no costs incurred in FY 2009-10.

Budget Year 2010-11

The costs in the 2010-11 budget cover the first full year of the project.

A. Expenditures

1. Personnel Expenditures—$71,500
   a) Salaries of $55,000 were determined based on Tri-City's job classifications and compensation ranges.
      Positions include:
      - Family Wellbeing Specialist—1.0 FTE

   b) Benefits of $16,500 were based on Tri-City's average benefit rate of 30% and include all payroll taxes, retirement costs, health insurance and worker's compensation insurance.

2. Operating Expenditures—$14,080
   a) Facility costs—None
   b) Other operating expenses of $14,080 include $6,300 for office supplies, training costs and on-going learning support costs expected to be incurred the first full year of the project. In addition, operating costs include an operating reserve of $7,780 representing 10% (ten percent) of the budgeted on-going project costs.

3. Subcontracts/Professional Services—None

4. Total Proposed PEI Project Budget—$85,580

B. Revenues

1. Total Revenue (other than PEI)—None
2. **Total Funding Requested for PEI Project—$85,580**
3. Total In-Kind Contributions—Not yet able to quantify
   Although it is expected that various community partners will provide free wellbeing classes and other supports—e.g., yoga classes, cooking classes, and others—at this time we cannot calculate the value of these in-kind contributions.

PEI PROJECT 05:
STUDENT WELLBEING

Forms 3 and 4

PEI PROJECT SUMMARY

County: Tri-City
PEI Project Name: Student Wellbeing **Date:** March 10, 2010

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition Age Youth	Adults	Older Adults
Select as many as apply to this PEI Project				
1. Disparities in Access to Mental Health Services				
2. Psycho-Social Impact of Trauma	●	●		
3. (Prevention and Early Intervention for) At-Risk Children, Youth, and Young Adults	●	●		
4. Stigma and Discrimination				
5. Suicide Risk	●	●		

2. PEI Priority Population(s)	Age Group			
	Children and Youth	Transition Age Youth	Adults	Older Adults
2a. Select as many as apply to this PEI Project				
1. Trauma Exposed Individuals	●	●		
2. Individuals Experiencing Onset of Serious Psychiatric Illness	●	●		
3. Children and Youth in Stressed Families	●	●		
4. Children and Youth at Risk for School Failure	●	●		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	●	●		
6. Underserved Cultural Populations				

2b. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

As noted previously, the on-line survey data and the delegates' deliberations converged on three priority populations:

- Individuals experiencing onset of serious psychiatric illness;
- Children and youth in stressed families; and
- Trauma-exposed individuals.

This project focuses on students K-12 and in college. Delegates reasoned that children and youth in stressed families are likely to be at higher risk for experiencing school failure, and are likely to be exhibiting behaviors in school that indicate mental and emotional distress.

3. PEI Project Description

3a. 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 tri-city area is served by three public school districts:

- Bonita Unified School District, with 10,000 K-12 students;
- Claremont Unified School District, with 6,900 K-12 students; and
- Pomona Unified School District, with 32,000 Pre-K-12 students.

A number of colleges are also located in the tri-city area, including:

- California State Polytechnic University, Pomona, better known as Cal Poly Pomona, serving 21,000 students;
- Claremont Colleges (7 independent colleges) serving 6,300 students; and
- University of La Verne, serving over 4,200 students.

The PEI guidelines require that at least 51% of a county's funding address the needs of children, youth, and young adults ages 0-25. From the beginning of the planning process, delegates knew that the schools, colleges, and universities would have vital roles to play in the PEI efforts. Data from the focus groups made clear the essential role for these institutions to play in this process. Through our conversations with teachers, students, families of school- and college-aged students, school personnel, and others, we heard numerous and detailed stories of the increased stress and emotional challenges confronting students and their families as they struggle to cope with the chaos of the economic downturn.

At the same time, the school districts, as well as the colleges and universities, are experiencing devastating budget cuts to both core education and support programs, including mental health programs for students.[17] These institutions are scrambling to

[17] For example, the Pomona Unified School District has experienced a $41 million reduction in funding since FY 2007-08. Federal stimulus funds have softened the impact of these reductions for the past two years, but the district is planning for profound reductions in staff and services in FY 2010-11. See www.pusd.org. Similarly, the administration for CalPoly Pomona has already announced 10% reductions across the board across all divisions of the University in the coming fiscal year, and is planning for even more substantial cuts before the beginning of the next fiscal year. See www.csupomona.edu.

discover new ways to support students under increasing and often debilitating stress, even as they have to dismantle programs they have relied on for years—e.g, Student Assistance Programs, counseling programs, and others.

We also learned through the focus groups, and from the delegates' deliberations, that the school districts have little experience engaging in collaborative programming, despite their close proximity and the frequent movement of students and families among the school districts. Similarly, the area colleges have little experience engaging in collaborative programming, either among themselves or with the school districts.

Given this data and analysis, we have designed the Student Wellbeing Project to support the three school districts in *evolving* and *integrating* current efforts to promote the mental and emotional wellbeing of K-12 and college students across the three cities.

3b. 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.

Schools and colleges will take the lead in providing supports for K-12 and college students who are experiencing mental and emotional distress, and who are at risk of school failure. The interventions will take place primarily on school and college campuses, but may also occur in community-settings appropriate for participating students and their families. Additional partners are likely to include faith-based organizations, community organizations and collaboratives, community businesses, and other non-traditional partners.

3c. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

The Student Wellbeing Project will focus on the mental and emotional wellbeing of students across the three cities. All three school districts, and the area colleges, have diverse student bodies. For example, Pomona Unified School District has a current enrollment of over 30,000 K-12 students: 78% are Hispanic/Latino; 16.5% are white; 8% are African Americans; and 8% are Asian and Pacific Islanders. Over 40% of the total student body is comprised of English Language Learners (ELL), and 77% of students qualify for free and/or reduced lunches. Claremont Unified School District has a total of almost 7,000 students: 39.6% are white; 28.9% are Hispanic; 10.5% are Asian and Pacific Islander; 7.1% are African American; and the remainder are a variety of other ethnicities, including Native American, Filipino, and others. Almost one-third of students receive free and/or reduced lunches. The Bonita Unified School District has a current enrollment of approximately 10,000 students: 38.5% are white; 30.3% are Hispanic; 4.5% are Asian and Pacific Islander; 3.2% are African American; and the remainder are a variety of other ethnicities, including Native American, Filipino, and others. Almost 20% of students are on free and/or reduced lunches, with some schools having almost 50% of students on the programs.

3d. Highlights of new or expanded programs
3e. Actions to be performed to carry out the PEI project, including frequency or duration of activities.
3f. Key milestones and anticipated timeline for each milestone

K-12 Student Wellbeing Program

Highlights: The three school districts are currently pursuing a range of strategies to provide support to students experiencing mental and emotional distress, including students at risk of suicide and students at risk of school failure. These include:

- The Student Assistance Program (SAP) in Pomona Unified School District. This program provides support to students who are exhibiting signs of mental and emotional distress, including aggressive behaviors, self-injury behaviors, detachment from school, and others. SAP services are designed to reduce school violence and behavioral incidents, improve school attendance, improve academic performance, and increase access to community supports and services. Referrals to the SAP can come from teachers, parents, administrators, other students, or through self-referrals. Referred students receive a range of supports—e.g., individual, group, and/or family counseling, parenting programs, after school programs, tutoring, mentoring, and/or peer assistance. In addition, SAP Intervention Specialists facilitate a variety of informal support groups for students (e.g., grief and loss, anger management).

- Claremont Unified School District has begun an Elementary School Counseling Program. Marriage and Family Therapy (MFT) graduate students from the University of La Verne provide counseling for 10 hours/week at each of seven elementary schools sites. The students are supervised by two licensed MFT's. This model is cost efficient as the district only pays for supervision and counseling materials, which amounts to approximately $10,000 per year. The graduate students use evidence-based practices including cognitive behavioral approach, play therapy and art therapy, to support children who are exhibiting signs of mental and emotional distress. The program's impact is evaluated using the Walker McConnell Scale of Social Competence and School Adjustment.

- Current mental health programs in Bonita Unified School District (BUSD) for K-12 grade students include services provided by Tri-City Mental Health Center. Services are offered from August through June for students in grades 6-12, and from January through June for students in grades K-5. Services include Every 15 Minutes, parent education, Community Family Fairs, individual, group, and/or family counseling, parenting programs, and other supports.

The K-12 Student Wellbeing Program will provide support for the three school districts, and representatives from private schools as well, to expand and better integrate their efforts to promote the mental and emotional wellbeing of their students. First, they will receive up to $600,000 in non-recurring funds (spread over two or more fiscal years) to

support the expansion and integration of their current efforts, consistent with the state prohibition against supplantation. Second, we will work to facilitate partnerships between the school districts and colleges in order to generate additional resources for the schools—e.g., student interns, research support, and other potential resources readily available through the colleges. Third, we will work to facilitate appropriate partnerships between the communities participating in the Community Capacity-Building Project and the school districts (e.g., to recruit volunteers for mentor programs and other support structures). Fourth, we will invite the school districts to have significant numbers of their teachers and staff trained as Mental Health First Aiders (see below). Fifth, as the school districts begin implementing their expansion and integration efforts, staff members, students, and others will be able to participate in various learning circles to help them share and receive lessons learned with the colleges and the communities who are participating in the Community Wellbeing Program.

