



*Improving Schools,  
Engaging Students*

*Center Report . . .*

**Prevention and Early Intervention in  
California's *Mental Health Services Act*:  
A Summary of School-Based Programs  
in Ten County Plans**

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## Preface

In November 2004, the voters in California passed Proposition 63 (now known as the Mental Health Services Act or MHSA) This created both a unique opportunity and great challenges for enhancing the state's mental health system and improving how communities and schools address long-standing problems. And, what transpires is of importance not only to California, but to others across the country who are concerned with enhancing public policy and practice.

When the focus on Prevention and Early Intervention (PEI) was introduced, it was indicated that schools were a possible venue for pursuing this component. Given our Center's work in this arena, we did an analysis and offered some guidance and cautions. See *Building Collaboration for Mental Health Services in California Schools: What Will be Built?*

<http://smhp.psych.ucla.edu/pdfdocs/buildingcollabformhrfpanalysis.pdf>

Now that the state guidance and the first wave of county plans for Prevention and Early Intervention are available, we can begin to look at plans for school related activities. This first look presents a *summary* of the ten county plans posted as of October 27, 2008 on the Prevention and Early Intervention webpages of the state's department of mental health

[http://www.dmh.ca.gov/MHSOAC/Prevention\\_and\\_Early\\_intervention.asp](http://www.dmh.ca.gov/MHSOAC/Prevention_and_Early_intervention.asp) .

A subsequent report will offer an analysis of the implications of what has been and what hasn't been proposed.

As always, we owe many folks for their contributions to this report, and as always, we take full responsibility for its contents and especially any misinterpretations and errors. We are extremely interested in any and all feedback. Please send all comments to us care of [ltaylor@ucla.edu](mailto:ltaylor@ucla.edu) .

Finally, we want to acknowledge that portions of the work were done as part of a cooperative agreement funded by the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services. At the same time, it should be noted that the report is an independent work.

Linda Taylor & Howard Adelman  
Center, Co-directors

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**Prevention and Early Intervention in  
California's *Mental Health Services Act*:  
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Those concerned with mental health bring to any policy and planning table a wide range of perspectives and agenda. Each new initiative related to California's Mental Health Services Act (MHSA) reflects this reality. There is much to be learned from what transpires. This report is the second of several our Center plans to prepare with a view to helping others across the country understand and build on this wide-ranging endeavor.

**Background**

The voters in California passed Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004. The act has provided the state's Department of Mental Health its first opportunity in many years to "increase funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults and families. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system." (Department of Mental Health website –

[http://www.dmh.ca.gov/prop\\_63/MHSA/default.asp](http://www.dmh.ca.gov/prop_63/MHSA/default.asp) )

*Brief Overview of  
the Mental Health  
Services Act*

With adoption of the Mental Health Services Act (MHSA), a 1% income tax on personal income in excess of \$1 million was imposed in California. Statewide, the Act was projected to generate approximately \$683 million in fiscal year 2005-06 and increasing amounts thereafter (not anticipating economic downturns). The MHSA plans call for providing funds to expand community mental health services related to six different components:

- **Community Planning** funds to involve the public in identifying local funding priorities;
- **Community Services & Supports** funds to provide integrated mental health and other support services to those whose needs are not currently met through other funding sources;
- **Prevention & Early Intervention** funds to reduce the stigma and discrimination associated with mental illness and provide preventative services to avert mental health crises;

- **Innovative Programs** funds to improve access to mental healthcare;
- **Capital Facilities and Technology** funds to improve the infrastructure of California's mental health system; and
- **Workforce Education & Training** funds to develop and grow the mental healthcare workforce.

A proportion of the funding is being distributed to county mental health programs upon approval of their plans for each component of the MHSA.

*Guidance for  
Prevention and  
Early Intervention  
Project Plans*

We begin with the guidance. The guidance was developed by the Mental Health Services Oversight and Accountability Commission (MHSOAC) Prevention/Early Intervention Committee as a proposed action plan for the first three years.<sup>1</sup> Exhibit 1 presents key excerpts from this document to provide a perspective on proposal writers responses.

*Exhibit 1*

Excerpts from: *Proposed MHSOAC Prevention/Early Intervention Committee Action Plan for the First Three Years* (Deborah Lee and Saul Feldman )

The Mental Health Services Act (MHSA) emphasizes prevention and early intervention as key strategies to transform California's mental health system.... The MHSA prioritizes the prevention of suicide, incarceration, school failure or drop-out, unemployment, prolonged suffering, homelessness, and removal of children from their homes. Prevention programs are required to include

- Outreach to various people who have the potential to recognize early signs of severe and potentially disabling mental illness
- Access and linkage to medically necessary care provided by county mental health programs at the earliest possible onset of severe mental illness, and
- Reduction of stigma and discrimination against people with mental disorders. ...

**What is Prevention?** Prevention in a mental health context, according to the Institute of Medicine, is part of a spectrum of interventions that includes prevention, treatment, and maintenance. The Institute of Medicine offers the following definitions for the three components:

- Prevention—interventions to prevent the initial onset of a mental disorder
- Treatment—identification of people with mental disorders and interventions to reduce the length of time the disorder continues, stop the progression of severity, and stop the recurrence of the disorder or increase the length between episodes
- Maintenance—interventions to reduce relapse and recurrence and provide rehabilitation.

*Exhibit 1 (cont.)*

Three levels of prevention have been identified in the literature: *universal*, intended to reach all members of the community; *selective*, directed toward people with some risk, often based on their membership in a vulnerable subgroup; and *indicated*, for people identified as having the greatest risk based on specific symptoms or signs but who lack the criteria for a mental health diagnosis. It is recommended that prevention strategies include all three levels. Prevention in mental health involves reducing risk factors or stressors, building skills, and increasing support. Prevention promotes positive cognitive, social, and emotional development and encourages a state of well being that allows the person to function well in the face of changing and sometimes challenging circumstances.

The MHSA charges the MHSOAC to create an approach to prevention that is integrated, accessible, culturally relevant, strength-based, effective, and that provides the best value for the money....

**School-based Services** Schools, in partnership with community-based mental health organizations, are among the largest providers of mental health services to children. Schools are critical sites to identify children and youth at risk for mental health problems and provide, or offer links to, services and supports. Three key reasons for the critical role of schools are

- Schools' central place in the lives of most children and families
- The fact that mental health problems often first become apparent at school
- The negative effect children's emotional problems have on their learning and school success, as well as the frequent impact of those problems on classroom peers.

Key activities include screening to identify students with early indicators of mental health challenges, and training teachers and other school personnel to identify and respond to the earliest signs of children's mental health concerns and to create a school environment that fosters mental health and resilience.

UCLA's Center for Mental Health in Schools has designated five models of school-based services, all of which can contribute to prevention and early intervention:

- School-financed student support services, such as school counselors
- School-based clinics or health centers: either mental health centers or general health centers with a mental health component
- Formal links with community mental health services, including co-location of community mental health personnel and services at schools, formal linkages with nearby service providers, or contracting with community providers for needed services
- Classroom-based curricula on social and emotional functioning
- Comprehensive, multifaceted, integrated approaches to create a full continuum of services and supports.

An overall priority is to ensure that school-based prevention efforts are integrated into the overall mission, priorities, and culture of schools. Successful models are likely to weave together school, home, and community. School-based services benefit from or require

effective collaboration between education and mental health; such partnerships have not historically existed in most communities.

School special education programs also deliver mental health services and supports to children with mental health disorders; however, special education has not historically placed emphasis on prevention.

School-based mental health programs face numerous challenges, including competing agendas, expanded roles for school and mental health personnel, difficulties sustaining parent and family involvement, and complexities related to evaluating outcomes. Many schools are already struggling with inadequate resources to help their often-stressed students meet mandated academic goals.

Despite these challenges, promising school-based prevention programs have demonstrated success with a broad diversity of students. There is strong and growing evidence that well-designed and well-implemented programs have positive effects on a variety of social, health, and academic outcomes, including mental health.

Various school-based programs have been developed to identify students with emotional or behavior problems that can indicate underlying mental health issues. Screening programs are most effective when they also identify students' strengths and resources. The success of screening programs depends on the availability of effective resources to address the needs of the children identified, and their families.

There has been growing interest in school-based programs that foster social-emotional learning (SEL) and enhance protective factors to increase students' assets and resiliency and reduce their risk for a variety of negative outcomes. These programs work to increase skills in self-management, communication, problem-solving, and resisting negative social influences as their primary focus. These programs have been shown to reduce interpersonal violence and other risk behaviors and increase resilience. Common factors in many successful SEL programs include:

- Multiple components that work with children, parents, and teachers and focus on changing behavior
- Programs that span multiple years
- Integration of programs into the general classroom rather than a separate, specialized approach for a few students
- Inclusion of an entire school, rather than individual classrooms; focusing on creating a positive, supportive school environment

School-based medical clinics with a mental health component are another promising approach. These comprehensive centers treat physical medical problems, and also respond to students' problems or concerns related to emotional distress, relationships, family issues, physical and sexual abuse, drug and alcohol use, exposure to violence and trauma, as well as depression, anxiety, and other symptoms of a potential mental disorder.

Comprehensive school-based clinics combat stigma by offering students, and in some instances their families, an acceptable, accessible, and confidential way to ask for and get help. Data indicate that up to 50% of visits at many clinics are for non-medical issues or concerns. Schools have also been utilized as sites for family support centers, offering comprehensive services for parents and other family members. ...

## County PEI Plans: School Facets

Now we turn to summarizing the prevention and early intervention school based facets of the ten submitted county proposals online as of October 27 (of which six have been approved).

In addition to what was provided in the online county plans, some additional descriptive data on a county is included in the following summaries. These data, abstracted from sources such as the U.S. Census and California's Department of Education, provide a perspective on the nature and scope of the situation in schools and communities across a county.

The summaries offered are taken from different sections of the proposals and regrouped to provide brief overviews of (1) a project's school-based facets (focus, numbers served, budget) and an indication of other PEI programs planned for children, adolescents, and/or their families, (2) plans for leveraging and sustaining the work, and (3) some details conveying the rationale and approach to mental health in schools.

Presented alphabetically, the counties are: Alameda, Glenn, Merced, Modoc, Mono, Monterey, Plumas, San Bernardino, San Mateo, and Solano. Exhibit 2 presents a synthesis of matters raised by stakeholders in the counties about mental health concerns relevant to children and youth. Exhibit 3 highlights what each county proposed for schools.

*Exhibit 2*

**Synthesis of Matters Raised by Stakeholders in the Counties about  
Mental Health Concerns Related to Children and Youth**

Stakeholder discussions underscored what research has indicated about mental health concerns related to children and youth:

- >Many live in stressed families and are exposed to various forms of trauma such as community and family violence
- >Other neighborhood, family, school, peer, and personal factors result in many being vulnerable (“at risk”) with respect to mental health and psychosocial problems
- >Disparities exist with respect to mental health services in terms of availability, access, quality of care, and ability to address the full range of diversity and life circumstances (e.g., ethnicity, race, gender and sexual orientation, primary spoken language, foster placement, juvenile placement, isolated communities, homelessness, development disabilities)
- >PreK-12 schools are not effectively utilized as a mental health services resource for children and youth and most school staff are not provided consultation and training about early symptoms of mental illness
- >Any focus on mental health and drug abuse, gang, pregnancy, and suicide prevention addressing children and programs for transition age youth must respond to the whole person with enhanced opportunities for positive relationships, and more healthy outlets for energy and creativity and concurrent interventions developed for parents, families, and school environments,
- >The need for better information and “social marketing” about mental health and mental illness and how to seek help
- >The need for greater outreach by using nontraditional settings such as homes, schools, neighborhoods, faith-based venues and community organizations to provide information and counter stigmatization
- >The need for more education about the family’s role in recovery
- >The need to enhance all facets of the system to facilitate access and quality, to integrate promotion of mental health, prevention and early identification, and renewed focus on “system of care” for children and adolescents, and to yield a consumer-friendly organization

*Exhibit 3*

**What the Ten Counties Propose for Enhancing Mental Health in Schools**

**Alameda** (submitted) – *Mental Health Consultation in Schools/Preschools* – provides an on-site Mental Health Consultant to schools and preschools; targets preK-12th grade students and their families who are at risk for school failure, suspension/expulsion, suicide and involvement in the juvenile justice system due to conditions of poverty and exposure to trauma.

**Glenn** (approved) – Did not propose any school related activity.

**Merced** (submitted) – *Skill Building in Children 0-13* – Two-pronged strategy includes *Mental Health Training for Educators* and is designed to

- (1) change the culture and understanding of mental health issues within schools and
- (2) provide three programs directly to children within the school (i.e., *Caring Kids, Second Step, Middle School Mentoring Program Expansion*).

**Modoc** (approved) – *Developing Youth and Family Assets* – includes three interrelated programs, two of which involve schools: a community asset-building process that includes schools and the Primary Intervention Program based solely in schools (extending the Early Mental Health Initiative into grades 4-6).

**Mono** (approved) – *Rotating Counselor* – adds a counselor to rotate among Mono County schools.

**Monterey** (approved) – Provides two school-based programs –

- (1) the *School Evidence-Based Practices (Counseling) Program* which adds MH professionals to two additional elementary school sites to address mental health needs early and eliminate or decrease the need for extensive future treatment and
- (2) the *School-based Domestic Violence Counseling program* which provides short term, low intensity group therapy to children who have been exposed to domestic violence.