Actions and activities: TCMHC staff will identify the consultant(s) who will support the school districts' expansion and integration efforts. Staff and consultants will meet with the delegates and other senior leaders from the school districts to identify the right participants from each district, and to finalize the timeline for the expansion and integration process. Through the process, the school districts will determine how to expand and integrate their programs and efforts devoted to improving results of mental and emotional wellbeing for their students.

Milestones

Apr-Jun 2010	Select the consultants who will support the school districts expansion and integration efforts
	Meet with leadership from the school districts to identify the participants who will finalize the design for the expansion and integration efforts
Jul 2010 – Jun 2011	Districts finalize the design for their expansion and integration efforts with feedback from joint staff-delegates committee
	Funding requests for subsequent fiscal years included in FY 2011-12 plan update
	Expansion and integration efforts begins

College Student Wellbeing Program

Highlights: The College Student Wellbeing Program will engage leadership from area colleges to expand wellness and prevention efforts for college students in the tri-city area. Efforts to be funded will likely include:

- College*Response*® prevention and early detection programs for mental health disorders and alcohol problems affecting college students. Year-round, online screening, via customized websites for each college, provide confidential and effective screening programs for depression, bipolar disorder, anxiety, post-traumatic stress disorder, eating disorders, and alcohol problems.

- Wellness Workshops, forty-five minute drop-in learning opportunities, offered

across multiple days, times, and locations on a range of topics—e.g., mindfulness wellness strategies; stress management; the psychology of happiness; the psychology of gratitude; overcoming procrastination and perfectionism; building social confidence; public speaking confidence; the art of sleeping well; and other wellness topics appropriate to college students.

- Self-Help Drop-In Centers that provide a quiet, student-friendly place where students and trained/supervised peer counselors can talk (see Peer Counseling Program below). No appointments or paperwork are necessary for students to talk with a peer counselor. Students can drop-in anytime, and peer counselors are available most days/evenings. The Drop-In Center will also include a Mind-Body Gym, with massage chairs for relieving muscle tension, a meditation room, a biofeedback lab where students can use computer software to learn good breathing and relaxation techniques, and a library of over 50 different music/sound/visual CDs and tapes on general wellness topics.

The College Student Wellbeing Program will provide support for area colleges to expand and better integrate their efforts to promote the mental and emotional wellbeing of their students. First, they will receive up to $230,000 in non-recurring funds (spread over two or more fiscal years) to jumpstart the implementation and expansion of their programs, consistent with the state prohibition against supplantation. Second, we will facilitate appropriate partnerships between the communities participating in the Community Capacity-Building Project and the colleges (e.g., to recruit volunteers for mentor programs and other support structures). Third, we will invite the colleges to have significant numbers of their faculty members and staff trained as Mental Health First Aiders (see below). Fourth, as the colleges begin implementing their expansion and integration efforts, staff members, students, and others will be able to participate in various learning circles to help them share and receive lessons learned with other colleges, the school districts, and the communities who are participating in the Community Wellbeing Program.

Actions and activities: TCMHC staff will identify the consultant(s) who will support the colleges' expansion and integration efforts. Staff and consultants will meet with the delegates and other senior leaders from the colleges to identify the right participants from each college, and to finalize the timeline for the expansion and integration process. Through the process, the colleges will determine how to expand and integrate their programs and efforts devoted to improving results of mental and emotional wellbeing for their students.

Milestones

Apr-Jun 2010	Select the consultants who will support the colleges' expansion and integration efforts
	Meet with leadership from the colleges to identify the participants who will finalize the design for the expansion and integration efforts

Jul 2010 – Jun 2011	Colleges finalize the design for their expansion and integration efforts with feedback from joint staff-delegates committee
	Funding requests for subsequent fiscal years included in FY 2011-12 plan update
	Expansion and integration efforts begin

Peer Support Program

See program description under Older Adult Wellbeing and TAYA Wellbeing Projects above.

The Peer Support Program will recruit and train transition-aged young adult volunteers who attend area colleges as peer counselors for this age group. These volunteers will be trained to assess the mental health and well-being of college students, to provide 1-1 peer counseling, and to lead age- and issue-based peer support groups. Groups organized under this program will focus on providing support *and* creating opportunities for members to engage in projects that serve their communities and other wellness activities.

Communities who have implemented the peer counseling program have implemented ratios of counselors to group members as low as 1-4 (Contra Costa county) and as high as 1-75 (Marin County). Our target is to recruit up to 10 volunteers for college students (5 in the first 15 months), and for each volunteer to support up to 25 peers each (10 each in the first 15 months) through a combination of groups and 1-1 counseling. We expect that supports offered through this program will include both targeted prevention and early intervention supports.

Volunteer counselors (who we expect will also be trained as Mental Health First Aiders) will receive part-time supervision from TCMHC clinical staff, and will meet regularly to receive support and share lessons learned. They will be recruited from communities across the three cities, including unserved and under-served communities; some will be fluent in languages other than English, and will conduct groups and 1-1 counseling sessions in these languages.

Actions and activities: TCMHC staff members will recruit volunteer counselors for college students who will then receive up to 50 hours of training. College staff will help coordinate the process of identifying college students to participate in the peer support structures. TCMHC clinical staff members will regularly convene the volunteer counselors for supervision, support, and sharing lessons learned.

Milestones

Apr-Dec 2010	Identify and hire clinical staff to train and supervise volunteer counselors
	Refine the design of the Peer Support Program to serve college students
	Begin recruitment of college student peer counselors

Jan-Jun 2011	Train college student peer counselors
	Publicity and outreach for program participants
	Groups begin to form
	Supervision and support of counselors begins

Mental Health First Aid Program

Highlights: See description under Community Capacity Building Project.

Actions and activities: See description under Community Capacity Building Project. TCMHC staff will recruit several college staff members to be among the first cohort of 25 instructors to take the five-day instruction course. These instructors will train a number of people, including other college staff and students, as Mental Health First Aiders.

Milestones

See description under Community Capacity Building Project.

4. **Programs** (These estimates assume expansion and integration efforts initiated by the school districts and colleges begin in the last quarter of FY 2010-11. We expect the numbers to be significantly higher in subsequent fiscal years.)

Program Title	**Proposed number of individuals** or families through PEI expansion **to be served through June 2011** by type		**# of months in operation thru June 2011**
	Prevention	**Early Intervention**	
Program: K-12 Student Wellbeing	Individuals: 90 Families:	Individuals: 30 Families:	# of months: 15
Program: College Student Wellbeing	Individuals: 90 Families:	Individuals: 30 Families:	# of months: 15
Program: Peer Support Program	Individuals: 30 Families:	Individuals: 25 Families:	# of months: 15
Program: Mental Health First Aid [18]	Individuals: 65 Families:	Individuals: 20 Families:	# of months: 15
Total Project Estimate of **Unduplicated Count** of Individuals to be Served	**271**	**101**	

[18] The numbers listed under the Mental Health First Aid Program are a subset of the numbers listed under the Mental Health First Program in the Community Capacity-Building Project above.

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

5a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

These linkages will happen in several ways. First, the supervisors for the volunteer peer counselors will be clinical staff, and so will be able to make immediate and direct connections to available supports for longer-term treatment. Second, the clinical supervisors and the volunteer counselors, as well as the staff for the school and college programs, will meet regularly with the Community Navigators, Community Wellbeing Specialists and the Mental Health First Aid Trainer/Facilitators to share resources and referrals, and to develop protocols for connecting traditional mental health services to these project efforts where appropriate. Finally, the CSS community navigators will meet with the Mental Health First Aid instructors to develop part of the regular 12-hour first aid training that will focus on how to connect with the Navigators or other emergency staff in the case of a mental health crisis, insuring that the school and college First Aiders will have access to this information.

5b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

These linkages will happen in myriad ways. First, as noted above, this will be an essential element of the training for Mental Health First Aiders, including the First Aiders who are school and college staff. Second, the clinical supervisors and the volunteer counselors will meet regularly with the Community Navigators and Community Wellbeing Specialists to learn about non-traditional mental health support services. Third, we will insure that staff from the school and college programs and staff engage with other non-traditional mental health community agencies as appropriate—e.g., domestic violence prevention programs, substance abuse prevention programs, and others.

5c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

The expansion and integration efforts for both the school districts and the colleges will facilitate relationships between school and campus leaders, and community organizations and providers who can provide potential supports for K-12 and college students. Moreover, the provision of *non-recurring* funding to jumpstart the efforts of

both the schools and the colleges is intended to encourage the school districts and colleges to identify other resources to sustain their efforts beyond PEI funding. The consultant(s) hired to support their efforts will focus participants' attention on the need for long-term sustainability.

6. Collaboration and System Enhancements

6a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

First, the expansion and integrations efforts will facilitate collaborations among the school districts, among the colleges, and between the school districts and colleges, an extraordinary and hopeful effort in itself. And again, we will introduce school district and college program staff to clinical staff from TCMHC, staff from other local mental health providers, the Community Navigators, staff from other community agencies as appropriate, and leaders from communities participating in the Community Wellbeing Program as appropriate.

6b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

School district and college program staff will meet with clinical staff from TCMHC and other local mental health providers, and primary health care providers as appropriate.

6c. Describe how resources will be leveraged and sustained.

The Student Wellbeing Project will leverage myriad community resources to support the programs within this project. Indeed, we are recommending this project specifically because its primary focus is on developing volunteer counselors, volunteer Mental Health First Aiders, and leveraging existing community resources on behalf of project participants.

7. Intended Outcomes

7a. Describe intended system and program outcomes.

Current programs implemented by the school districts demonstrate decreased adverse behaviors, and improved academic performance, by student participants. We expect the expanded and integrated programs will demonstrate similar positive outcomes. We also expect that the programs developed and expanded by the colleges will demonstrate similar decreases in adverse behaviors, and improved academic performance, by participants. Finally, we expect the colleges and the school districts to demonstrate effective collaborative behavior in expanding and integrating their various programs.

7b. Describe other proposed methods to measure success.

We will use simple feedback forms to assess participants' satisfaction with the programs expanded and integrated among the three school districts and among the colleges.

7c. What will be different as a result of the PEI project and how will you know?

In the short-term, we will create concrete experiences of collaboration and shared learning among the school districts, among area colleges, and between the school districts and colleges. Over time, we expect the expanded and integrated programs to improve conditions of mental and emotional wellbeing among K-12 and college students across the tri-city area.

8. Coordination with Other MHSA Components

8a. Describe coordination with CSS, if applicable.

Program staff for all the programs in this project will meet with the Community Navigators and other TCMHC staff to understand the emerging mental health system in the tri-city area, including CSS programs and resources that may be available to support K-12 and college students.

8b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

TCMHC has planned uses for the *PEI training and technical assistance funds*, but has not yet assessed how it will use its Workforce Education and Training funds to support the PEI plan.

8c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

TCMHC has not yet assessed how it will use its Capital Facilities and Technology funds to support the PEI plan.

PEI Revenue and Expenditure Budget Worksheet

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

County Name: **Tri-City** Date: March 10, 2010

PEI Project Name: **Student Wellbeing**

Provider Name (if known): Tri-City Mental Health System; Others TBD

Intended Provider Category: County agency; others TBD

Proposed Total Number of Individuals to be served:	FY 09-10: 0	FY 10-11: 295
Total # of Individuals currently being served:	FY 09-10: 0 [19]	FY 10-11: 0
Total # of Individuals to be served through PEI expansion:	FY 09-10: 0	FY 10-11: 295 [20]
Months of operation:	FY 09-10: 3	FY 10-11: 12

	Total PEI Project/Program Budget		
Proposed Expenses and Revenues	**FY 09-10**	**FY 10-11**	**Total**
A. Expenses			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	0	0	0
b. Benefits and taxes @ 30%	0	0	0
c. **Total personnel expenses**	**0**	**0**	**0**
2. Operating expenditures			
a. Facility costs	0	0	0
b. Other operating expenses	0	120,000	120,000
c. **Total operating expenses**	**0**	**120,000**	**120,000**
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
a. Consultant support for expansion and integration efforts	5,000	45,000	50,000
b.	0	0	0
c. **Total Subcontracts/Professional Services**	**5,000**	**45,000**	**50,000**
4. Total proposed PEI project budget	**5,000**	**165,000**	**170,000**
B. Revenues (list/itemize by fund source)			
1. Total revenue (other than PEI)	0	0	0
2. **Total Funding Requested for PEI Project**	**5,000**	**165,000**	**170,000**
3. **Total In-Kind Contributions**	**0**	**230,000**	**230,000**

[19] While we expect that both the K-12 Student Wellbeing Program and the College Student Wellbeing Program will expand and integrate existing programs on campuses, we don't know exactly which programs will be expanded until the school districts and colleges finalize the designs for their expansion and integrations efforts.

[20] The numbers listed to be served under this program do not include the numbers for the Mental Health First Aid Program. These numbers are listed under the Community Capacity-Building Project.

BUDGET NARRATIVE

County Name: **Tri-City** Date: March 10, 2010
PEI Project Name: **Student Wellbeing**

Note: The budget for this project shows a three-month period for FY 2009-10 and a twelve-month period for FY 2010-11. It includes program costs expected to be incurred only in these fiscal years, although the allocation of funds to the school districts and colleges will continue beyond these first fiscal years.

Brief Program Description
The Student Wellbeing Project will support the three area school districts and the colleges in evolving and integrating programs to promote the mental and emotional wellbeing of K-12 and college students across the three cities.

Budget Year 2009-10

The costs included in the 2009-10 budget cover the initial three-month period of the project.

A. Expenditures

1. Personnel Expenditures—None

2. Operating Expenditures—None
   These costs are not projected to be incurred until fiscal 2010-11.

3. Subcontracts/Professional Services—$5,000
   a) These expenses include consultant fees to support the expansion and integration efforts of the schools and colleges under the Student Wellbeing Project. We estimate that this process will begin during the last month of 2009-10, and therefore, have budgeted only $5,000 in this fiscal period.

4. Total Proposed PEI Project Budget—$5,000

B. Revenues

1. Total Revenue (other than PEI)—None
2. **Total Funding Requested for PEI Project—$5,000**
3. Total In-Kind Contributions—None

Budget Year 2010-11

The costs in the 2010-11 budget cover the first full year of the project.

A. Expenditures

1. Personnel Expenditures—None

2. Operating Expenditures—$120,000
   a) Facility costs—none
   b) Other operating expenses of $120,000 include $90,000 to support program expansion and integration efforts by the three school districts, and $30,000 to support program expansion and integration efforts by the colleges.

3. Subcontracts/Professional Services—$45,000
   a) These expenses include consultant fees of $45,000 as non-recurring costs for the Student Wellbeing Project.

4. Total Proposed PEI Project Budget—$165,000

B. Revenues

1. Total Revenue (other than PEI)—None
2. **Total Funding Requested for PEI Project—$165,000**
3. Total In-Kind Contributions—$230,000
   These contributions include:
   - Meeting space contributed by the schools
   - School personnel time contributed
   - Community volunteers time
   - School contribution of drop-in centers
   - In-kind contributions by the schools for programs expanded and integrated through the Student Wellbeing Project

ADMINISTRATION BUDGET

Form 5

PEI Administration Budget Worksheet

County Name: **Tri-City** Date: March 10, 2010

	Client + Family Member FTEs	Total FTEs	Budgeted Expenses FY 2009-10	Budgeted Expenses FY 2010-11	Total
A. **Expenses**					
1. Personnel Expenses					
a. PEI Coordinator		1.0	5,000	60,000	$65,000
b. MHSA Manager		0.15	1,625	9,750	$11,375
c. Administrative Financial Support		0.45	1,800	21,600	$23,400
d. Employee benefits @ 30%			2,528	27,405	29,933
e. **Total personnel expenses**			**$10,953**	**$118,755**	**$129,708**
2. Operating expenditures					
a. Facility costs			1,067	12,800	13,867
b. Other operating expenses			834	5,000	5,834
c. **Total operating expenses**			**$1,901**	**$17,800**	**$19,701**
3. County Allocated Administration					
a. Total County Administration Cost			1,250	15,000	16,250
4. Total PEI Funding Request for Administration			**$14,104**	**$151,555**	**$165,659**
B. **Revenue**					
1. Total revenue			0	0	0
C. **Total Funding Requirements**			**$14,104**	**$151,555**	**$165,659**
D. **Total In-Kind Contributions**			0	0	0

BUDGET NARRATIVE

County Name: **Tri-City** Date: March 10, 2010
PEI Project Name: **Administration**

Note: The budget for PEI Administration shows a three-month period for FY 2009-10 and a twelve-month period for FY 2010-11. It is anticipated that the administration costs of the PEI projects will approximate 15% of the total PEI ongoing budgets.

Budget Year 2009-10

The costs included in the 2009-10 budget cover the initial three-month period of the project.

A. Expenditures

1. Personnel Expenditures—$10,953
   a) Salaries of $8,425 were determined based on Tri-City's job classifications and compensation ranges.
      Positions include:
      - PEI Coordinator—1.0 FTE
      - MHSA Manager—.15 FTE
      - Administrative Financial Support—.45 FTE
   b) Benefits of $2,528 were based on Tri-City's average benefit rate of 30% and include all payroll taxes, retirement costs, health insurance and worker's compensation insurance.