**Plumas** (submitted) – Did not propose any school related activity.

**San Bernardino** (approved) – three school-based programs –

- (1) the *Student Assistance Program (SAP)* which uses a multi-disciplinary team to provide both universal and indicated services to minimize barriers to learning and support students in developing academic and personal success through asset development; links education, programs and services within and across systems for students and their families;

- (2) the *Resilience Promotion in African-American Children* project aims at mediating the development of Post Traumatic Stress Disorder, mood disorders, other anxiety disorders, substance abuse/misuse, and psychotic disorders; it consists of a 12-week intensive program and on-going weekly interventions, and tracking off site at youth centers, churches, or other community settings through adulthood; also includes a mentoring component and
- (3) the *Preschool PEI Project* targets preschool populations and their parents/caregivers; it involves components for direct service to children and training for parents and early childhood educators on: (a) dealing effectively with challenging behaviors, (b) addressing bereavement and loss, (c) recognizing potential mental health issues, and (d) utilizing school centered interventions with mental health professionals, when appropriate.

**San Mateo** (submitted) – *Project SUCCESS* (Schools Using Coordinated Community Efforts to Strengthen Students) is one part of a project entitled *Community Interventions for School Age and Transition Age Youth* – it is designed to prevent and reduce substance use and abuse and associated behavioral issues among high risk, multi-problem adolescents by placing highly trained prevention and early intervention professionals (Project SUCCESS counselors) in the schools.

**Solano** (approved) – three school-based programs –

- (1) the *School-Based Targeted Student Assistance Program* which serves students in grades 4-8 providing short-term selective early intervention services for those at risk of school failure due to social/emotional issues such as loss of a parent, exposure to substance abuse or domestic violence, parental divorce, lack of social skills or emotional resiliency, or other early indicators of mental health issues; and
- (2) *Educational Liaison to Juvenile Probation Multi-Disciplinary Teams (MDTs)* which serves secondary students who are at risk of or who have had a first contact with the juvenile justice system; will fund the multi-disciplinary team pilot program in Vacaville and expand it to Fairfield and Vallejo and ensure the teams include county social services, mental health and school district representatives to provide mental health and school-related information on academic achievement, attendance and disciplinary issues.

## Alameda

Alameda County occupies most of the East Bay region of the San Francisco Bay Area covering 821 square miles. The San Francisco Bay borders the county on the west. The crest of the Berkeley Hills form part of the northeastern boundary, and reach into the center of the county. A coastal plain several miles wide lines the bay, being home to Oakland and the most populated regions. Livermore Valley lies in the eastern part of the county.

### About the Schools in the County

There are about 213,483 students enrolled in 21 school districts (e.g., 17 unified, 1 elementary, the county, and 2 state special schools) and 394 schools. The school population is fairly evenly distributed across grades. 40 charter schools enroll 10,110. Current population data project the local school-aged population to be 32% Latino, 25% Asian/Pacific Islander (API), 25% White, 12% African American, 5% Multiracial and less than 1% American Indian. Ethnicity concentrations differ from school to school.

With respect to special placements, 1,220 are in alternative schools; 145 are identified as in special education; 2,455 in continuation; 176 in community day; 558 in opportunity; 325 in juvenile court; 191 in county community; 478 in state special schools.

Data from 2006-2007 indicate:

- >Dropouts (grades 9-12) = 2,161
- >Unexcused absences or tardy on 3 or more days = 69,893 (truancy rate = 33%)
- >Expulsions = 510
- >Suspensions = 29,483

### Brief Overview of School Facets of PEI Plan

The submitted PEI plan for Alameda County encompasses eight programs. The intent is to address all ages and a full range of community mental health needs (disparities, trauma, at risk populations, stigma & discrimination, suicide risk). The eight programs are:

- > Mental Health Consultation in Schools/Preschools
- >Early Intervention for the Onset of First Psychosis & SMI Among Transition Age Youth
- >Mental Health Primary Care Integration for Older Adults
- >Stigma & Discrimination Reduction Campaign
- >Outreach, Education & Consultation for *four* specific ethnic communities (i.e., the Latino Community, the Asian Pacific Islander Community, the South Asian and Afghan Community, and the Native American Community).

The one program focused on mental health in schools is designated as *Mental Health Consultation in Schools/Preschools* and is designed for several levels of schooling. It targets

preK-12th grade students and their families who are at risk for school failure, suspension/expulsion, suicide and involvement in the juvenile justice system “due to conditions of poverty and exposure to trauma. Families are self-defined in this project and shall include non-custodial parents and guardians.” Activities are to include outreach, on-site mental health consultation, and screening and evaluation at preschools.

“This project provides an on-site Mental Health Consultant (MHC)... Training and consultation to teachers and other school staff on recognition and effective response to early indicators of mental illness and the onset of psychosis will result in opportunities for early intervention to reduce negative outcomes such as trauma, school failure, involvement in the juvenile justice system, hospitalization and suicide, which may be associated with untreated mental illness.”

“It is expected that the Elementary and Middle School component will serve three to six elementary/ middle schools and the High School component will serve two new place-based health/wellness centers. Schools served by the Elementary and Middle School and High School components will likely be located in multiple regions of Alameda County.”

The project “creates an infrastructure of complementary interventions to provide solutions for underserved children and youth including:

- Providing in-class support for teachers to decrease stigma and assist with mental and behavioral health issues
- Making mental health services available at schools as a support for learning and parent engagement
- Increasing coordination of services to better leverage community mental health resources for schools.”

The work will be staffed by a local education agency or community mental health provider. District, school or classroom staff are to work in collaboration with community based organizations to create a continuum of both school-based and school-linked services.

*Numbers to be served annually (families, students, staff)*

>Preschools = 280 unduplicated families/individuals

>Elementary and Middle = 1575 unduplicated families/individuals

>High Schools = 3535 unduplicated families/individuals

*Total annual nonadministrative budget request for schools = \$491,331*

*Total annual budget request for PEI plan = \$4,983,302*

### **Other PEI Programs for Children, Adolescents, and/or Their Families**

- >Early Intervention for the Onset of First Psychosis & SMI Among Transition Age Youth
- >Stigma & Discrimination Reduction Campaign
- >Outreach, Education & Consultation for the Latino Community, the Asian Pacific Islander Community, the South Asian and Afghan Community, and the Native American Community.

## **Leveraging and Sustaining the Work**

The following were the main points mentioned with respect to leveraging and sustaining:

The PEI project, “in partnership with schools/preschools and community organizations, will leverage city, county, and state dollars to increase access and broaden the infrastructure of support for children, youth and families. In return, schools/preschools and community organizations will provide significant in-kind support including space, equipment, staff and volunteer time, referrals, cross-training, access to caseloads, tutoring, mentoring, after-school programming, general funding and opportunities for Medi-Cal reimbursement. ... In the procurement process, agencies will be asked to describe their plan for leveraging additional resources and/or funding.” ...

“In partnership with existing county, state and community organizations, Mental Health Consultation in schools/preschools will be sustained through leveraging existing resources, and/or ongoing fund development. ... As part of implementation, ACBHCS will assess potential providers’ management and capability to fiscally manage and sustain this program. Fiscal and program monitors will be assigned to the program at start-up. Quarterly progress reports and follow-up will be scheduled to address any emergent issues. Program evaluation will address sustainability and progress in achieving goals. Program success will be sustained through ongoing MHSA funding.”

## **Alameda County Mental Health in Schools: Rationale and Description**

The General PEI Planning Panel selected the *School-Based Mental Health Consultation* “as the most effective strategy to address the community needs relevant to children and youth....” Schools were chosen because they are both “easily accessible and culturally appropriate for youth [and school enrollment is] the most common denominator for Alameda County children and youth. A continuum of care will be created to decrease risk and foster resiliency through collaborative partnerships.”

“Easily accessible, on-site MH consultation, which promotes early identification and referral, has been shown to effectively interrupt the progression to more serious issues such as school failure, involvement with the juvenile justice system and suicide.” “A school may have a limited degree of mental health services, such as academic counselors, school nurses or special education psychologists, but not have adequate psychological counseling services to address the mental health needs of students outside of the special education program.” “Research has shown that school-based mental health consultation is efficacious in increasing young people’s access to and utilization of services, enhancing their protective factors and resilience, and decreasing over the long term negative outcomes that can be associated with untreated mental illness such as school failure, juvenile justice involvement, the onset of serious mental illness, and suicide. In addition, the integration of mental health services into schools ...creates a more seamless service delivery system for children, youth and their families.” “School/ preschool-based mental health services improve educational outcomes by decreasing absences and discipline referrals and improving test scores. ...”

“Students exhibiting emotional or behavioral distress will receive timely screening/ evaluation by the MHC, who will also provide outreach to the family. Service provision will ‘meet the family where they are at’ and focus on their goals through the development of a consumer-driven treatment plan. The student and his/her family will have the support of the MHC as a counselor and family advocate.

Underserved students and families lacking mental health support will receive a culturally responsive assessment, counseling and referral services to ameliorate emotional and behavioral barriers to learning. Through a multidisciplinary team approach, the MHC will coordinate teachers, academic counselors, school nurses and other caring adults to broaden a youth’s support network, including an array of individuals who share a similar racial/ethnic, cultural and linguistic heritage.”

The project is to both initiate new services and expand existing ones. “The proposed interventions will link students and families with the available resources in the school and community including after-school enrichment, tutoring, mentoring, case management, assessment/evaluation, conflict mediation, family counseling, sports and recreation, community service and employment programs.”

This project is split into three components. Component A targets preschool and childcare settings, Component B elementary and middle schools, and Component C high schools.

*A. Preschool and Childcare Settings* – includes mental health consultation at a maximum of 12 preschool and childcare classrooms (depending on the size of the individual classrooms). About 250 children per year, with between 30-40 receiving more intensive consultation with their teachers and families (also called “collateral” therapy). This component builds upon the success of a number of existing local programs (e.g., Alameda County First Five).

*B. Elementary and Middle Schools* – includes clinical case management and consultation in 3-6 new elementary/middle school sites (depending on the size of the individual schools). About 1,500 children and youth per year, with between 75-135 students receiving brief therapy/case management or more intensive consultation (collateral therapy) with their teachers and families. This component builds upon the Our Kids Program, which is currently run through the Alameda County Health Care Services Agency (ACHCSA) School Health Services Coalition and now serves 28 local elementary and middle schools.

[Note: The local Our Kids Model, is currently used in the Oakland and Hayward Unified School Districts. It is described in the proposal as an umbrella project that will utilize many of the programs listed in the PEI Resource Materials, e.g., the Red Flags Curriculum, Strengthening Families Program (SFP), Reconnecting Youth, Trauma-Focused Cognitive Behavioral Therapy, Parents and Teachers as Allies, Signs of Suicide (SOS), Coping and Support Training, and Parent Project.]

*C. High Schools* – includes mental health consultation and coordination at two new place-based health and wellness centers that serve high school students. About 3,500 youth per year, with between 200-400 key stakeholders including school staff, families and students receiving training on mental health issues and between 35-40 students receiving more intensive case management or consultation with their teachers and families. In addition, the Mental Health Consultant/Coordinator will provide the foundation for starting-up and coordinating a greater array of mental health counseling/therapy services at these sites. This component builds upon the School-Based Health Center model. School-Based Health Centers now sit in 10 high school sites in Alameda County provided by a number of different agencies including CBOs, school districts and city agencies. These services are currently coordinated through the ACHCSA School Health Services Coalition, which provides technical assistance to both existing and emerging program sites.

[Note: The High School component, the School-Based Health Center Model, is described as another umbrella project that will utilize many of the programs listed in the PEI Resource Materials.]

The program expects the following results: “Consumers, family and the community will see a higher rate of engagement by school staff and families in the proactive resolution of behavioral health issues. School/preschool-based mental health services will improve educational outcomes by decreasing absences and discipline referrals and improving test scores. The community will see an improvement in services as measured by satisfaction surveys due to increased collaboration among mental health services and education. School staff and teachers will show an increased knowledge of children and youth’s social, emotional and behavioral issues. For example, a 2006 survey of teachers showed that 51% felt that mental health consultation changed the way they thought about children’s emotional development and 72% reported it changed the way they thought of children’s social development.”

The proposal stresses: “It is important to note that the portfolio of PEI projects is not meant to stand alone; it is meant to complement and expand the network of existing local programs and the new programs that are now being developed through other MHS funding streams, including Community Services and Supports (CSS) and Workforce Education and Training (WE&T).” “The exact ethnic populations to be served will be determined by the location of these services within Alameda County.”

## Alameda County Demographics

The County usually is described in four regions; North, Central, South and East County. North County contains 42% of Alameda County's population. It consists of the cities of Alameda, Albany, Berkeley, Emeryville and Oakland. Central County holds 23% of the entire county's population and is comprised of the cities of Hayward, San Leandro and unincorporated areas of Castro Valley, San Lorenzo, Cherryland, Ashland and Fairview. South County is home to 22% of the county's population and includes the cities of Fremont, Newark and Union City. Lastly, East County holds 13% of the county population and is defined as the cities of Dublin, Livermore, Pleasanton and the unincorporated area of Sunol.

The proposal notes: "A number of high need communities exist throughout Alameda County. For example, 69% of the students that attend Oakland public schools are enrolled in the program for free and reduced price lunches, an indicator of economic need. Many families living in conditions of poverty lack basic health insurance and mental health coverage. ... the vast majority of youth in the juvenile justice system are economically disadvantaged, with African Americans representing a disproportionate 53% of the youth entering into juvenile hall."

As of the 2000 census:

- >Population = 1,443,741 (population density averages 1,957 people per square mile)
- >Households and Families = 523,366 households and 339,141 families
  - (32.6 of households had children under the age of 18 living within them;
  - 47.0% married couples living together; 13.0% had a female householder with no husband present; 35.2% were non-families; 26.0% of all households were made up of individuals and 7.3% had someone living alone who was 65 years of age or older. The average household size was 2.71 and the average family size was 3.31.)
- >Median age = 34 years
  - (With respect to age spread, 24.6% are under the age of 18; 9.6% from 18 to 24; 33.9% from 25 to 44; 21.7% from 45 to 64; and 10.2% who were 65 years of age or older.)
  
- >Per capita income for county = \$26,680
- >Median income
  - >>household = \$55,946
  - >>family = \$65,857
  - >>Males = \$47,425
  - >>Females = \$36,921
- >Number below poverty line
  - >>11.0% of the population
  - >> 7.7% of families
  - >>13.5% of those under age 18
  - >> 8.1% of those age 65 or over

As reported in the proposal, the racial makeup of the county is 829,275 (38%) White non-Hispanic individuals; 367,271 (26%) APIs; 311,889 Hispanic/Latinos; 199,667 (14%) Black/African American individuals; 51,009 (4%) Multi-Racial/Other individuals and 10,202 (1%) Native Americans. Additionally, twenty-seven percent of the population is born outside of the United States. Moreover, 37% of Alameda County's population over the age of five speaks a language other than English at home. According to the 2000 census, 63.2% spoke English, 14.3% Spanish, 5.0% Chinese or Mandarin, 3.5% Tagalog, 1.6% Vietnamese and Cantonese as their first language.

## Glenn

Glenn County is located in the Central Valley, in the northern part of California. It covers 1,327 square miles. The county seat is the city of Willows.

### About the Schools in the County

There are almost 6,000 students enrolled in 10 school districts (4 unified, 4 elementary, 1 high school, and the county) and 36 schools. A charter school enrolls 135. The school population is fairly evenly distributed across elementary and secondary grades. With respect to special placements, 134 are identified as in special education; 93 in continuation; 45 in community day; 43 in opportunity; 17 in juvenile court; 135 in county community.

Data from 2006-2007 indicate:

- >Dropouts (grades 9-12) = 101
- >Unexcused absences or tardy on 3 or more days =688 (truancy rate = 12%)
- >Expulsions = 18
- >Suspensions = 732

*Glenn County did not propose any school related activity.*

The submitted plan is to focus on two programs:

- >Welcoming Families Project: Newborn Home Visiting Program
- >Warm Line Project: providing info about local resources and to provide support.

*Total annual budget request for PEI plan = \$155,300*

### Glenn County Demographics

As of the 2000 census:

- >Population = 26,453 (population density averages 20 people per square mile)
- >Households and Families = 9,172 households; 6,732 families  
(38.1% of households had children under the age of 18 living within them;  
56.7% married couples living together; 10.9% had a female householder with no husband present; 26.6% were non-families; 22.0% of all households were made up of individuals and 10.7% had someone living alone who was 65 years of age or older. The average household size was 2.84 and the average family size was 3.33.)
- >Median age = 34 years  
(With respect to age spread, 30.8% are under the age of 18; 8.7% from 18 to 24; 26.8% from 25 to 44; 20.7% from 45 to 64; and 13.0% who were 65 years of age or older.)

>Per capita income for county = \$14,069	>Number below poverty line
>Median income	>>18.1% of the population
>>household = \$32,107	>>12.5% of families
>>family = \$37,023	>>26.3% of those under age 18
>>Males = \$29,480	>> 7.6% of those age 65 or over
>>Females = \$21,766	

According to Census 2000, the racial makeup of the county was 71.78% White, 0.59% Black or African American, 2.09% Native American, 3.38% Asian, 0.13% Pacific Islander, 18.18% from other races, and 3.86% from two or more races. 29.64% of the population were Hispanic or Latino of any race. 10.8% were of German, 9.4% American, 6.2% English and 5.9% Irish ancestry. 69.5% spoke English, 27.0% Spanish and 2.1% Hmong as their first language.

## Merced

Merced County lies in the heart of California's San Joaquin Valley and covers approximately 2,000 square miles.

As reported in the plan: "Formerly characterized by small rural agricultural communities, in recent decades, as more families are attracted to the affordable housing, expanding economy and small town 'feel', Population centers are clustered along two parallel freeways, Highway 99 and Interstate 5. The County seat, Merced City, is located along the southern end in Highway 99. The next largest city, Los Banos, is located 35 miles away along Interstate 5. This geographic distance between communities has resulted in distinct cultures and attitudes. Los Banos and neighboring Dos Palos, Gustine, Volta and Santa Nella are often referred to as "West County," and access to services are a major concern. In addition to the geographic divide there is also an "urban/rural" divide. Most of the towns in Merced County are very small and accessing nearly all public services requires significant travel.

The primary industry in Merced County is agriculture, although service sectors, health care, and education make up a growing proportion of the local economy. UC Merced recently began accepting undergraduate students.... Los Banos and other West County communities are frequently characterized as commuter towns with a large portion of the residents driving to San Jose and other Bay Area cities for work everyday."

### About the Schools in the County

There are about 57,000 students enrolled in 21 school districts (e.g., 5 unified, 13 elementary, 2 high, 1 county) and 102 schools. The school population is fairly evenly distributed across grades. 2 charter schools enroll 617. The school population is fairly evenly distributed across elementary and secondary grades. With respect to special placements, 336 are in alternative schools; 575 are identified as in special education; 758 in continuation; 270 in community day; 114 in juvenile court; 890 in county community.

Data from 2006-2007 indicate:

- >Dropouts (grades 9-12) = 594.
- >Unexcused absences or tardy on 3 or more days = 13,137 (truancy rate = 23%)
- >Expulsions = 177
- >Suspensions = 120,230

As stated in the plan:

"The educational attainment and English language proficiency of the County's population are important characteristics to consider when designing interventions. Data from the US 2000 Census illustrates that many in the County have lower levels of educational attainment and lack English language proficiency. School district data provides more insight into the language capacity of the County. In the 2004-2005 school year, 32% of students in the County were classified as English Language Learners, the vast majority of whom were Spanish speakers (27% of all students). Included in this group were also Hmong, Punjabi, Portuguese, and Mien speakers. The elementary school districts with the greatest proportion of English Language Learners were Planada (71%), Livingston Union (61%), Winton (58%), El Nido (54%), Le Grand Union (46%), and Ballico-Cressey (45%)."

## Brief Overview School Facets of the PEI Plan

The submitted PEI plan for Merced County encompasses four projects:

- >Public Awareness and Education
- >Skill Building in Children 0-13
- >Life Skills for At-Risk Transitional Age Youth 14-25
- >Integrated Primary Care and Mental Health

Of the four, *Skill Building in Children 0-13* is most directly involved with schools. It will encompass four subcontracted programs. The program aims to (1) change the culture and understanding of mental health issues within schools and (2) provide three programs directly to children within the schools.

>The Project will begin with *Mental Health Training for Educators* related to the importance of appropriate mental health prevention and early intervention programming in the schools. The aim is to (1) promote an awareness of mental health issues and give information on how to recognize signs and symptoms and how to access assistance when it is needed and (2) enhance interest and support for the range of services offered through the Skill Building Project. An RFP will be used to acquire one or more providers to offer mental health training in English and Spanish for (a) early care and education staff and child care providers and (b) school teachers (grades k-12). “Training activities will be coordinated by Merced County’s Mental Health Department and will be conducted by a collaboration of local agencies, including ACCESS (the local Child Care Resource and Referral Agency), the Office of Education, and other community based organizations, including consumer focused organizations. \$64,500 is available to purchase speakers and resource materials and to award stipends for teacher participation. Activities will be conducted within the first 12 months and are intended to build support for the instillation of the other three skill building programs within various educational settings. The \$64,500 in funding hopes to cover school costs of \$100 for a two hour substitute for 500 teachers and \$14,500 to pay for speakers and training materials.”

The three school-based programs for students target different age groups, and the intention is for program coordinators to “feed” children to the next level program as they “age out” of an earlier program. The programs are:

>*Caring Kids* which is and will continue to be provided by the Merced County Office of Education. The intent is to expand this program for “(a) screening large numbers of young children in multiple environments for social, emotional, developmental, or behavioral delays, (b) teaching strategies to child care providers and early care and education staff with children 0-5 who are identified with social, emotional, or behavioral delays to develop social competence and resilience in children in their environments, (c) providing one-on-one assessment and early behavioral intervention for children 0-5 and facilitating referrals for more long-term interventions to Merced County Interagency Children’s Roundtable, Mental Health Department or special education, and (d) conducting parent trainings (for groups and individuals) and home visits as necessary to teach parenting strategies and support the development of home environments that promote social competence in young children and assist parents in responding well to children with social, emotional, and behavioral delays.

The expansion ... is intended to both increase capacity to serve more children and to enhance the service delivery through one time funding (\$25,000) for training, materials, and equipment needed to enhance programming and to build the capacity of the program to have more staff for the program expansion. The annual allocation of \$160,000 for the program expansion will be used for four part-time staff members. It is anticipated that with the additional funding Caring Kids will be able to serve 300 of additional children and their families and provide an average of 30 hours of intervention services to each child identified of being at-risk of future school failure or mental health issues.”

>*Second Step* is and will continue to be provided by the Merced County Office of Education. The project objectives are to “(a) provide training and curricula materials for elementary school classrooms k-3, (b) provide fidelity oversight to the program, (c) provide for teaching assistants at schools to ensure model integration, and (d) provide for one Second Step Coordinator to work with participating schools.” The program includes screening.

“The expansion ... is intended to both expand capacity to serve more children and enhance service delivery through one time funding (\$50,000) for training, materials and ongoing fidelity support and consultation by the Committee for Children, the creators of the Second Step program. With this funding enhancement six new schools will be eligible to implement the Second Step program serving approximately 216 children and their families. Funding will be allocated as follows: \$66,000 to provide 12 hours of supervision for 48 weeks at six new sites and \$80,000 to provide part time teaching aides at six school sites to conduct small group sessions (up to four students) with children identified as benefitting from this intervention. \$34,000 (19% of total program costs) will be allocated for indirect costs, project supervision, materials and facility space.”

>*Middle School Mentoring Program Expansion* is and will continue to be provided by the Merced County Alcohol and Drug Programs, Prevention Unit. The project objectives are to (a) enhance curricula to include *Across the Ages* evidence based mentoring components to improve positive relationships and attitude towards school and (b) expand target schools from three sites with six schools to nine sites with eighteen schools.

*Numbers to be served annually:*

- >Mental Health Training for Educators = 500 individuals
- >Caring Kids (program expansion) = 300 individuals; 300 families; ECE staff;  
Early Intervention = 5 individuals and 5 families
- >Second Step = 216 individuals and 216 families
- >Middle School Mentoring (program expansion) = 168 individuals

*Total budget nonadministrative request for school-oriented programs = \$544,500*

*Total annual budget request for PEI plan = \$1,903,000*

## **Other PEI Programs for Children, Adolescents, and/or Their Families**

>Life Skills for At-Risk Transitional Age Youth 14-25

>Integrated Primary Care and Mental Health

[Note: The *Transition to Independence* program included in the County's proposal will serve 15 individuals aged 14-17 and 30 individuals aged 18-25 and will connect with schools as appropriate.]

### **Leveraging and Sustaining the Work**

The following were the main points mentioned with respect to leveraging and sustaining:

“This PEI Skill Building Project will promote collaboration and partnership with community based organizations and service agencies by conducting trainings and education sessions within public elementary and middle schools and child care providers, since these institutions are deeply embedded in the community.” “The potential to leverage additional MHSA funding proved to be critical in retaining existing funding for at least one very successful program.” “All funding released in Merced County through the Prevention and Early Intervention Component of the Mental Health Services Act will be made available through a formal RFP and/or MOU process. All funded entities will be asked to demonstrate the ways in which their activities reach out to underserved and isolated communities including language/cultural communities and the many geographically isolated communities of Merced County.”

“Funding will primarily be used to expand capacity and enhance programming of existing programs. Caring Kids will be a true county-wide public/private partnership, receiving core funding from First 5 Merced County, expansion funding from Merced County Mental Health, and in-home and child care services from the Office of Education.”

## **Merced County Mental Health in Schools: Rationale and Description**

(1) *Mental Health Training for Educators of Children 0-13* – During the planning process parents continually expressed dismay that teachers and other professionals did not know enough about mental health to refer them for an assessment. A countywide effort will be made to help teachers understand mental health issues and identify students for screening and referral earlier. This component envisions mental health classes that reach into every child care center and family day care home in the county and teacher trainings that are mandatory for all school staff on the topic of mental health. The classes will be offered one time. One or more existing Merced County programs will likely be funded for this work.