2. Operating Expenditures—$1,901
   a) Facility costs of $1,067 include one month allocation of rental and utilities costs expected to be incurred during the first three months of implementation.
   b) Other operating expenses of $834 include office supplies and miscellaneous costs.

3. County Allocated Administration—$1,250
   a) County Administration Cost of $1,250 includes a small allocation of Tri-City's Clinical Director's costs.

4. Total PEI Project Funding Request for County Administration Budget—$14,104

B. Revenues—None
C. Total Funding Requirements—$14,104
D. Total In-Kind Contributions—None

Budget Year 2010-11

The costs in the 2010-11 budget cover the first full year of the project.

A. Expenditures

1. Personnel Expenditures—$118,755
    a) Salaries of $91,350 were determined based on Tri-City's job classifications and compensation ranges.
    Positions include:
        - PEI Coordinator—1.0 FTE
        - MHSA Manager—.15 FTE
        - Administrative Financial Support—.45 FTE
    b) Benefits of $27,405 were based on Tri-City's average benefit rate of 30% and include all payroll taxes, retirement costs, health insurance and worker's compensation insurance.

2. Operating Expenditures—$17,800
    a) Facility costs of $12,800 include allocation of rental, utility and telephone costs for the year.
    b) Other operating expenses of $5,000 include office supplies and other miscellaneous costs.

3. County Allocated Administration—$15,000
    a) County Administration Cost of $15,000 includes a small allocation of Tri-City's Clinical Director's costs.

4. Total PEI Funding Request for County Administration Budget—$151,555

B. **Revenues—None**
C. **Total Funding Requirements—$151,555**
D. Total In-Kind Contributions—None

SUMMARY BUDGET

Form 6

Prevention and Early Intervention Budget Summary

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 funding being requested for each PEI project from Form No. 4 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:	Tri-City
Date:	February 2010

		Fiscal Year			Funds Requested By Age Group			
#	List each PEI Project	FY 09-10	FY 10-11	Total	Children, Youth + Families*	TAY*	Adults	Older Adults
PEI 01	Community Capacity Building Project	79,871	929,862	1,009,733	151,460	353,406	302,920	201,947
PEI 02	Older Adult Wellbeing Project	7,480	54,593	62,073	0	0	0	62,073
PEI 03	Transition-Aged Young Adult Wellbeing Project	7,480	54,593	62,073	0	62,073	0	0
PEI 04	Family Wellbeing Project	0	85,580	85,580	41,946	21,817	11,817	10,000
PEI 05	Student Wellbeing Project	5,000	165,000	170,000	110,500	59,500	0	0
PEI 06	Administration	14,104	151,555	165,659	36,246	59,223	37,522	32,668
Total PEI Funds Requested		$113,935	$1,441,183	$1,555,118	$340,152	$556,019	$352,259	$306,688
Percentage of funding request by age group					**21.88%**	**35.75%**	**22.65%**	**19.72%**

* A minimum of 51% of the overall PEI component budget must be dedicated to individuals who are between the ages of 0 and 25 ("small counties" are excluded from this requirement). Under our proposed fifteen-month budget, we estimate that over 57% of our budget will benefit individuals 0-25.

LOCAL EVALUATION OF A PEI PROJECT

Form 7

LOCAL EVALUATION OF A PEI PROJECT

County: **Tri-City** Date: March 10, 2010
PEI Project Name: **Community Capacity-Building**

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

- Community Wellbeing Program
- Mental Health First Aid Program

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

As delegates reflected on the purposes of the PEI plan, and the data that emerged from the surveys, focus groups, and their own deliberations, several guiding values began to emerge:

- A focus on *communities*, defined as a groups of people who have sufficiently strong relationships that they provide tangible support to each other and can act together. Communities have strengths and assets that *already* support their members' health and wellbeing. With culturally appropriate support and encouragement, communities can leverage and extend these strengths and assets to improve and sustain the wellbeing of their members over time.

- A commitment to *strengthen the capacities of communities* to promote the mental and emotional wellbeing of their members. This commitment reflects an understanding that communities have the primary responsibility for promoting and sustaining the mental and emotional wellbeing of their members. No service system, no matter how efficient and effective, can ever be a complete and permanent substitute for the care and nurturing that becomes available to individuals and families through their natural communities of support.

- A commitment to *sustainability*. Given the volatile and highly unstable economic environment, and the resulting uncertainty around MHSA funding, delegates committed to invest in strategies that would strengthen community capacity for caring and action that could continue regardless of future funding realities.

- A commitment to community-defined *results.* Too often data about effectiveness is unavailable, incomprehensible to anyone but program experts, or irrelevant to communities and families striving to decide on courses of action culturally appropriate to their contexts. Transformative action within communities will more likely emerge when community leaders can design their own rigorous assessment plan, and access data they care about in a timely manner, to help them assess whether actions they are taking are having a positive impact.

- A commitment to *learning.* Too often within complex systems, data is used to enforce compliance with static and predetermined program guidelines, and/or to affix blame if something goes wrong. These two values—compliance and blame—profoundly diminish the capacity of communities to adapt to complex and shifting realities. Many of the challenges confronting local communities, including those that undermine their health and wellbeing, defy simple analyses and responses. What is needed are structures of support and learning that help communities learn from each other, even cross-culturally, to expand their respective repertoires of effective action.

The design of Tri-City's entire PEI plan, and the Community Capacity-Building Project in particular, reflects the commitment of delegates and TCMHC staff members to embody these values. The choice of the Community Capacity-Building Project for our local evaluation project was easy. We are driven to know: will this work?

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

Community Wellbeing Program

In the first phase of the Community Wellbeing Program, TCMHC staff and consultants will engage in discussions with community leaders across the three cities, focusing particularly on unserved and under-served communities, to assess their readiness and capacity to engage in the program. Ultimately a first cohort of communities, currently estimated at four, will be chosen to participate in the first year. (We will continue to add communities in subsequent years of the project.)

Once identified, staff (and consultants in the first year) will work with community leaders to master the skills and frameworks needed to support their communities' actions to promote the mental health and wellbeing of their members. Examples of actions communities may take to promote the mental and emotional wellbeing of their members include organizing:

- Community wellness fairs;
- Cultural events to promote deeper understanding and connection to culture, language, and healing traditions;
- Community mentoring efforts to provide support to young people experiencing emotional or mental distress;
- Peer support circles for veterans returning from Afghanistan or Iraq;
- Volunteers to be trained as Mental Health First Aider Trainers, and as Mental Health First Aiders (see below); and
- Other community-driven activities to promote the mental and emotional wellbeing of their members.

Community leaders and partners will receive several forms of on-going support to support their actions. First, communities can apply for funding for up to three years from

a community grants fund to support their actions focused on results of emotional wellbeing. Second, communities will receive support so that they are able to generate and analyze reliable and timely data to assess the effectiveness of their efforts. Third, communities will be able to participate in various learning circles and other structures that help them share and receive lessons learned with other communities who are also participating in this program.

Given the structure of the program, there are multiple tiers of person/family level outcomes. The first tier of person/family level outcomes involves the leaders and others who participate in finalizing the community wellbeing efforts. Some of the outcomes we expect through this phase of the work include:

- Greater awareness among participants about mental health issues particular to their community;
- Greater commitment to effect conditions of mental and emotional wellbeing for members of their communities; and
- Improved skill sets to effect change, and promote mental and emotional wellbeing, in their communities.

Once the communities begin implementing their wellness efforts, they will track a second tier of person/family level outcomes, namely, community indicators of mental and emotional wellbeing to be impacted by their initiatives, as well as the particular impacts their strategies and programs have on people in the community who directly participate in these efforts. What community-level indicators each community chooses, and how they will assess the impacts of their programs and strategies on the people who directly participate in these efforts, will be decided by community leaders. We cannot know in advance what measures the communities will choose.

At the program/system level, we expect that multiple communities will implement initiatives to improve conditions of mental and emotional wellbeing for their members, and participate in cross-community learning structures. We will track our progress on these measures throughout the course of the project. We also expect to document diminished stigma and fear among members of participating communities toward people in their community who struggle with issues of mental and emotional wellbeing, including people who struggle with mental illness.

Mental Health First Aid Program

The components of this program are straightforward. An initial group of people successfully completes a five-day course to become certified MHFA instructors. We estimate that 25 people from the tri-city area will complete this instructor course in the first year: two will be new staff members from TCMHC; the others will come from a range of community partners, including schools, colleges, health clinics and other primary care providers, faith-based organizations, community organizations and collaboratives, community businesses, and other non-traditional partners.

Each of these 25 people will then be certified to offer the 12-hour MHFA course to members of their community. The course provides knowledge and skills to people to help them learn how to help someone struggling with mental or emotional distress, or developing a mental health problem or crisis. The budget includes non-recurring funds to support the wide-ranging delivery of these 12-hour programs, including funds to purchase people's time—e.g., funds for substitutes so teachers can take the 12-hour first aid training—and stipends for food, space, childcare, and other support.

Our intention is to train over 1,000 Mental Health First Aiders within the first several years of the program. These First Aiders will know how to appropriately respond to a person they encounter who is struggling with a mental health issue, and how to help the person connect to their natural communities of support, and to other support structures and resources such as peer counseling, wellness activities, self-help programs, and others.

Like the Community Wellbeing Program, the Mental Health First Aid Program also has two tiers of person/family outcomes. The first tier focuses on the skills and learning that emerge among the 25 instructors and the more than 1,000 First Aiders trained through the program. Over time, we expect these instructors and First Aiders to report and demonstrate:

- Greater awareness about mental health issues particular to their community;
- Increased confidence about responding appropriately to individuals who are experiencing mental health issues;
- Increased awareness and ability to connect people in mental distress to their natural communities of support, and to other appropriate community resources; and
- Diminished stigma and fear toward people who struggle with mental and emotional health issues in their communities.

The second tier of person/family outcomes involves the people who receive mental health first aid from the First Aiders. Over time, we expect hundreds of people to receive mental health first aid annually. We anticipate that these individuals and families will report:

- Positive experiences with the First Aiders;
- Progress in responding to and resolving the immediate experience of mental and emotional distress; and
- Increased access to supports that can help them maintain their mental and emotional wellbeing going forward;
- Increased confidence that they will be able to maintain their mental and emotional wellbeing going forward.

At the program/system level, we expect that the presence of the more than 1,000 First Aiders will have a positive impact on stigma and discrimination experienced by people who struggle with issues of mental and emotional distress, including those people who

suffer from mental illness. We do not yet know how we will assess this expected long-term impact of the Mental Health First Aid Program.

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., lesbian, gay, 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.

Community Wellbeing Program

Given the design of this program, we have no principled way to assess in advance the number of people under each priority population that will be engaged and served through the Community Wellbeing Program. The priority populations who are engaged will vary by community, as will the strategies developed to promote mental and emotional wellbeing among community members. Given our focus on unserved and under-served communities, we expect that people across the spectrum of the priority populations will be engaged in each community. But the precise numbers? There is no way to predict. Here's what we can project:

- We will engage a range of ethnic and other unserved and under-served communities, including African American, API (particularly Vietnamese and Taiwanese), Latino, Native American, Older Adults, LGBTQ, seniors (including seniors with physical disabilities), faith-based, family members of people who struggle with mental health issues (focused on the wellbeing of the *family* members), and others.

- Each community who participates in the Program will likely engage several dozen or more people in the processes to finalize their wellbeing efforts, including house meetings, 1-1 interviews, group action sessions, and others. Based on our experiences with the focus groups and community presentations, we can readily anticipate that many of these participants will fall within one or more of the priority population categories. But again, the exact numbers? There is no principled way to make this projection. Once communities begin implementing their wellbeing initiatives, we will be able to generate plausible projections, but not now.

- We will insure that most communities address, at minimum, the needs of children, youth, and young adults ages 0-25 in their communities. Given the prioritization of unserved and under-served communities, we know that many of the community members who participate directly in the community-initiated

programs and efforts will fall within one or more of the priority population categories.

Once the communities are chosen and begin implementing their wellness initiatives, we will be able to more readily estimate by ethnic group which priority populations will be engaged.

Mental Health First Aid Program

We have a similar challenge with the Mental Health First Aid Program. We plan to recruit the first cohort of 25 instructors from a range of community partners who engage people from unserved and under-served communities, including schools, colleges, health clinics and other primary care providers, faith-based organizations, community organizations and collaboratives, community businesses, and other non-traditional partners.

These 25 instructors will, over time, train over 1,000 First Aiders from their communities and organizations across the tri-city area. Based on our experience with the focus groups, community presentations, and surveys, we expect that many of these First Aiders will be people who fall within one or more of the priority population categories, though again, there is no principled way to estimate these numbers.

Once trained, the First Aiders will be part of a community's informal "early response" system. They will be present in settings all across the tri-city area, able to respond immediately when they encounter someone who is experiencing mental and emotional distress. Who will they assist? Anyone they encounter who is showing signs of mental and emotional distress and appears to need mental health first aid? How many people do we think the First Aiders will assist in a year? Perhaps thousands: with over 1,000 First Aiders trained, even if each First Aider connects with two persons over the course of a year, that's 2,000 people.

What will the demographics be of the people helped by First Aiders? They will come from all across the community, and will likely reflect the demographics of the area:

Ethnic Population	Total # Tri-City Area	% Tri-City Area
African American	14,664	6%
Asian Pacific Islander	17,587	8%
Latino	125,458	55%
Native American	884	0.003%
White	66,951	29%
Other	3,929	2%
Totals	229,473	100%
Source for Tri-City Area: United Way 2007 Zip Code Data Book San Gabriel Valley		

Since we will target people who work in or engage traditionally unserved and under-served communities when recruiting the First Aid instructors, we expect that a relatively greater concentration of First Aiders will be trained in these communities, and therefore, we expect that the First Aiders will serve relatively greater numbers of people from these communities. But again, the precise numbers? And the precise numbers of people by ethnicity who will fall within one or more of the PEI priority population categories? We have no principled way to make those estimates at this time.

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

Community Wellbeing Program

We will use surveys and other self-report mechanisms to assess the effectiveness and impact of the leadership development and support processes in the local communities. We will use the Results-based Accountability framework to guide communities through the process of identifying community results of mental and emotional wellbeing, and the indicators they will track to assess their progress toward improving these results. The Community Data Specialist will be hired and trained specifically to help empower communities to design and implement a rigorous community-driven protocol for assessing their progress.

Mental Health First Aid Program

We will use surveys and other self-report mechanisms to assess the effectiveness and impact of the 5-day training for the instructors, and similar instruments to assess the effectiveness of the 2-day trainings the instructors provide for the First Aiders. We also expect that the National Council for Community Behavioral Health Care, the organization sponsoring the dissemination of the MHFA model in the United States, will have their own mechanisms for assessing the effectiveness of their instructor training, and the effectiveness of instructors' training of First Aiders. We will work with the Council to integrate their assessment tools into our on-going evaluation efforts.

As First Aiders begin to provide support to people in their communities who experience episodes of mental and emotional distress, we will develop tools to assess the effectiveness of their interventions without violating privacy concerns or continuing the trauma experienced by the persons who receive aid. We will work with the National Council in the first year of this program to learn what other communities have done to assess the effectiveness of the First Aid interventions, and will develop instruments and processes appropriate to the communities in the tri-city area served by the First Aiders.

5. How will data be collected and analyzed?

Community Wellbeing Program

TCMHC staff and consultants will regularly offer and tabulate the surveys and other self-report mechanisms we use to assess the effectiveness and impact of the leadership development and support processes in the local communities. The Community Data Specialist will work with the communities to help them develop the data collection methods appropriate for the indicators the communities will track to assess their progress toward improving their priority results.

Mental Health First Aid Program

TCMHC staff will work with the National Council to offer and tabulate the surveys assessing the effectiveness of the 5-day instructor training. The instructors will deliver the surveys to assess the effectiveness of the 2-day trainings they provide to the First Aiders. TCMHC staff or consultants will tabulate the results of these surveys, and use these results to identify areas of excellence and areas of improvement. Again, the focus of these efforts will be on supporting a process of continuous learning and improvement, especially across cultures and communities.

While we know how we will assess the effectiveness of the Instructor training and the First Aider training, we do not yet know how we will collect and analyze data related to the effectiveness of the First Aiders' *interventions*. This will be a focus of our work in the first year of the program.

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

Just as we have done with the hiring of the CSS Community Navigators, we will insure that Community Wellbeing Specialists, the Community Data Specialist, the MHFA Trainer/Facilitators, the MHFA instructors, and the MHFA First Aiders reflect the diversity of tri-city area, and have the relational skills to effectively engage and partner with leaders and people from different communities.

Under the Community Wellbeing Program, leaders from the communities themselves will be designing and implementing the interventions for their communities, with support from the Community Wellbeing Specialists, the Community Data Specialist, and other identified community partners. This will not be a program *done to* communities; the plans and programs will be developed *by and for* the communities themselves.

Under the Mental Health First Aid Program, each First Aider will be responsible for offering their first aid in ways that are appropriate for the individual in distress. We will be regularly convening learning circles and other processes to assess what First Aiders from different communities are learning about what works and what doesn't for people in their communities.

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

Under the Community Wellbeing Program, we will be in regular conversation with Mark Friedman about our adaptation of the Results-based Accountability (RBA) model. John Ott, one of our lead consultants, is also a seasoned trainer in this model. We will also be in contact with people from the Asset Based Community Development (ABCD) Institute as needed to discuss our adaptation of the ABCD model. The Institute has supported the training a number of ABCD organizers through the Los Angeles County Children's Council and other organizations.