“Training will include information about what mental illnesses are, what causes them, prevalence, behaviors indicative of mental illness, and what to do about it. Trainings will discuss a broad spectrum of risk factors as well and talk about childhood depression, anger, violence, eating disorders, and substance use in the context of mental health. It will also help educate teachers on the difference in development and appropriate expectations for children with mental health issues or early onset of mental health illnesses.” The classes also will help “advertise the availability of new prevention and early intervention resources in the county and will talk to teachers and school staff about the existing programs available to come to their schools to aid prevention and early intervention efforts. This approach will build early buy-in for the three programs described below.”

(2) *Caring Kids* – “Rather than spend resources on training and fidelity support of a new model program, the Planning Council unanimously agreed to use the PEI funding to expand services for a known and trusted community program.” Caring Kids is an evidence-based model (similar to *Incredible Years*) and has a successful history in the County. Research indicates a statistically significant impact on reducing problem behaviors and increasing social skills (e.g., reports indicate that 70% of participants improved to the extent that they no longer qualified as having high problem behaviors and/or low social skills).

Expansion of this program will increase staff so that services can be provided to more children and families in a wider array of community environments. The approach uses a “positive behavioral support” model to deliver direct services as well as provides teachers, parents, and child care providers with skills and strategies to (a) assess current and ongoing social behaviors, (b) teach new socially acceptable skills, (c) ensure that the resources and services necessary for appropriate social and emotional development are available and implemented, and (d) include parents and child-care providers as partners in the process).

PEI funding will enable expansion to work with preschools and early childhood education centers, more individual activities in homes, and more direct services for those parents who seek assistance outside child care setting. Training will include a focus on infant MH (0-12 months) and on working with parents in different cultural contexts.

(3) *Second Step* – Based on the program’s current success in three Merced County elementary schools, the importance of expanding this program was supported by parents, school administrators, and community planning participants. Expansion will enable more schools to implement the Second Step curriculum. Children served through Caring Kids will be referred to this program as appropriate. Databases for this purpose will be requested through the Information Technology component of the MHSA funding.

“Second Step is a classroom-based social-skills program for children 4 to 14 years of age that teaches socio-emotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. The program builds on cognitive behavioral intervention models integrated with social learning theory, empathy research, and social information-

processing theories. The program consists of screening, in-school curricula, parent training, and skill development. Second Step teaches children to identify and understand their own and others' emotions, reduce impulsiveness teaches children to identify and understand their own and others' emotions, reduce impulsiveness and choose positive goals, and manage their emotional reactions and decision making process when emotionally aroused. The curriculum is divided into two age groups: preschool through 5th grade (with 20 to 25 lessons per year) and 6th through 9th grade (with 15 lessons in year 1 and 8 lessons in the following 2 years). Each curriculum contains five teaching kits that build sequentially and cover empathy, impulse control, and anger management in developmentally and age-appropriate ways. Group decision making, modeling, coaching, and practice are demonstrated in the Second Step lessons using interpersonal situations presented in photos or video format.”

Second Step funding will be granted to the Merced County Office of Education with a charge to expand the program county wide based on principal commitment and school need and risk factors for mental health. The program will be overseen by a coordinator housed within the Office of Education.

(4) *Middle School Mentoring* (aka Friday Night Live) – Based on stakeholder feedback of the need for a greater focus on middle schoolers, an expansion of the middle school mentoring program was included. The program is an extension of a state funded alcohol and drug prevention program for middle school children that targets the highest risk eighth graders. Through the expansion, the Merced County Alcohol and Drug Programs Prevention Unit will implement it in every middle school (six additional sites). Funding will support an additional full time staff position and the purchase of curriculum materials and training.

The program works toward alcohol and drug prevention through a peer mentoring model, pairing trained high school leaders with at-risk eighth graders. “Each site is comprised of a Middle School and a partnering High School. Fourteen additional eighth graders and 14 additional high school mentors will be identified for each site, serving an additional 168 children, 84 of whom are identified as high risk.” Core curriculum activities include education about the ill effects of alcohol and drugs. The expansion will include an incorporation of components of *Across Ages*, which is a SAMHSA approved evidence based mentoring program designed to improve attitudes towards school, peer relations, and adults.

The mentoring program also is seen as providing a greater opportunity to connect a trusted young person to work with middle school children should a crisis arise. All youth mentors will be trained in MH issues, how to talk with middle school children, and when to ask for adult help. Mentors will be trained to “help identify middle school children for whom a more serious intervention is needed as when there are suspected instances of cutting, eating disorders, or other more serious mental health issues or traumas.”

As a result of the school-based work, Merced County expects to

- >reduce the psycho social impact of trauma
- >improve the lives of at risk children
- >reduce stigma and discrimination by talking more openly about mental health issues
- >increase protective factors.
- >increase knowledge about and negative attitude toward drug use and decrease alcohol and tobacco use
- >increase school attendance, decreased suspensions from school, and improved grades
- >improve attitudes toward school and the future
- >improve attitudes toward adults in general and older adults

## Merced County Demographics

As noted in the proposal: “Merced County has the youngest population of any California county; thirty-four percent of the population is under 18, 29% is under 15, and 9% is under 5. Seventy-five percent of those under five are minorities, with Latinos representing the bulk of this group.

Merced County has been hit very hard by recent economic downturns. Household median income in Merced is far below the State average (\$38,000 vs. \$53,000) and home prices have declined 35% in the past year. In the past months Merced foreclosure rates have been some of the highest in the nation. The April 2008 unemployment rate for Merced County was 12.3% (13,900 unemployed), nearly double the state rate of 6.3%.

Merced residents are less likely to have medical insurance than the average Californian, irrespective of age. Central Valley-wide, the percentage of all children under age 18 lacking health insurance is twice the State rate of 8.6%, according to Children Now and the CHIS. Golden Valley Health Clinics, a major provider of health care in the County, serving 40,000 residents annually (or 20% of all county residents) estimates that approximately one third of their patients are farm workers (12,800) and nearly 40% (16,000) have no insurance at all.”

As of the 2000 census:

- >Population = 210,554 [255,000 reported in the plan as a 2008 estimate]  
(population density averages 109 people per square mile)
- >Households and Families = 63,815 households and 49,775 families  
(45.4% of households had children under the age of 18 living within them;  
57.8% married couples living together; 14.1% had a female householder with no husband present; 22% were non-families; 17.7% of all households were made up of individuals and 7.4% had someone living alone who was 65 years of age or older. The average household size was 3.25 and the average family size was 3.69.)
- >Median age = 29 years  
(With respect to age spread, 34.5% are under the age of 18; 10.3% from 18 to 24;  
27.9% from 25 to 44; 17.8% from 45 to 64; and 9.5% who were 65 years of age or older.)
  
- >Per capita income for county = \$14,257
- >Median income
  - >>household = \$35,532
  - >>family = \$38,009
  - >>Males = \$31,721
  - >>Females = \$23,911
- >Number below poverty line
  - >>21.7% of the population
  - >>16.9% of families
  - >>28.4% of those under age 18
  - >>10.7% of those age 65 or over

According to Census 2000, the racial makeup of the county was 56.21% White, 3.83% Black or African American, 1.19% Native American, 6.80% Asian, 0.19% Pacific Islander, 26.13% from other races, and 5.65% from two or more races. 45.34% of the population were Hispanic or Latino of any race. 6.6% were of Portuguese and 6.0% German ancestry. 55.1% spoke English, 35.3% Spanish, 3.2% Hmong, 2.9% Portuguese and 1.0% Panjabi as their first language.

## Modoc

Modoc County is located in the far northeast corner of California. It covers 4,203 square miles. The current county seat is Alturas, the county's only incorporated city. A large portion of Modoc County is federal reservations. A variety of overlapping government agencies form a significant part of the economy and provide services to this rural area. The federal presence includes the US Forest Service, Bureau of Land Management, National Park Service, Bureau of Indian Affairs, and the US Fish and Wildlife Service.

### About the Schools in the County

There are about 2,200 students enrolled in 4 school districts (e.g., 3 unified, 1 county) and 23 schools. The school population is fairly evenly distributed across grades. 1 charter school enrolls 471. The school population is fairly evenly distributed across elementary and secondary grades. With respect to special placements, 37 are identified as in special education; 33 in continuation; 13 in community day; 25 in juvenile court; 19 in county community.

Data from 2006-2007 indicate:

- >Dropouts (grades 9-12) = 28
- >Unexcused absences or tardy on 3 or more days = 501 (truancy rate = 23%)
- >Expulsions = 24
- >Suspensions = 314

### Brief Overview of School Facets of PEI Plan

The approved plan for Modoc County is entitled *Developing Youth and Family Assets in Modoc County*. It includes three interrelated programs, one of which is based solely in schools and another includes schools. The three programs are: “(1) a community asset-building process based on implementing projects to address the 40 Developmental Assets in various sites and community settings, utilizing public and private partners to identify asset-building settings and train and encourage child and family activities; (2) development of a Primary Intervention Program that extends local success with the Early Mental Health Initiative into grades 4-6; and (3) expansion of the Strengthening Families Program curriculum, which supports skill building with parents and children, to increase the frequency of programs for parents and children ages 6-12 and 13-18, and to add a curriculum for children ages 3-5 and their parents.

With respect to assets building, activities are to include:

- outreach and engagement with schools, public and private agencies, faith-based organizations, civic organizations, recreational organizations, and others
- Training for trainers willing to participate in asset building, including training in Spanish and specific outreach to Hispanic and Native American groups and communities to identify cultural specific asset building activities
- background and inspirational training on individual assets and their power to affect youth development; baseline survey of young people to identify assets; activities to identify target assets and strategies to improve assets in young people
- Continued operation of the Prevention Collaborative to support and encourage asset development
- Expanded outreach to identify isolated or high risk young people and individuals/communities that can support their asset development

(1) *Community Asset Building* – “It is anticipated that asset building activities will take place in one school district and two or more youth settings in the first year. The goal is to have a total of 500 children participate in 40 Developmental Assets surveys to establish their asset development. Planned activities are to address specified assets in each location in the first year.

(2) *Primary Intervention Program* – While not described in the plan, the usual program description (see <http://www.childrensinstitute.net/>) states it is designed to enhance the social and emotional development of young students experiencing mild to moderate school adjustment difficulties. Early screening detects school adjustment difficulties. Once the systematic screening is done to determine which children will benefit, each child is paired with a trained and supervised paraprofessional (referred to as a child associate). Each paraprofessional works to foster a healthy self-concept and to develop social skills in the child – skills necessary for improving social and school adjustment. The model calls for the pair to spend 30 to 40 minutes a week together. The setting for primary grade students is “a safe and welcoming playroom environment. Expressive play is the primary activity, with the child setting the pace. The child associate participates in the play only when invited by the child and supports and reflects on what the child says and does. This playtime reinforces and builds upon the child's strengths.”

Activities as described in the PEI plan will include:

- Identification of school site in-kind resources to support Primary Intervention Program
- Development of referral protocols for services at the classroom site, that are culturally competent and that identify children at risk of school failure for Primary Intervention Program services
- Development of parent involvement efforts to assure that parents/guardians and teaching staff support children’s participation and growth in the Primary Intervention Program
- Development of referral protocols with Modoc County Mental Health for students and families who need more intensive services
- Establishment of tracking and monitoring tools to determine effectiveness

*Proposed number of individual or families to be served:*

>*Community Asset Building* – First year 500 children surveyed  
 (“Planned activities are to address specified assets in each location in the first year”)

>Primary Intervention Program: 50-100 children in grades 4-6 (two schools in the first year)

*Total annual nonadministrative budget request relevant to school facets = \$40,000*

*Total annual budget request for entire plan = \$120,500*

### **Other PEI Programs for Children, Adolescents, and/or Their Families**

>Extension of the Strengthening Families programs and adding a curricula for ages 3-5.

### **Leveraging and Sustaining the Work**

The following were the main points mentioned with respect to leveraging and sustaining:

*Community Asset Building* – “Modoc County Prevention Collaborative offers the opportunity to leverage PEI funds with funding available from the education system.” “Modoc County Office of Education has provided funds for initial training and orientation on 40 Developmental Assets, and has contracted for specific training with Tulelake Unified School District and the Alturas community under the auspices of the Prevention Collaborative. Tulelake Unified School District has committed to provide staff to be trained as facilitators, and classroom time for surveys and activity development. Every member of the Prevention Collaborative has committed to expand collaborative partnerships to include a wider range of recreation providers, faith community leaders, and civic organizations that can identify facilitators, participate in site-based surveys of children and youth, and participate in the identification and implementation of asset-building activities.”

*Primary Intervention Program* – “This program will utilize a formal MOU between Modoc County Mental Health and MCOE.... Modoc County Office of Education has committed to providing management and supervision to identify classrooms, leverage administrative and supervision resources from selected school sites, hire classroom aide staff, and administer pre- and post-tests to participating children MCOE has experience with managing Early Mental Health Initiative programs and will utilize this experience to assure that our program meets research-based program guidelines. The MCOE will identify school locations willing to site the new program, based on the school district’s willingness to provide space, child referrals, supervision and other in-kind management supports....”