Similarly, we expect to be in regular conversation with representatives from the National Council for Community Behavioral Health Care to discuss our adaptation of the Mental Health First Aid model for the tri-city area.[21]

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

We will regularly share data from the multiple streams of evaluation with community leaders, delegates, stakeholders, and other interested parties. Data will be shared via email, regular reports, and in-person presentations. We will also use the data to guide the creation of learning circles and other support structures focused on areas of needed improvement. Finally, our annual PEI Summit will provide a dynamic forum for community leaders and others participating in this project to share their data and the meaning they are making of it, and to celebrate their successes and progress.

[21] One example of a possible modification: during the delegates' deliberations about the PEI plan, one delegate expressed concern that the term "mental health first aid" might suggest the need for *clinical* expertise among the First Aiders, thus discouraging some people from getting trained. We will explore this issue with community leaders and with staff from the National Council when we begin implementation.

ATTACHMENTS

ATTACHMENT A: LIST OF FOCUS GROUPS

	Focus Group Name	# in group	Ethnicity						Language		Age Group		
			L	AA	W	API	NA	O	Eng	Span	TAY	Adult	OA
1	API Community Group	13	0	0	0	13	0	0	•	•	13	0	0
2	BIACO Consumers Club	25	6	15	2	2	0	0	•		0	25	0
3	Bliasdell, Older Adults Group	26	2	2	15	2	3	2	•		0	2	24
4	Church of the Brethren, La Verne	12	1	0	11	0	0	0	•	•	0	9	3
5	Claremont Youth Activity Center	13	1	7	5	0	0	0	•		13	0	0
6	Costanoan Rumsen Tribe	32	0	0	0	0	32	0	•		8	18	6
7	Costanoan Rumsen Tribe II	28	0	0	0	0	28	0	•		7	17	4
8	Costanoan Talking Circle	28	0	0	0	0	28	0	•		8	13	7
9	Costanoan Talking Circle II	22	0	0	0	0	22	0	•		8	10	4
10	Costanoan, Olohoni, Tongva Tribes	16	0	0	0	0	16	0	•		1	15	0
11	Havenly House, Substance Abuse	18	5	1	11	1	0	0	•	•	2	13	3
12	Inland Valley Family Homeless Shelter	7	1	5	0	0	0	1	•		4	3	0
13	Islamic Community Group	5	0	0	0	5	0	0	•		0	5	0
14	Joslyn Senior Center	29	22	4	3	0	0	0	•	•	0	4	25
15	Joslyn Senior Center II	31	18	4	7	1	1	0	•	•	0	4	27
16	Joslyn Senior Center III	22	20	2	0	0	0	0	•	•	0	1	21
17	LGBTQ Community Group I	10	10	0	0	0	0	0	•	•	10	0	0
18	LGBTQ Community Group II	8	6	2	0	0	0	0	•	•	8	0	0
19	NAMI	24	3	1	17	3	0	0	•		1	15	8
20	NAMI II	20	0	2	13	0	0	5	•		0	13	7
21	Parent Group - Bueno Vista Elem.	10	6	0	2	2	0	0	•	•	0	10	0
22	Parenting Group Pomona	11	11	0	0	0	0	0	•	•	4	6	1
23	Renacimeintos, Women in Poverty	20	20	0	0	0	0	0	•	•	2	18	0
24	Taiwanese Community Group	10	0	0	0	10	0	0	•		0	10	0
25	TCMHC - Bridges Support Group	13	8	0	4	0	1	0	•	•	2	11	0
26	TCMHC - Depression Therapy Group	11	6	2	3	0	0	0	•	•	1	9	1
27	TCMHC - Spanish Spkg Therapy Grp	2	2	0	0	0	0	0	•	•	0	2	0
28	TCMHC - Symptoms Mgnt Group	6	3	0	2	1	0	0	•	•	0	5	1
29	TCMHC – Trauma Recovery Group	3	3	0	0	0	0	0	•	•	0	2	1
30	University of La Verne Soccer	12	10	1	1	0	0	0	•	•	12	0	0
31	University of La Verne Sorority	12	12	0	0	0	0	0	•		12	0	0
32	University of La Verne Students	12	4	4	4	0	0	0	•		12	0	0
33	University of La Verne Students II	16	6	2	8	0	0	0	•		16	0	0
34	Veteran's Group	23	4	15	4	0	0	0	•	•	0	22	1
35	Veteran's Group II	17	3	14	0	0	0	0	•	•	8	3	6
36	Vietnamese Community Group II	7	0	0	0	7	0	0	•		4	0	3
37	Vietnamese Group	7	0	0	0	7	0	0	•		0	0	7
38	Washington Park II, Older Adults	26	26	0	0	0	0	0	•	•	0	0	26
39	Washington Park, Older Adults	27	27	0	0	0	0	0	•	•	0	3	24
40	White Cane Center	21	3	3	15	0	0	0	•		4	1	16
	TOTALS	**655**	**249**	**86**	**127**	**54**	**131**	**8**			**160**	**269**	**226**
		100%	**38%**	**13%**	**19%**	**8%**	**20%**	**1%**			**24%**	**41%**	**35%**

Legend	L: Latino	AA: African American	W: White	API: Asian Pacific Islander	NA: Native American	O: Other	Eng: English	Span: Spanish	TAY: Transition-Aged Youth	OA: Older Adults

ATTACHMENT B: PARTIAL LIST OF TCMHC STAFF PRESENTATIONS

Community Constituency	# Engaged	Notes
Claremont Community Care Council	60	
Claremont Parent Group	15	
Claremont Psychologists meeting	20	
Claremont Youth Activity Center	13	
Department of Social Services meeting	9	
East San Gabriel Consortium	40	
Hyoun Moon Korean Church	1	
LA County Alcohol and Drug meetings	15	
La Verne Youth and Family meeting	20	
LA County, SPA 3 Systems Navigator	1	
LA County, Child Support Services Dept	2	
Mental Health Collaborative	10	
Mental Health Court Linkage Program	1	
Mercy House	1	
NAMI Pomona Valley	60	
Older Adult Health Fair	25	
Pomona Continuum of Care	40	
Pomona Neighborhood Center	2	
Pomona Police Department	1	
Pomona Village Shopping Center	20	
Pomona Youth and Family meeting	50	
Project Homeless Connect	534	One-day event that was part of a national campaign to provide one-stop services—e.g., physical health services, dental services, mental health services, etc. Event drew over 500 individuals, 30 agencies, 40 volunteers
Project Homeless Connect Agencies	20	
Prototypes	1	
San Gabriel Coalition for Homeless	1	
Street outreach at 7-11, La Verne	25	
Street outreach in Pomona	7	
Taiwan Buddhist Tzu Chi Foundation	1	
TCMHC staff members	63	
TCMHC CSS Community Navigators	524	Outreach to people with SMI/SED and families; city and county departments; providers of physical and mental health, social services; schools and faith-based org.
Tri-City city managers	3	
Total	**1585**	

GRADIENTS OF AGREEMENT

Question: How much do you support the recommendation?

Endorse	**Endorse** with minor point of contention	**Agree** with reservations	**Abstain**	**Stand aside**	**Disagree** but will support the majority	**Disagree** and want out from implementation	**Can't go forward**
I like it	*Basically, I like it*	*I can live with it*	*I have no opinion*	*I don't like it, but I don't want to hold up the group*	*I want my disagreement noted in writing, but I'll support the decision.*	*I don't want to stop anyone else, but I don't want to be involved in implementation*	*We have to continue the conversation.*

This scale (not the color scheme) was developed by Community at Work, www.communityatwork.com.

Public invited to hearing on mental health plan

Wes Woods II, Staff Writer

Created: 01/24/2010 06:02:03 AM PST

CLAREMONT - Those at risk for mental illness will the focus of a public hearing this week.

A public hearing on a Tri-City Mental Health Systems Prevention and Early Intervention (PEI) plan draft is set for 5:30 p.m. Wednesday at Taylor Hall in Claremont.

The plan, with input from approximately 3,000 community members, tackles improving the emotional well-being and mental health of children, families, seniors, adults, underserved cultural communities and young adults in Claremont, La Verne and Pomona.

Toni Navarro, director of clinical program services for Tri-City, said Friday that everyone's feedback "is necessary to see how they're feeling about what's happening in the community and how they see new services augmenting what's already here. We don't want to re-create anything."

The plan is organized around three projects:

The Community Capacity-Building Project, helping communities create and implement plans to improve and sustain members' emotional and mental well-being, and a separate training program.

Peer Support and Family Well-being Project, recruiting and training peer counselors to assess mental health and separate identification of community resources to help.

Student Well-being Project, with a program for the Bonita, Claremont and Pomona unified school districts, and a college program.

The PEI is Tri-City Mental Health Center's second of five plans to be developed under the Mental Health Services Act, which California voters passed in 2004 as Proposition 63.

About $1 million a year will fund the PEI plan, which comes from an annual 1 percent tax on personal incomes over $1 million that will be used to help California's mental health system.