## **Modoc County Mental Health in Schools: Rationale and Description**

Both programs were selected as evidence-based practices and our County Office of Education experience with the Early Mental Health Initiative in Grades K

*Community Asset Building* – “The Prevention Collaborative has initiated and supported parenting education and other youth activities, including 4-H, Boy Scouts, After School Programs, sports programs, and health-based prevention education programs.” The community is seeking the “unifying focus of a community-wide commitment to develop assets for our children and youth.” The Collaborative arranged a half-day training and consultation session with the Search Institute in February 2007, to review in detail national experiences with a community-wide effort to build child, youth and family assets. This led to a desire for training and coordination of programs and activities to build 40 Developmental Assets.

“The goal of this effort is to involve all of Modoc County, including every geographic area of the county and public and private, faith community, recreational and civic groups in the development of activities and program to support asset building with children and youth. Initially, the Prevention Collaborative will begin with training in the Tulelake Joint Unified School District, in the northwest corner of the county. This initial training will be followed by a train-the-trainers effort in Alturas in the central part of the county....”

*Primary Intervention Program (PIP) Grades 4-6* – Stakeholders sought an early intervention program that can supplement the broad community asset building efforts to “meet the needs of children with early indications of trauma, school difficulties and family problems.” The Primary Intervention Program was identified (known in California as the Early Mental Health Initiative). The intent is to extend the program to Grades 4-6.

As described by the developers, PIP is designed to enhance the social and emotional development of young students experiencing mild to moderate school adjustment difficulties. After screening to detect which children need and will benefit, each student is paired with a trained and supervised paraprofessional. For primary grade students, the model calls for the pair to spend 30 to 40 minutes a week together.

To assess the intended *outcomes for individuals*, the project intends to use responses to the following questions on the state’s *Healthy Kids Survey*: (a) Do you feel safe at school? (b) Do you feel safe outside of school? (c) Have you been hit or pushed or had rumors spread about you? (d) Have you hit or pushed other kids or spread rumors about other kids? (e) Does the child experience meaningful participation at home and in school?

With respect to *system outcomes*, the focus is on adoption of a commitment to improving the assets of Modoc children and youth, measured by an improvement in assets as measured by the Healthy Kids Survey. A strengthened Prevention Collaborative and an increase in resources devoted to children and youth also are expected. And, it is expected that there will be improvement in the capacity of schools to meet the needs of children in stressed families and an increase in County Mental Health services to children.

## Modoc County Demographics

As of the 2000 census:

- >Population = 9,449 (population density averages 1 person per square mile)
- >Households and Families = 3,784 households and 2,550 families  
(29.1% of households had children under the age of 18 living within them;  
54.6% married couples living together; 8.8% had a female householder with no  
husband present; 32.6% were non-families; 28.1% of all households were made up of  
individuals and 12.7% had someone living alone who was 65 years of age or older. The  
average household size was 2.39 and the average family size was 2.91.)
- >Median age = 42 years  
(With respect to age spread, 25.6% are under the age of 18; 5% from 18 to 24;  
23.3% from 25 to 44; 27.7% from 45 to 64; and 17.6% who were 65 years of age or  
older.)
  
- >Per capita income for county = \$17,285
- >Median income
  - >>household = \$27,522
  - >>family = \$35,978
  - >>Males = \$30,538
  - >>Females = \$23,438
- >Number below poverty line
  - >>21.5% of the population
  - >>16.4% of families
  - >>29.7% of those under age 18
  - >> 8.6% of those age 65 or over

According to Census 2000, the racial makeup of the county was 85.94% White, 0.69% Black or African American, 4.21% American Indian, 0.61% Asian, 0.07% Pacific Islander, 5.69% from other races, and 2.78% from two or more races. 11.51% of the population were Hispanic or Latino of any race. 13.9% were of American, 13.1% English, 12.2% Irish and 11.7% German ancestry. 90.4% spoke English and 8.8% Spanish as their first language.

Modoc County has been identified as having the county with the lowest median household income in California. At the same time it has been noted that since 2000 there has been a 40% increase in median home price (reaching \$100,000 for the first time in 2005). Much of this is attributed to an influx of residents from other parts of the state who find the housing bargains attractive. The rise in housing prices has made home purchasing unaffordable for many locals given their limited incomes.

## Mono

Mono County is located in the east central portion of California, to the east of the Sierra Nevada between Yosemite National Park and Nevada and covers 3,132 square miles.

### About the Schools in the County

There are roughly 1,900 school aged children in the county spread out amongst eleven schools and 3000+ square miles. In addition to the county districts, there are two unified school districts (Eastern Sierra Unified, Mammoth Unified) encompassing 19 schools. 1 charter school enrolls 30 students. The school population is fairly evenly distributed across grades and mirrors the County demographics (roughly 4% Native American, 20% Latino and 76% Caucasian).

With respect to special placements, 201 are identified as in special education; 26 in continuation; 17 in opportunity; 3 in community day; 17 in county community.

Data from 2006-2007 indicate:

- >Dropouts (grades 9-12) = 64
- >Unexcused absences or tardy on 3 or more days = 211 (truancy rate = 8%)
- >Expulsions = 16
- >Suspensions = 125

### Brief Overview of School Facets of PEI Plan

Since there is a great deal of overlap within the two priority populations (i.e., children and youth) identified by stakeholders, it was overwhelmingly decided to focus on schools. The planners concluded that one intervention program, a *School Counseling Program*, would adequately reach both children and youth. The approved plan is to run for roughly one year.

“Mono County proposes to partner with the two local school districts, Mammoth Unified (MUSD) and Eastern Sierra Unified (ESUSD), as well as with the Mono County Office of Education (MCOE) to place a rotating counselor in Mono County schools. Our proposed program is Universal in nature. The rotating counselor would be an employee of Mono County Mental Health and would be a licensed or license-eligible mental health clinician. This individual would provide the following school-based services:

- >Family intervention and counseling (brief intervention model)
- >Individual counseling for youth (brief intervention model)
- >Support groups on a variety of topics to include children of divorce, anger management, alcohol/drug topics, and topics relevant to growing up in a very isolated, rural environment
- >Helping youth with decision making, values clarification and refusal skills
- >Promoting a positive peer culture and pro social behaviors
- >Encouraging development of self esteem.”

*Proposed number of individuals and families to be served through June 2009 by type:*  
 Students = 325; Parents = 150 (it is anticipated that out of 120 families served,  
 perhaps 30 would have two parents)

*Total annual budget request for PEI plan= \$181,100*

### **Other PEI Programs for Children, Adolescents, and/or their Families**

None

### **Leveraging and Sustaining the Work**

The following were the main points mentioned with respect to leveraging and sustaining:

Mono County Mental Health has already entered into an active dialogue with the school boards and site principals to determine what is needed at each school. Our experience from the Safe and Drug Free Schools project was that each campus had substantively different needs. In order to provide sensitive and readily accepted customer service, we have historically crafted our offerings to meet the individual needs of each school campus. By the time that the staff person has been hired, Mono County Mental Health will have an idea of which days and times the clinician will be available on each campus. The newly hired staff person will then spend time visiting each campus and meeting key administrative and teaching personnel. After this initial time period, s/he will begin providing services. As noted earlier, Mono County plans to use some MHSA CSS resources to add at least one half additional FTE to this school-based prevention/early intervention effort.”

“Relationships and collaborations with the schools, primary care, other governmental entities and the domestic violence provider have been amply described elsewhere within this document. The proposed MHSA PEI project will not create any new partnerships; rather it will build on existing relationships.”

“There are so few resources here in Mono County, that we blend our assets amongst agencies as much as possible. Between desperately thinly staffed school districts and the new MHSA-funded school-based hires, there should be enough in the way of personnel to provide a badly needed safety net for youth in danger of academic failure and youth from stressed families.”

“Our partners, the schools, provide our staff people with office space as well as student referrals. Additionally, the schools call our main office should they require emergency intervention between regularly scheduled counselor visits. Because we are targeting all school aged children within the County, this population mirrors the County demographics that run roughly 4% Native American, 20% Latino and 76% Caucasian. Services will be available in Spanish, principally through interpreter services available at each school site.”

“It is anticipated that the MHSA PEI program will be sustained by MHSA PEI funding as well as by the prudent reserve if tax revenues are reduced for a period of time. Additionally, when project staff are doing billable mental health work, they will make every effort to secure sufficient information from families to bill a variety of third party payors. Any realized revenue will be returned to the project and used specifically for our school-based staff. ...”

## **Mono County Mental Health in Schools: Rationale and Description**

“While placing a counselor in the schools per se is not specifically listed in the ... PEI resource guide, nonetheless, there are many programs within which this approach is a primary component. These include student assistance programs, social decision making/ problem solving, reconnecting youth and families and schools together. Unfortunately, all of these programs cost money and with our annual stipend of only \$100,000, Mono County did not feel that we had enough money to purchase both staff and a formalized program. Salary and benefits for one clinician run around \$84,000/year. This clinician will utilize a county car to reach schools throughout our large county at a cost of roughly \$10,000/year in mileage. This leaves only \$6,000 for office supplies and art materials to support youth growth and development.”

“We believe that our chosen program is, in fact, consistent with the PEI Community Needs, Priority Populations and principles. Additionally, since we are planning to address needs of K-12 youth, we were unable to actually find a school-based program within the resource guide that did this. It appeared that most of the listed programs targeted specific age groups....”

“Five years ago, Mono County was awarded a Safe and Drug Free schools grant that required use of a model program. We were funded to replicate Brief Strategic Family Therapy, a very expensive (\$60,000) intervention model targeting troubled youth and families. Two of the three staff who were trained in the BSFT model are still working for Mono County Mental Health; thus we do have access to interventions and strategies taught by a state-of-the-art model program, albeit not one listed in the PEI resource guide.”

“Because there are roughly 1600 school aged children in the county spread out amongst eleven schools and 3000+ square miles, it is unrealistic for one person to provide adequate school-based counseling coverage. It was the desire of the communities within Mono County to utilize some MHSA CSS monies to add one half to one FTE clinician to the FTE proposed for the MHSA PEI funding source.” “The projected one-and-a-half to two FTE positions will spend between one half and one day each week at each school site.

The program is expected to result in:

- Improvement in youth self concept and self control
- Reduction in youth behavior problems including substance abuse and association with antisocial peers as measured by reduced suspensions, expulsions, and other school problems
- Increased parental involvement in school activities
- More effective parental interventions and management of youth behavioral problems
- Improvement in family cohesiveness, collaboration and child bonding to the family
- Improvements in family communication, conflict resolution and problem-solving skills
- Increases in positive attachment to schools as measured by improved grades and greater participation in school activities and sports; as well as by a decrease in incidents of class disruption and defiance



## Monterey

Monterey County is located on the Pacific coast, its northwestern section forming the southern half of Monterey Bay. The county encompasses 3,771 square miles. The county seat is Salinas. Monterey County is a member of the regional governmental agency, Association of Monterey Bay Area Governments. The coastline, including Big Sur, State Route 1, and the 17 Mile Drive on the Monterey Peninsula has made the county world famous.

The city of Monterey was the capital of California under Spanish and Mexican rule. The economy is primarily based upon tourism in the coastal regions, and agriculture in the Salinas River valley. Most of the county's people live near the northern coast and Salinas valley, while the southern coast and inland mountain regions are almost devoid of human habitation.

### About the Schools in the County

There are about 70,000 students enrolled in 25 school districts (e.g., 7 unified, 15 elementary, 2 high school districts, 1 county) and 126 schools. The school population is fairly evenly distributed across grades. 6 charter schools enroll 1,372 students. The school population is fairly evenly distributed across elementary and secondary grades. With respect to special placements, 230 are in alternative schools; 569 are identified as in special education; 888 in continuation; 38 in community day; 49 in juvenile court; 168 in county community.

Data from 2006-2007 indicate:

- >Dropouts (grades 9-12) = 532
- >Unexcused absences or tardy on 3 or more days = 13,097 (truancy rate = 19%)
- >Expulsions = 267
- >Suspensions = 8,499

### Brief Overview of School Facets of PEI Plan

The approved PEI plan for Monterey County adopts the title *Underserved and Unserved Cultural Populations* and encompasses three projects, each of which connects with current programs and initiatives. The three projects and their respective programs are:

- >Trauma Exposed Individual
  - >>Child Advocate Program
  - >>School-based Domestic Violence Counseling
  - >>Critical Incident Debriefing
  - >>Suicide Prevention Hot Line Extension
  - >>Alcohol and Drug Early Intervention with PTSD/Adults/Criminal Justice
- >Children and Youth in Stressed Families
  - >>Pathways to Safety
  - >>AVANZA
  - >>TAY Wellness Center
- >Children and Youth At Risk of or Experiencing Juvenile Justice Involvement.
  - >>Youth Diversion Program

Nineteen specific arenas of focus cited in the plan are:

- >Depression/Anxiety Screening Days
- >Early Intervention 0-5 Secure Families/Familias Seguras Program
- >Mental Health Screening for Children 0-8
- >System Navigator Program
- >African American Community Partnership
- >Latino Community Partnership – Promotores
- >Multi-lingual Parenting Services – Parenting Education Program
- >LGBTQ Community Partnership
- >School Evidence-Based Practices (Counseling) Program
- >Prevention Services for Native American Youth
- >Peer to Peer Counseling
- >Emotions Anonymous
- >Family Support Groups
- >Adult Wellness Center
- >Senior Peer Counseling
- >Community Warm Line
- >Toll-free 24/7 Telephone Referral System
- >Social Marketing
- >Network of Care

Within the three projects, their respective programs, and the 19 arenas of focus, two are school-based: (1) School Evidence-Based Practices (Counseling) Program and (2) the School-based Domestic Violence Counseling program

(1) *School Evidence-Based Practices (Counseling) Program* – will use PEI funds to add mental health professionals to two additional elementary school sites. The program is to function as a highly interactive partnership with designated school staff and will provide low intensity brief therapy by qualified therapists for individuals who are at risk of developing a mental illness or have begun to experience the first onset of such illness. A second component of this program addresses the education needs of parents with children enrolled in the two elementary schools.