Rimmi Hundai, Mental Health Services Act coordinator, said the Tri-City Mental Health Commission board will vote after the public hearing. More than 100 people are expected to attend, Hundai said. There will also be translators for Spanish, Vietnamese and sign language communicators.

Hundai said the plan had been presented in senior centers of each of the three cities involved and also had been discussed at churches, Rotary meetings and even on street corners.

Gilbert Salbate, public outreach coordinator, said "the importance of this is this plan came from the community ... the public needs to be there because it's for them. It's not from Tri-City."

Navarro said if passed, the plan will go before the state where officials have a 50-day window for review. If approved, in April or May the plan would come back and the programs could be implemented locally. **Tri-City Mental Health Systems Prevention and Early Intervention (PEI) plan draft**

Where: Walter Taylor Hall, 1775 N. Indian Hill Blvd., Claremont

When: 5:30 to 8:30 p.m. Jan. 27

Cost: Free

Information: Rimmi Hundai, Mental Health Services Act coordinator, (909) 623-6131

Tri-City board approves draft of early intervention mental health program proposal

Wes Woods II, Staff Writer

Created: 01/28/2010 05:59:51 PM PST

CLAREMONT - Residents and officials were visibly pleased after a Tri-City Mental Health Systems plan draft was unanimously adopted by the board Wednesday night.

The plan, with input from about 3,000 community members, tackles improving the emotional well-being and mental health of children, families, seniors, adults, underserved cultural communities and young adults in Claremont, La Verne and Pomona.

The Prevention and Early Intervention (PEI) plan draft presentation at Taylor Hall included a presentation, workshop and question-and-answer session.

Upland resident Haleema Shaikley, principal of City of Knowledge Islamic School in Pomona, praised Tri-City officials for "reaching out to the community and being sensitive to the needs of the community. I think it's successful. It's very much needed as there are a lot of mental issues and many do not know how to approach it. There is a lot of misdiagnosis in different communities."

Bernardo Rosa, adult co-chairwoman of the Pomona Youth and Family Master Plan Community Board, and Candace Barry, former co-chair of the community board and Gift of Time Mentoring Project organizer, said they supported the plan.

"I'm excited to be part of it," Rosa said. "I can't wait to see it implemented."

Funding the PEI plan will cost about $1 million, which comes from an annual 1 percent tax on personal incomes over $1 million used to help California's mental health system.

This plan is the second of five Tri-City Mental Health Center will develop in accordance with the Mental Health Services Act, established under Proposition 63, passed by voters in 2004.

The current plan will now go before the state where officials have a 50-day window for review.

If approved, in April or May the plan would come back and the programs could be implemented locally.

Joseph McLellan, program coordinator for the Youth Activity Center in Claremont, said he enjoyed how officials reached out to him and the youths in his organization for assistance.

"We'll do everything we can to help," McLellan said. "It's a good thing." He said while funds given out would not affect his center directly, the health issues would affect his youths and their school districts.

The cities of Claremont, Pomona and La Verne created Tri-City Mental Health in 1960 as a Joint Powers Authority. It has offices in Claremont and Pomona to offer health care treatment, education and prevention programs.

TRI-CITY MENTAL HEALTH SYSTEM JANUARY 27, 2010 PEI PUBLIC HEARING SUMMARY OF WRITTEN AND PUBLIC FEEDBACK TO DRAFT PLAN

1. **How many people in the room**
   78 Are hearing about MHSA and the Prevention and Early Intervention plan for the first time?
   82 Have gone to a few meetings about the Prevention and Early Intervention plan
   59 Have been substantially involved in the planning process for the PEI plan from the beginning

SUMMARY OF PUBLIC COMMENTS MADE DURING LARGE GROUP DISCUSSION

2. **What we liked (a sample of the comments)**

- We liked everything about the plan. If we had to highlight one thing it would be the sustainability plan and the prevention training.
- Our table was most excited by the school program. It will be great to have the schools all working together.
- We really liked how the plan focused on leveraging resources, especially given all the budget reductions and the economy.
- At our table, we talked about how we all liked the fiscally responsible and conservative approach taken by the planning effort.
- Like the other table, we also liked everything about the plan. We really liked the focus on community and its members' well being. That's key. We also liked the commitment to sustainability. We also thought that the training made a lot of sense and was very well thought out. We especially liked how the plan directly incorporates feedback from the unique communities in our three cities. This approach is inherently respectful and ensures that the implementation will address the specific needs, circumstance, and culture unique to each community. We also really liked the age-ranges that the plan focuses on.
- Our table really liked the sustainability focus of this program. It means our efforts won't go away.

3. **Questions asked during the large group discussion and a summary of the response offered)**

- How will the programs be evaluated? Response:
  - Through the Community Wellbeing Program under the Community Capacity-Building Project, we will be using Results-based accountability as the framework to help communities assess if their efforts are making a difference, and to report to the community and to the state if this project is improving the wellbeing of members of the participating communities. We have included a Community Data Specialist in the plan to help us with this work.
  - Under the Mental Health First Aid Program, we will create a protocol to assess and report to the state (along with the data from the Community

Capacity-Building Project) the experiences both of the people trained as First Aiders, and of the people they help.
- We will be holding gatherings like this at least annually to report on the progress under the entire plan.

- What about people who don't identify with a community? How will the plan help them? Response:
  - One example of how this could work is through the Mental Health First Aid Program. The Mental Health First Aiders will be trained to help people in distress connect with others who can support them. If a person does not have a support community, the First Aiders, like the Community Navigators under the CSS plan, will work to connect the person with people who could be of support. This might be through a peer support group; it might be through a faith community, or through some other community that the person wants to connect to and who will welcome that person.

- Will the schools also be encouraged to develop plans that foster long-term sustainability? Response:
  - You bet. We have talked with all of the school districts that the funding we are creating is seed funding, non-recurring funding to help them launch an effort to promote the mental and emotional wellbeing of their students. Part of the process will be to help them develop plans for sustaining the efforts they begin with these resources.

- Can you provide examples of the types of training that will be provided by MHFA? Response:
  - There will be a variety of modules that focus on different mental health problems and challenges, including anxiety/trauma, depression, eating disorders, substance use disorders, self-injury, and psychosis and psychotic disorders.
  - First Aiders will also develop an understanding of the prevalence of various mental health disorders in the U.S. and the need for reduced stigma in their communities

- Our table also really liked every part of this plan but we did have a question. What criteria such as income will be used for people receiving these services?
  - The beauty of the PEI funding is that it is help first funding, not fail first. We do not have to meet medical necessity or other criteria established under Medi-Cal or other government funded programs.
  - The focus of this plan is to strengthen the capacities of communities across the three cities. We will particularly focus on unserved and under-served communities in the Community Wellbeing Program, the Peer Support Program, and the Family Wellbeing Program. For the Mental Health First Aid program, we will train First Aiders in a wide array of settings across the three cities.

- We are really excited by the train the trainer program. Who will select the trainers to participate in this process? Response:
  - TCMHC staff, working with a delegates committee, will develop criteria for the selection of the trainers. The institutions where the trainers are located will ultimately choose the trainers consistent with the criteria.

- How will the linkages to primary care work? Response:
  - Doctors have told us how challenging it is for them to respond to the mental health needs of their patients, particularly those in crisis. They want to learn how to respond better, how to prescribe medications more effectively. Our work will be to develop relationships with doctors in a variety of health care settings across the three cities, learn from them what kinds of information and expertise will be helpful to them, and then work with them to access that expertise. We'll do the same with clergy and other leaders and professional who are often "first responders."

- How can we continue to participate in the process? Will there be more meetings?
  - There will always be another meeting!
  - You will have multiple opportunities to engage in the next steps in this process: through your community, or as a Mental Health First Aider, or as a Peer Support volunteer, or as someone to provide or participate in family wellbeing programs, and other ways.
  - We will also have at least annual update meetings like this where we report on the progress made and the next steps and changes to the plan.
  - Similarly, we will have a meeting like this in March where we provide the same kind of information regarding the CSS plan.

4. **General comments offered toward the end of the public hearing**
   - (In Spanish) I would just like to say thank you to everyone. This is the first time that I can remember being part of a space like this in our community. It feels great to know what's going on and to have a say. Thank you very much for providing this space.
   - I'm most impressed by how all the cultures in our community are coming together through this effort. The Native American dancing during this event is a type of medicine for everyone here and our community. I really like seeing all the different cultures here. Thank you so much for bringing all the cultures and different age groups together. It's very important to show respect like this.
   - Over the years, I have been a vocal critic of Tri-City. I am a Vietnam veteran and have a son with mental illness. I am just so excited by what I'm hearing and experiencing tonight. I read every page of the plan and I wanted to see if it was really real. What you're doing here is the most engaging of community that I've seen any organization attempt to do. Your plan is truly humble so I also want to be humble and say that I'm wrong to continue being a critic. The delegates here have done an incredible job. This plan shows they want to connect to this community at a real level. All I can say is thank you. I just want to say thank you, thank you - to all of you.

- I work for a major hospital in this area and I have been talking about this plan to the doctors. I would like to share with everyone that the doctors I spoke with can't wait for this plan to start up. I can't wait for this to start up.
- As the Commission chair, I just wanted to say how excited I am by this plan. It's also only the beginning. Through this plan, a real potential exists to have far-reaching effect in our communities. We all worked together to develop this plan. We must continue to work together and I know we will.
- I have been on the Tri-City board for more than a decade. The past 7 years have been very painful and unexpectedly also very exhilarating. I want to say that Tri-City really has changed. We have made new commitments and the values that you see on the tables have been a part of this process. There's new staff on board. We have a totally new commission. The composition of the board was formally changed and new community board members were added. I see people here who in the past would never have been here. There are representatives from all the schools and colleges. It's amazing to see all the people who are here today. Thank you so much for coming and participating in this process. We really are committed to this process and our new vision.

SUMMARY OF TABLE DISCUSSIONS AND WRITTEN FEEDBACK

5. **What we like most about this plan includes (in no particular order; all had many checkmarks)**
   - How many people have participated in the process to develop the plan
   - The focus on communities and community wellbeing
   - The commitment to results
   - The commitment to sustainability
   - The commitment to address disparities in access to services
   - The commitment to deliver services in culturally appropriate ways
   - The Community Wellbeing Program
   - The Mental Health First Aid Program
   - The Peer Support Program
   - The Family Wellbeing Program
   - The K-12 Student Wellbeing Program
   - The College Student Wellbeing Program
   - Training people because will never have enough services
   - Early intervention focus
   - Financial prudence
   - Well thought out training program
   - Getting community input on what works and what doesn't for that community
   - Age range from young to old
   - Help is easily accessible
   - Involving faith community
   - Integrated and interactive approach
   - Leveraging existing services in the community
   - Accessibility
   - Recognition that there is no one answer, but lots of answers.

6. **The parts of the plan that we have the most questions about are (in no particular order):**
   - Where does spirituality fit? Specifically, training to include spirituality into people's wellbeing?
   - Is there an order for how projects will roll out?
   - Need clarification on 51% funding requirement for 0-25
   - Mental Health First Aid Program: what's the timeline? How will they be selected?
   - How will communities be selected for the Community Wellbeing Program?
   - What kind of programs will be developed under the Family Wellbeing Program?
   - How will we connect MDs and Mental Health First Aiders?
   - How will results be communicated?
   - Who will train the trainers? What will the training look like?
   - How will we connect with people who are not in communities?
   - What about people who don't have primary care providers?
   - Sustainability of trained volunteers
   - How will the plan address disparities in access to services?
   - What about the instability of state funding?
   - How will this overcome stigma?
   - K-12 Student Wellbeing: How will schools keep the ball rolling?
   - If faith-based people are trained, will they be allowed to share their "religious beliefs" with those individuals needing mental health assistance at the time they are Mental Health First Aiders? How would this be prevented if at all?
   - What are the qualifications for accessing the supports under this plan?
   - Who will be distributing the money?

7. **Other comments we want to share**
   - Sounds exciting
   - Appreciate the focus on connecting with and using existing structures of support in communities: peer groups, places people already gather to work, play, etc.
   - How will these plans be measured in terms of effectiveness and accountability?
   - I like the meeting and I am loving the idea [of the plan]. [The delegates] did an excellent job. Keep up the good work.
   - Great job! Could not have done better! Results-based and perpetuates itself.
   - Particularly like sharing of resources between the schools and colleges
   - Fantastic dream! Can it be a reality?
   - Thank you John for the mindful leadership without which this plan could not have come into being. Namasté
   - I'm very happy with this program because it is very important for the community. In one occasion I needed Tri-City and they really helped me a lot. Thank you very much. (in Spanish)
   - We're happy to know about these programs and we're very interested in knowing more about this program. Thank you. (in Spanish)

LOCAL TRAINING, TECHNICAL ASSISTANCE AND CAPACITY BUILDING FUNDS REQUEST FORM

Training, Technical Assistance and Capacity Building Funds Request Form
(Prevention and Early Intervention Statewide Project)

Date: March 10, 2010	County Name: Tri-City
Amount Requested for FY 2008/09: $30,800	Amount Requested for FY 2009/10: $30,800

Briefly describe your plan for using the Training, Technical Assistance and Capacity Building funding and indicate (if known) potential partner(s) or contractor(s).

We are requesting **$61,600** to provide three kinds of training:

- **$40,000** to train 25 Mental Health First Aid (MHFA) instructors. The people trained will include staff members from the three school districts, local colleges, a range of community- and faith-based organizations, as well as Tri-City staff. Once trained, these individuals will be certified to conduct two-day mental health first aid trainings with interested individuals and groups across the three cities. The National Council for Behavioral Healthcare will provide the training. They are currently providing this training to several counties in California, including Madera and Yolo counties.
- **$9,600** to train up to 25 peer counselors. Counselors will be volunteers from the tri-city area. Many will likely be connected to community-based organizations. The training will be provided by the Center for Healthy Aging in Santa Monica, CA. The Center has provided this training to a number of counties in California, including Contra Costa and Marin counties.
- **$12,000** to train up to 25 people to become Results-based Accountability (RBA) trainers. Results-based Accountability is a framework we will use to help local communities develop and track progress toward community-defined outcomes of mental and emotional wellbeing. Participants will include community leaders, as well as staff members from the three cities, school districts, TCMHC staff, and others. Mark Friedman from the Fiscal Policy Studies Institute, the creator of the RBA framework, will conduct the training. Mark has worked extensively in California, including work with state government, county governments, First 5 Commissions, United Ways, and others. He is slated to be a keynote presenter at the Stanislaus County PEI Summit in May 2010.

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)

FY 2009-10 PEI PRUDENT RESERVE REQUEST

Mental Health Services Act (MHSA)
Community Services and Supports (CSS) and Prevention and Early Intervention (PEI)
FY 2009/10 Prudent Reserve Funding Request

County: **Tri-City** Date: March 10, 2010

Instructions: Utilizing the following format please provide a plan for achieving and maintaining a local Prudent Reserve.

Most Recent Annual Approved Funding Level

A. CSS Annual Funding Level for Services (See Note 1 below)	$ 3,721,400		
B. PEI Annual Funding Level for Services (See Note 2 below)	$ 1,289,628		
Total (A+B)			$ 5,011,028
C. Less: Total Non-Recurring Expenditures CSS and PEI Subtract any identified non-recurring expenditures for CSS and/or PEI, included in A and B above.			- 347,500
D. Plus: Total Administration CSS and PEI Subtract any identified non-recurring expenditures for CSS and/or PEI, included in A and B above.			+ 151,555
E. Sub-total			$ 4,815,083
F. Maximum Prudent Reserve (50%) Enter 50%, or one half, of the line item E Sub-total. This is the estimated amount the County must achieve and maintain as a local Prudent Reserve by June 30, 2011			$ 2,407,542
G. Prudent Reserve Balance from Prior Approvals Enter the total amounts previously approved through Plan Updates for the local Prudent Reserve.			**$ 1,860,700**

Amount Requested to Dedicate to Local Prudent Reserve

H. Plus: CSS Component Enter the Sub-total amount of funding requested for CSS in H.				
*FY 2009/10	Unapproved Funds	$ 0		
	Unspent Funds	$ 0		
*FY 2008/09	Unapproved Funds	$ 0		
	Unspent Funds	$ 0		
*FY 2007/08	Unapproved Funds	$ 0		
	Unspent Funds	$ 0		
	Sub-total			$ 0
I. Plus: PEI Component Enter the Sub-total amount of funding requested for PEI in I.				
*FY 2007/08	Unapproved Funds	$ 410,500		
	Unspent Funds	$ 0		
	Sub-total			$ 410,500
J. Total Amount Requested to Dedicate to Local Prudent Reserve Enter the sum of lines H and I.				$ 410,500
K. Prudent Reserve Balance Enter the sum of G and J.				$ 2,271,200
L. Prudent Reserve Shortfall to Achieving 50% (See Note 3 below)				$ 136,642

Note 1: In May 2009, during the approval process for Tri-City's CSS plan, CADMH agreed to allow Tri-City to fund its "CSS" Prudent Reserve based on Tri-City's 2008-09 Planning Estimate of $3,721,400 instead of actual planned expenditures. Upon approval of Tri-City's CSS plan in June 2009, CADMH transferred $1,860,700 (50% of 3,721,400) into Tri-City's Prudent Reserve Account. We have therefore made all subsequent calculations on this form based on this initial CSS allocation of $3,721,400.

Note 2: Depending on OAC approval, we may begin implementing PEI projects as early as April 2010. The figure recorded in B, however, represents the annual PEI funding level proposed for FY 2010-11, the first full year of PEI activities.

Note 3: Our intention is to use unspent CSS and/or PEI funds from prior fiscal years to make up the balance of $136,642 for our Prudent Reserve. We will make the necessary analyses in the second quarter of FY 2010-11 and submit a supplemental request at that time.