(2) *The School-based Domestic Violence Counseling Program* will address domestic violence issues of children who are witnesses to violence. It will provide short term, low intensity group therapy to children who have been exposed to domestic violence. A total of ten (10) schools will be served with four (4) ten (10) week program series. In each ten (10) week series up to five (5) children will be served. The program will be delivered by counselors who will work in a non-traditional setting – schools – to reduce the stigma children may otherwise face as a result of having to endure the effects having been a witness of violence. Counselors will work with parents initially to obtain their authorization and secondly they will provide education and brief counseling to provide parents with the tools to create a home environment that fosters a child’s healthy psychological development. Counselors will help children find ways to be safe when violence occurs; let them know the violence is never the child’s fault; and that it is not the child’s responsibility to intervene. Counselor’s will also help trauma exposed children understand their anger, hurt, fear, or sadness about domestic violence and community violence.

*Proposed number served annually:*

- >160 children
- >up to 250 families in parent education classes

*Annual nonadministrative budget request for*

- >School Evidence-Based Practices (Counseling) Program = \$183,500
- >School-based Domestic Violence Counseling program = \$75,000

*Total annual budget request for PEI plan = \$3,357,700*

### **Other PEI Programs for Children, Adolescents, and/or Their Families**

Within the three projects, their respective programs, and the 19 arenas of focus, there are a number not directly school-focused that address children, adolescents, and families. These include all the agencies and programs serving such populations (e.g., Child Advocate Program, Suicide Prevention Hot Line Extension, Pathways to Safety, Youth Diversion Program, Peer to Peer Counseling, Emotions Anonymous, Community Warm Line, Early Intervention 0-5 Secure Families, Mental Health Screening for Children 0-8)

### **Leveraging and Sustaining the Work**

The following were the main points mentioned with respect to leveraging and sustaining:

Related to *School-based Counseling*, “Monterey County Office of Education (MCOE) provides oversight, curriculum development, staff development, and other resources to elementary schools, home charter schools, migrant education, special education, and Head Start students and their families. This program is expected to further strengthen the links that exist between MCBH and MCOE. Resources will be leveraged through MCOE in-kind contributions and Medi-Cal supports. Plans for sustainability of the program will be developed in collaboration with key Behavioral Health staff and the PEI Coordinator. Needs for technical assistance will be identified and provided accordingly.”

“Resources also will be leveraged by in-kind contributions such as administrative costs and facilities, in addition to the planning activities for establishing additional funding sources. It is anticipated that the community partners will research and submit grant proposals to funding entities seeking to support prevention, education, and early intervention.”

*School-based Domestic Violence Counseling Program* will be provided by Harmony at Home, a non-profit serving children who have witnessed domestic violence, community violence and/or have been direct victims of abuse. Services include individual and family therapy, group counseling and expressive arts camp. “Resources are leveraged through in-kind contributions. Plans for sustainability of the program will be developed in collaboration with key Behavioral Health staff and the PEI Coordinator. Needs for technical assistance will be identified and provided accordingly.”

As with the other trauma focused programs, personnel in the *School-based Domestic Violence Counseling Program* will be encouraged to participate in cultural competency and program/system level improvement training to assure program success. PEI funded services are expected to contribute to increased capacity among community partners.

Social marketing is expected to contribute to community level improvements.

## **Monterey County Mental Health in Schools: Rationale and Description**

(1) *The School Evidence-Based Practices (Counseling)* is highly interactive with designated school staff. The program will use PEI funds to add MH professionals to two additional elementary school sites. (Four others were launched in June 2007.) As with other early intervention programs, the intent is to eliminate or decrease the need for extensive treatment in the future by addressing a mental health need at an early stage.

School selection is based on survey responses and statements of need provided by schools, with comparative analysis by County Health Department epidemiologists. Areas of greatest need are served first, with the program growing as funding allows. County Education and six elementary schools are collaborating with MCBH in this program.

The program will provide low intensity brief therapy by qualified therapists for individuals who are at risk of developing a mental illness or have begun to experience the first onset of such illness. A second component addresses education about mental illness and related behavior problems for parents with children enrolled in the two elementary schools. The intent is to counter the stigma and parent apprehensiveness related to their children accessing MH services. The outreach and engagement components of the program include evening parent workshops (in English or Spanish). Content includes education about mental health, indicators of behavioral problems, and age-appropriate social and emotional development. Workshop facilitators will be mental health professionals who will also provide low intensity brief therapy to children and families referred to the program. This is seen as providing the opportunity to develop trust and rapport with parents, thereby abating concerns about the services to which their child is referred.

The goals of the program are to provide early services to address MH needs of elementary-aged children, provide prevention education for parents and school faculty, provide information concerning MH issues, and decrease stigma where the concepts of MH and mental illness are often taboo. The program also is seen as reducing disparities.

(2) *School-based Domestic Violence Counseling* – provides short term, low intensity group therapy to children exposed to domestic violence. The program will be delivered by counselors who will work to reduce the stigma children may otherwise face as a result of having to endure the effects of having been a witness of violence.

In a school setting, it is seen as more likely that children will accept a counseling program. In turn, children who have become more familiar and comfortable with mental health services are expected to educate their parents who may have stigmatized perceptions about mental illness or seeking mental health services.

Counselors will work with parents initially to obtain authorization and then they will provide education and brief counseling to provide parents with the tools to create a home environment that fosters a child's healthy psychological development. Counselors will help children find ways to be safe when violence occurs; let them know the violence is never the child's fault; and that it is not the child's responsibility to intervene. Counselors will also help trauma exposed children understand their anger, hurt, fear, or sadness about domestic violence and community violence. Such a program is seen as reducing the need for clinical treatment to address serious emotional disturbance or mental illness later in life.

“A qualified counselor will be assigned to each school and will establish a group of students through teacher or parent referral. Students will receive both individual and group counseling, utilizing various evidence based practice theories. Such as expressive arts. A total of ten (10) schools will be served with four (4) ten (10) week program series. In each ten (10) week series up to five (5) children will be served. Low intensity counseling services will be provided on a short term basis, and referrals to additional services will be provided as needs for more intensive treatment are identified. It is anticipated that a total of 160 children will be served annually.”

The goals are to reduce stigma, improve child and family functioning, assess psychosocial needs and provide brief early intervention individual and group counseling, promote parent involvement in meeting the child’s academic, social and psychological needs, and provide community resource information and referrals as needed.

In general, along with the other PEI programs, these school programs are expected to

- Widen the access portal to increase consumer and family member access to wellness, resiliency, supports, and services by providing programs in nontraditional settings;
- Increase the number of school age children and families that receive first-time counseling and referral services for entry into the mental health system
- Reduce disparities in the utilization of mental health services;
- Increase availability of prevention services;
- Increase service provider competency;
- Strengthen links between PEI and other Monterey County MHSA components; and the creation of links between ... MCBH and new community partners (e.g., build and strengthen partnerships between MCBH and Monterey County Office of Education, First 5 Monterey County, Monterey County Social and Employment Services, Monterey County Probation, and other area agencies).

## Monterey County Demographics

As of the 2000 census:

- >Population = 401,762 people (population density averages 121 people per sq. mile)
- >Households and Families =121,236 households and 87,896 families
  - (39.1% of households had children under the age of 18 living within them; 56% married couples living together; 11.6% had a female householder with no husband present; 27.5% were non-families; 21.2% of all households were made up of individuals and 8.2% had someone living alone who was 65 years of age or older. The average household size was 3.14 and the average family size was 3.65.)
- >Median age = 32 years
  - (With respect to age spread, 28.4% are under the age of 18; 10.9% from 18 to 24; 31.4% from 25 to 44; 19.3% from 45 to 64; and 10% who were 65 years of age or older.)
- >Per capita income for county = \$ \$20,165
- >Median income
  - >>household = \$48,305
  - >>family = \$51,169
  - >>Males = \$38,444
  - >>Females = \$30,036
- >Number below poverty line
  - >>13.5% of the population
  - >> 9.7% of families
  - >>17.4% of those under age 18
  - >> 6.8% of those age 65 or over

According to Census 2000, the racial makeup of the county was 55.92% White, 3.75% Black or African American, 1.05% Native American, 6.03% Asian, 0.45% Pacific Islander, 27.82% from other races, and 4.98% from two or more races. 46.79% of the population were Hispanic or Latino of any race. 6.3% were of German and 5.4% English ancestry.. 52.9% spoke English, 39.6% Spanish and 1.6% Tagalog as their first language. Note that the county is divided by race, with higher-income Whites and Asians living near the coastal areas, and virtually all Latinos (including an enormous number of illegal immigrants) live in the Salinas Valley due to its agricultural productivity.

## Plumas

Plumas County is located in the Sierra Nevada area, covering 2,613 square miles. Outdoor activities are a major tourist draw; the County has numerous lakes and streams and is renowned for fishing. A small part of Lassen Volcanic National Park extends into the northwest corner of the county. The county seat is Quincy. The only incorporated city in the county is Portola, other towns are CDPs.

### About the Schools in the County

There are about 2,600 students enrolled in 2 school districts (e.g., 1 unified, 1 county) and 15 schools. The school population is fairly evenly distributed across grades. 1 charter schools enrolls 178 students. The school population is fairly evenly distributed across elementary and secondary grades. With respect to special placements, 569 are identified as in special education; 21 in continuation; 25 in opportunity; 6 in county community.

Data from 2006-2007 indicate:

- >Dropouts (grades 9-12) = 40
- >Unexcused absences or tardy on 3 or more days = 345 (truancy rate = 13%)
- >Expulsions = 47
- >Suspensions = 713

### *Plumas County did not propose any school related activity.*

The submitted plan states:

“Having identified the target population as youth at-risk and juvenile youth, and the strategy of family therapy, then PCMH utilized expertise with California Institute of Mental Health (CIMH) to assess potential best practices that serve the target population and that may meet the identified goals. PCMH also took input from Dr. Troy Armstrong, Director of the Center for Delinquency and Crime Policy studies at California State University in Sacramento. Those models that were considered included: Functional Family Therapy; Multi-dimensional Family Therapy; Multisystemic Therapy.

From this data analysis, PCMH believes that the optimal point of investment would be a short-duration (12-15 session) family therapy program that combines the best of family models, such as Functional Family Therapy, but flexibly structured and culturally sensitive to a small and rural community. The PCMH 12-15 session family therapy model shall successfully apply established clinical theory and supported principles, and extensive clinical experience with solution focused therapy.”

*Total annual budget request for PEI plan = \$200,000*

## Plumas County Demographics

As of the 2000 census:

- >Population = 20,824 people (population density averages 8 people per sq. mile)
- >Households and Families =9,000 households and6,047 families
  - (26.4% of households had children under the age of 18 living within them;
    - 55.4% married couples living together; 8% had a female householder with no husband present; 32.8% were non-families; 27.5% of all households were made up of individuals and 10.1% had someone living alone who was 65 years of age or older. The average household size was 2.29 and the average family size was 2.77.)
- >Median age = 44 years
  - (With respect to age spread, 22.7% are under the age of 18; 6% from 18 to 24; 22.6% from 25 to 44; 30.8% from 45 to 64; and 17.9% who were 65 years of age or older.)
- >Per capita income for county = \$19,391
- >Median income
  - >>household = \$36,351
  - >>family = \$46,119
  - >>Males = \$38,742
  - >>Females = \$25,734
- >Number below poverty line
  - >>13.1% of the population
  - >> 9% of families
  - >>16.7% of those under age 18
  - >> 6.4% of those age 65 or over.

According to Census 2000, the racial makeup of the county was 91.78% White, 0.62% Black or African American, 2.55% Native American, 0.53% Asian, 0.10% Pacific Islander, 1.81% from other races, and 2.61% from two or more races. 5.65% of the population were Hispanic or Latino of any race. 16.1% were of German, 15.0% English, 10.1% Irish and 8.0% American ancestry. 95.4% spoke English and 3.6% Spanish as their first language.

## San Bernardino

San Bernardino County is located in the southeast area of the state. The deserts and mountains of this vast county stretch from the outskirts of the densely populated Riverside-San Bernardino Area to the Nevada border and the Colorado River. The county seat is San Bernardino. The county is considered to be part of the Inland Empire region.

### About the Schools in the County

There are about 428,000 students enrolled in the equivalent of 35 school districts (i.e., 20 unified, 11 elementary, 2 high school districts, the county, and the California Youth Authority) and over 500 schools. The school population is fairly evenly distributed across grades. 24 charter schools enroll 10,331. The school population is fairly evenly distributed across elementary and secondary grades. With respect to special placements, 2,097 are in alternative schools; 2,878 are identified as in special education; 6,940 in continuation; 1473 in community day; 505 in juvenile court; 237 in county community; 539 in California Youth Authority.

Data from 2006-2007 indicate:

- >Dropouts (grades 9-12) = 7,104
- >Unexcused absences or tardy 3 or more days = 155,468 (truancy rate = 37%)
- >Expulsions = 2,228
- >Suspensions = 73,453

### Brief Overview of School Facets of PEI Plan

The approved PEI plan for San Bernardino contains twelve separate programs. There is a *School-based Initiative* that contains three programs to target children and youth exclusively; there are four components included in the *Community-based Initiative* that provides services for children, youth, adults, and older adults; and five *System Enhancement projects* that cut across all ages, providing interventions to older adults, system involved (child welfare or juvenile justice) children and youth, military families, and even offering, prenatal support. “It is estimated that over the next three years over 66,625 individuals and 18,427 families will receive prevention and early intervention services.”

The three school-based programs are: (1) the Student Assistance Program, (2) the Resilience Promotion in African-American Children project, and (3) the Preschool PEI Project

(1) *Student Assistance Program (SAP)* uses a multi-disciplinary team to provide a wide range of services both universal and indicated in scope. The program is a science-based

model designed to minimize barriers to learning and support students in developing academic and personal success through the asset development process. Students identified as stressed, at-risk, or displaying signs of high-risk substance use and/or mental health risks receive appropriate interventions at school or through referrals. Both prevention (pre-diagnosis) and early intervention services can be offered through SAP. Services can include; group and individual counseling, substance abuse/misuse services, anger management classes, or curriculum based psychosocial education. Activities involve a focus on Policy and Procedures, Communications, Referral Mechanisms, Parent Participation, Team Planning, Intervention and Recommendations, Follow-up and Support, Training, Outcome Evaluation

It is anticipated that a portion of funding will be allocated to County Schools to administer the training component with the remainder of the allocation being contracted to community-based organizations through a Request for Proposal (RFP) process.

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

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

Preschool PEI Project addresses three (3) key community needs, disparities in access to mental health services, at-risk children, youth and young adult populations, and stigma and discrimination. This school-based project is aimed at four (4) priority populations, including children and youth who have experienced trauma; children and youth in stressed families; children and youth at risk of school failure; and/or children and youth experiencing, or at risk of, juvenile justice involvement.

*Proposed number served annually:*

- >Student Assistant Program = 50,500 individuals and 6,317 families.
- >Resilience Promotion = approximately 240 individuals and 240 families.
- >The Preschool PEI = approximately 400 individuals and 435 families.

*Annual nonadministrative budget request for*

>Student Assistant Program = \$1,375,000

>Resilience Promotion = \$516,000

>The Preschool PEI = \$468,289

*Total annual budget request for PEI Plan = \$14,239,611*

### **Other PEI Programs for Children, Adolescents, and/or Their Families**

The four components of the Community-based Initiative provide services for children, youth, and adults (i.e., Family Resource Center Associations, Native-American Resource Center, NCTI Crossroads Education Classes, Promotores de Salud) and the five System Enhancement projects (child welfare or juvenile justice) cut across all ages children and youth, military families, and even offer prenatal support (i.e., Child and Youth Connection, Nurse Family Partnership, Active Duty and Family Support Project, Community Wholeness and Enrichment Project). “It is estimated that over the next three years over 66,625 individuals and 18,427 families will receive prevention and early intervention services.”

### **Leveraging and Sustaining the Work**

The following were the main points mentioned with respect to leveraging and sustaining:

“The formation of partnerships between SB County agencies and community organizations that do not duplicate established services and focus more intently on delivering culturally competent and professional PEI services, allows for a more comprehensive, accessible and sustainable mental health system for consumers.”

“As subsequent training takes place the number of those who will receive direct benefit from the service will increase. After a site has been trained in developing an effective program only technical assistance is needed for follow up. Sustainability is built into the training model. Districts and/or individual school sites would be required to create positive relationships with community based organizations and social service agencies in order to build an infrastructure to promote individual success.”

## San Bernadino Mental Health in Schools: Rationale and Description

The plan emphasizes the following: “While the PEI Plan cannot meet the demand for all services, it is intended to continue the transformation of mental health services at the local level. The Prevention and Early Intervention concept is seen as beginning the work of changing the mental health system from a fail first system to a help first system.”

The stated goal of the School-Based Initiatives is to strengthen student health and wellness by working to reduce risk factors, barriers and/or stressors, build protective factors and supports, and provide appropriate interventions at schools and after school programs.

The objectives are to:

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

(1) The *Student Assistance Program (SAP)* is described as a science-based model that minimizes barriers to learning and supports students in developing academic and personal success through asset development. The initiative links education, programs and services within and across systems and provides linkages for students and their families to behavioral health education, programs, and services. When appropriate, referrals are made to longer-duration counseling. New partnerships will be developed and services will be delivered in settings which are non-threatening/non-stigmatizing to students and families. And, the intent is to strengthen school infrastructure for supporting student’s mental health and the coordination of resources.

Students identified as stressed, at-risk, or displaying signs of high-risk substance use and/or mental health risks receive appropriate interventions at school or through referrals. Both prevention (pre-diagnosis) and early intervention services can be offered through SAP. Services can include: group and individual counseling, substance abuse/misuse services, anger management classes, or curriculum based psychosocial education.

The SAP team generally is comprised of administrators, counselors, nurses, community resource workers, psychologists, school resource officers, and any teacher or faculty member who holds a vested interest in supporting students in meeting their individual challenges. DBH plans to strengthen these efforts by contracting with Community-based organizations to work with local education areas to provide the PEI and mental health expertise that will optimize student success. Educators will also be trained in identifying students who need additional interventions, the referral process, developing a menu of services, and developing

## SAN BERNARDINO (cont.)

a crisis plan. Additional supports to provide early intervention and prevention counseling services at schools for identifying at risk, stressed, and underserved students will be implemented by community-based organizations.

All this stems from providing selected district and community based staff members with an intensive five-day training/workshop on effective curriculum, focused on promoting resiliency through asset development. Cultural competence issues are addressed in this initiative by providing training in the culture of poverty, cultural norms of the represented ethnic groups, and respect for all cultural and ethnic groups.(While all staff members are expected to participate in modeling pro-social skills and promoting positive choices, a core group of staff members are trained in the SAP process.)

(2) The *Resilience Promotion in African-American Children* project intends to mediate development of Post Traumatic Stress Disorder, mood disorders, other anxiety disorders, substance abuse/misuse, and psychotic disorders. It consists of (a) a 12-week intensive program and (b) on-going weekly interventions, and tracking off site at youth centers, churches, or other community settings through adulthood. The program also includes a mentoring component and will be administered through a community-based organization.

Thirty students, ages 5 through 11, will work with health care educators, tutors and African-American professionals each school day. “Through age appropriate African-American History education, bibliotherapy and story telling activities, exercise and health education, conflict resolution skills training and academic tutoring, the participants will gain academic competence, a sense of African-American identity, and the confidence that they can address life’s challenges successfully within the African-American community and develop allies outside the community. A community site will be used for follow up in a group setting designed to promote leadership and encourage school participation and community connection. On-going monitoring of the program’s efficacy will be done during this second phase of the program.

The design of the program allows frequent self-assessment and appropriate adaptations as it grows. The main goal is to start small, build on the successes, retain the participants and include them in positions of increasing responsibility until adulthood. Youth participate until adulthood. By the end of the first year, 120 participants and their families will continue to participate.

Program participants come from referrals from schools, churches and other settings. Baseline self esteem measures, degree of distress measures, exposure to violence measures as well as school academic and behavioral rating questionnaires will enable program effectiveness monitoring. Six (6) small, age specific groups will learn to work together to complete short term and long term learning objectives in African-American history, conflict resolution, health and academic areas.”

The following are program elements of this project:

*Peacemakers* – This school-based violence prevention program will be offered to 30 students in each of four groups (total 120 students). The curriculum consists of 17 lessons and will be delivered over a 17-week period.

SAN BERNARDINO (cont.)

*Group presentations* -- Participants experience working together, sharing feelings and problem solving while promoting trust and reinforcing emotional competence and promoting resilience.

*Cultural Awareness* – Through bibliotherapy, students read and discuss African-American themed literature designed to promote discussions regarding African-American cultural awareness, sensitivity toward other cultures, trust, conflict resolution and effective ways of managing feelings in general and feelings related to confronting racism and marginalization in particular. Other Afro-centric cultural components like art, music and science are integrated into the program as well.

*Conflict Resolution* – Conflict resolution counselors promote empathy and teach healthy conflict resolution strategies using operational conflict resolution manuals and drama therapy.

*Educational Workshops* – Peacemakers curriculum will be utilized, along with mental health, nutrition education, and stress reduction techniques that will be taught in a fun and age appropriate fashion. General health education programs and healthy life styles promotion are important prevention principles.

*Meet a Pro* – Black African-American professionals will talk with the participants about their careers, their experience of racism and the concept of the need to be twice as good in order to make it. Six-year old children are noted to devalue potential careers if they perceive them to be careers for African-Americans. The mere presence of African-American professionals will mitigate such negative automatic thinking by altering participants' self-perception and challenging their concepts regarding careers. Discussions of career mapping and "how to get there," will stir imagination and instill hope. The professionals will model generativity and enhance participants' sense of community.

*Parent Involvement* – Weekly parent groups will be facilitated by a Parenting Skills Counselor to promote discussion about the common challenges they face as African-American parents and development of healthy parenting strategies to help their children develop self esteem and promote resilience. Resilience is strongly related to the feeling of being loved by ones' family. The Effective Black Parenting, an evidence-based curriculum will be used.

*Follow up phase* – Participants will engage in school activities, extracurricular activities and continued involvement with their program cohorts and community activities as they mature and matriculate into colleges and universities. Most effective programs occur over several years.

(3) The *Preschool PEI Project* implements targets preschool populations and their parents/caregivers. It involves several components that will include direct service to children and training for parents and early childhood educators on: (a) dealing effectively with challenging behaviors, (b) addressing bereavement and loss, (c) recognizing potential mental health issues, and (d) utilizing school centered interventions with mental health professionals, when appropriate. This project is a collaborative planning effort of the County Department of Behavioral Health, local universities, local school districts, and the Head Start Program. It will be delivered in preschools with Head Start Programs. Implementation partners include: County Preschool Services Department, DBH, local universities, local school districts and community based organizations.

## SAN BERNARDINO (cont.)

The project includes provisions to deliver three separate yet complimentary services. The *Incredible Years* program which is an evidence-based model for addressing aggressive behaviors in young children. It includes training both parent/caregiver and teacher. The second component is a preschool bereavement and loss program that addresses significant trauma in a child's life (loss of a parent/caregiver, divorce, etc.). The third component is the *Mental Health Intern Program*, a screening and early assessment component aimed at those who need referrals for more intensive mental health services. The latter provides direct services to the preschool children, their caregivers (parents and teachers), as well as support and consultation to the teacher as necessary. Additionally, children may be referred to local County service providers, including the County Screening, Triage, Assessment, Referral, and Treatment (START) Program, for follow-up and services.

Expected outcomes of the school-based initiatives include:

- Strengthened student health and wellness by working to reduce risk factors, barriers and/or stressors, build protective factors and supports, and provide appropriate interventions at schools and after school programs.
- Improved knowledge of educators in regards to identification, early signs and symptoms, and risk factors contributing to mental illness and co-occurring disorders.
- Increased opportunities to access prevention and early intervention services for students at risk of school failure, in stressed families, exposed to trauma, at risk of juvenile justice involvement, or experiencing onset of serious psychiatric illness.
- Improved school/community bonding, resilience promotion, and access to PEI services for underserved populations.
- Improved ability to provide selective prevention and early intervention services to families of young children experiencing behavior problems, experiencing grief or loss, and/or in need of early childhood evaluation.

The school-based initiative will track data through systems integration and student level results. The results focus first on the students' linkages to the behavioral health care education, programs and services in the school and community. Second, school outcomes of improved attendance, decreased suspensions, and grade promotion, graduation or retention after participation in the initiative programs are examined.

Note: The PEI project as a whole aims not only to achieve positive outcome for individuals and families, the intent is enhance programs and systems.

## San Bernardino County Demographics

As of the 2000 census:

- >Population = 1,709,434 people [2007 estimate 2,028,013]  
(population density averages 85 people per sq. mile)
- >Households and Families = 528,594 households and 404,374 families  
(43.7% of households had children under the age of 18 living within them;  
55.8% married couples living together; 14.8% had a female householder with no husband present; 23.5% were non-families; 18.4% of all households were made up of individuals and 6.6% had someone living alone who was 65 years of age or older. The average household size was 3.15 and the average family size was 3.58.)
- >Median age = 30 years  
(With respect to age spread, 32.3% are under the age of 18; 10.3% from 18 to 24; 30.2% from 25 to 44; 18.7% from 45 to 64; and 8.6% who were 65 years of age or older.)
  
- >Per capita income for county = \$16,856
- >Median income
  - >>household = \$42,066
  - >>family = \$46,574
  - >>Males = \$37,025
  - >>Females = \$27,993
- >Number below poverty line
  - >>15.8% of the population
  - >>12.6% of families
  - >>20.6% of those under age 18
  - >> 8.4% of those age 65 or over

According to Census 2000, the racial makeup of the county was 58.91% White, 9.09% African American, 1.17% Native American, 4.69% Asian, 0.30% Pacific Islander, 20.82% from other races, and 5.03% from two or more races. 39.16% of the population were Hispanic or Latino of any race. 8.3% were of German, 5.5% English and 5.1% Irish ancestry. 66.1% spoke English, 27.7% Spanish and 1.1% Tagalog as their first language. The number of homeless in San Bernardino County grew from 5,270 in 2002 to 7,331 in 2007, a 39% increase.

## San Mateo

San Mateo County is located in the San Francisco Bay Area. It encompasses 741 square miles and covers most of the San Francisco Peninsula just south of San Francisco, and north of Santa Clara County. San Francisco International Airport is located at the northern end of the county, and Silicon Valley begins at the southern end. The county seat is Redwood City. It is among the 20 most affluent counties in the United States, in term of personal, per capita and household income, and is ethnically diverse. The county's built-up areas are mostly suburban, and are home to several corporate campuses.

### About the Schools in the County

There are about 89,000 students enrolled in 24 school districts (i.e., 3 unified, 17 elementary, 3 high school districts, and the county) and 177 schools. The school population is fairly evenly distributed across grades. 5 charter schools enroll 5,084. The school population is fairly evenly distributed across elementary and secondary grades. With respect to special placements, 866 are in alternative schools; 229 are identified as in special education; 902 in continuation; 4 in community day; 191 in juvenile court; and 119 in county community.

Data from 2006-2007 indicate:

- >Dropouts (grades 9-12) = 1,248
- >Unexcused absences or tardy on 3 or more days = 18,802 (truancy rate = 21%)
- >Expulsions = 310
- >Suspensions = 11,691

### Brief Overview of School Facets of PEI Plan

The submitted PEI plan for San Mateo County encompasses six projects:

- >Early Childhood Community Team
- >Primary Care/Behavioral Health Integration: Impact Model
- >Total Wellness for Adults/Older Adults with Serious Mental Illness
- >Stigma Initiative
- >Community Interventions for School Age and Transition Age Youth
- >Youth/Transition Age Youth Identification and Early Referral

The project entitled: *Community Interventions for School Age and Transition Age Youth* focuses on reaching out to non-traditional settings such as schools and community based agencies (e.g., substance abuse programs, drop-in centers, youth focused and other organizations operating in communities with a high proportion of underserved populations). The project will use community based agencies to provide population and group based interventions to at-risk children and youth 6-25.

There are three related interventions to be implemented as part of this project:

- >Teaching Prosocial Skills
- >Project SUCCESS
- >Seeking Safety

Of the three, Project SUCCESS is specifically slated for schools.

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

The following four program components are utilized in Project SUCCESS:

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

>*Numbers to be served*

Unstated

>*Annual nonadministrative budget request for Project SUCCESS = \$30,000*

>*Annual nonadministrative budget request for Community Interventions for School Age and Transition Age Youth = \$538,520*

>*Total annual budget request for PEI plan= \$2,071,177*

### **Other PEI Programs for Children, Adolescents, and/or Their Families**

>Early Childhood Community Team

>Stigma Initiative

>Youth/Transition Age Youth Identification and Early Referral

### **Leveraging and Sustaining the Work**

The following were the main points mentioned with respect to leveraging and sustaining:

The intent is to leverage existing resources and, where possible, build on and integrate those efforts to support sustainability. The County's prevention framework (Spectrum of Prevention) for behavioral health is described as helping to clarify activities that can support achieving and sustaining the work. And, it is stated that "We plan on seeking funding support from community partners and foundations to make this effort sustainable.

"This project will require the broad collaboration of the mental health system, all of the middle and high schools within the 23 San Mateo County school districts, and school based family resource centers. A central aspect of implementing this project is the completion of community wide mapping of the services provided within the schools by governmental and community based agencies, and identification of gaps to be addressed. This project will also require collaboration with organizations that support and serve school aged youth and transition aged youth, including community based agencies, such as substance abuse and mental health programs, drop-in centers, youth focused and other organizations operating in communities with a high proportion of underserved populations."

## San Mateo Mental Health in Schools: Rationale and Description

Participants in the planning process conceived this project as a set of interventions focusing on school age and transition age youth, reaching out to them in nontraditional settings such as schools and community based agencies, such as substance abuse programs, drop-in centers, youth focused and other organizations operating in communities with a high proportion of underserved populations. While different interventions are planned, the intent is to implement a cohesive project that uses community-based agencies (including schools) to provide population and group-based interventions to at-risk children and youth 6-25.

*Project SUCCESS* (Schools Using Coordinated Community Efforts to Strengthen Students), is considered a SAMHSA model program that prevents and reduces substance use and abuse and associated behavioral issues among high risk, multi-problem adolescents. It places highly trained professionals (Project SUCCESS counselors) in the schools to provide a full range of prevention and early intervention services designed to reduce risk factors and enhance protective factors. The intent is to fund up to three separate school sites.

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

The following four program components are utilized in Project SUCCESS:

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

The projects is expected to result in

- >An increase in the degree to which students report they care about their families
- >An increase in the amount of help students say they expect to receive from the police, when needed
- >Greater confidence among students that their parents would try to stop them if they were to start smoking

## San Mateo County Demographics

As of the 2000 census:

- >Population = 707,161 people. [2005 estimate 712,462.]  
(population density averages 1,575 people per sq. mile)
- >Households and Families = 254,103 households and 171,265 families  
(31.1% of households had children under the age of 18 living within them;  
53% married couples living together; 10.1% had a female householder with no husband present; 32.6% were non-families; 24.6% of all households were made up of individuals and 8.4% had someone living alone who was 65 years of age or older. The average household size was 2.74 and the average family size was 3.29.)
- >Median age = 37 years  
(With respect to age spread, 22.9% are under the age of 18; 7.9% from 18 to 24; 33.2% from 25 to 44; 23.5% from 45 to 64; and 12.5% who were 65 years of age or older.)
- >Per capita income for county = \$36,045.
  - >Median income
    - >>household = \$70,819
    - >>family = \$80,737
    - >>Males = \$51,342
    - >>Females = \$40,383
  - >Number below poverty line
    - >> 5.8% of the population
    - >> 3.5% of families
    - >> 6% of those under age 18
    - >> 5.1% of those age 65 or over

According to Census 2000, the racial makeup of the county was 59.49% White, 3.51% Black or African American, 0.44% Native American, 20.04% Asian, 1.33% Pacific Islander, 10.17% from other races, and 5.02% from two or more races. Hispanic or Latino of any race were 21.88% of the population. 7.4% were of Italian, 7.1% Irish, 7.0% German and 5.3% English ancestry. 55.6% spoke English, 19.3% Spanish, 6.5% Tagalog, 4.5% Chinese or Mandarin and 1.4% Cantonese as their first language.

From the proposal:

“About 10,000 children are born to San Mateo County residents each year. In 2007, 41% of all children and youth in the county were Caucasian/white, followed by Latinos/Hispanics (31%), Asians (19%), multiracial children (5%), African Americans (2%), Pacific Islanders (2%), and Native Americans (0.4%). ... Among San Mateo County mothers of children ages 0-5 in 2006, 6.4% reported symptoms of depression, with marked differences in rates by race/ethnicity and income level. Caucasian/white mothers were least likely to show signs of depression, and very low-income mothers (< \$15,000 per year) were about 12 times more likely to report symptoms of depression than mothers with annual household incomes of more than \$80,000.

There are significant health disparities among racial, ethnic and income groups in San Mateo County, on issues ranging from physical health to school success to safety. African American mothers, for example, continue to have the highest percentage of babies born at low birth-weight (14 percent compared to 6.6 percent for all county infants in 2004). Though the overall teen birth rate has fallen in the last decade, rates for Latinas and African Americans were eight to 10 times higher than for Caucasian/white and Asian teens in 2004.”

## Solano

Solano County is a county located in Bay-Delta region of the U.S. state of California, about halfway between San Francisco and Sacramento and is one of the nine San Francisco Bay Area counties. It encompasses 907 square miles. The county seat is Fairfield and the largest city is Vallejo. A portion of the South Campus at the University of California, Davis is in Solano County.

### About the Schools in the County

There are about 68,000 students enrolled in 7 school districts (i.e., 6 unified and the county) and 106 schools. The school population is fairly evenly distributed across grades. 6 charter schools enroll 1,853. The school population is fairly evenly distributed across elementary and secondary grades. With respect to special placements, 8 are in alternative schools; 270 are identified as in special education; 853 in continuation; 260 in community day; 93 in juvenile court; and 117 in county community.

The proposal notes that county-wide:

- >Dropout rate (grades 9-12) = 2,207
- >Unexcused absences or tardy on 3 or more days = 18,890 (truancy rate = 27%)
- >Expulsions = 538
- >Suspensions = 16,140

### Brief Overview of School Facets of the PEI Plan

The approved PEI plan for Solano County encompasses four projects, each of which has several program components. The four projects and their respective programs are:

- (1) Early Childhood Mental Health
  - >Parent and Caregiver Education
  - >Provide Education and Training
  - >Parent Coaching
- (2) School-Aged
  - >School Based Targeted Assistance Program
  - >Educational Liaison to Juvenile Probation Multi-Disciplinary Teams (MDTs)
- (3) Education, Employment, and Family Support for At-Risk Transition Aged Youth
  - >Supported Education and Employment
  - >Parent/Caregiver Education
- (4) Older Adult
  - >Gatekeeper
  - >Navigator
  - >Health Provider Training

Based on the prevention and early intervention needs identified, Solano plans to focus on two distinct but complementary school-based programs for the School-Aged Project.

>*School-Based Targeted Student Assistance Program.* This new school-based program, serving students in grades 4-8, will provide short-term selective early intervention services to children who have been identified as at risk of school failure due to social/emotional issues such as loss of a parent, exposure to substance abuse or domestic violence, parental divorce, lack of social skills or emotional resiliency, or other early signs of mental health issues.

The remaining students (second tier) are considered at risk of school failure; at some point they will need targeted supplemental intervention to prevent current emotional needs from escalating to the need for more intensive treatment. PEI will fund second tier supplemental services to students in elementary and middle schools, using either the unfunded tier 2 supplemental services components of Second Step or other intervention strategies (anger regression therapy, grief counseling, post traumatic stress counseling).

Supplemental services/Second Step (tier 2) includes:

- Student interventions, including anger management; handling stressful emotions; problem solving; resolving conflict; dealing with rumors, peer pressure and bullying; and communication skills. Additional targeted support groups for grief counseling, divorce groups, and social skills will be incorporated.
- Parent education and support through collaboration and consultation with the parent to support the strategies being learned in counseling.
- Teacher education and support through collaboration and consultation with the teacher to support the strategies being learned in counseling.
- Outreach and information through existing school information venues, and existing community partnership referral networks, and school district information and referral processes.
- Training for schools so that they can sustain the program.

>*Educational Liaison to Juvenile Probation Multi-Disciplinary Teams (MDTs).* The second strategy in the school-aged project will serve secondary students who are at risk of or who have had a first contact with the juvenile justice system. The Vacaville Police Youth Services Department has begun initial implementation of an unfunded pilot program to convene a multidisciplinary team composed of police officers, probation officers, school district staff, family support services, child protective services and mental health staff to review cases of youth referred for criminal citations. Most of these youth have been cited for misdemeanors including drug related violations, vandalism, battery, theft, etc. A range of five to ten youth are referred to the team each week. The team works with the youth and his/her family to collaborate on addressing community, family and school related issues, so that the youth can get back on track and lead a productive, non-criminal life.

Juvenile justice teams in the other two large cities of Solano County, Vallejo and Fairfield are limited to police and juvenile probation officers. Missing from these teams are county social services, mental health and school district representatives who could provide crucial mental health and school-related information on academic achievement, attendance and disciplinary issues. Absent this participation, this crucial information remains confidential, and police and probation staff report that the youth frequently do not receive the necessary support to reenter the educational setting, or become involved in healthy community activities or employment. Instead, these teams typically invoke punitive rather than preventive or rehabilitative measures, leaving youth at greater risk of future police involvement.

This PEI project would fund the multi-disciplinary team pilot program in Vacaville and expand it to Fairfield and Vallejo, the three communities with the highest youth crime and youth gang involvement.

- >Annual Projection for Numbers to be served
  - >School Targeted Assistance Program = 4,000 individuals
  - >Educational Liaison to Juvenile Probation Multidisciplinary Teams = 200 individuals and 100 families.
- >Annual nonadministrative budget request for school facets = \$539,000
- >Total annual budget for PEI plan \$1,890,633

### **Other PEI Programs for Children, Adolescents, and/or Their Families**

- >Early Childhood Project
- >Education, Employment and Family Support for At-risk Transition Aged Youth

### **Leveraging and Sustaining the Work**

The following were the main points mentioned with respect to leveraging and sustaining:

This program is grounded in partnerships collaboration among the Solano County Office of Education, local school districts, the Special Education Local Planning Area, community-based organizations and city and county agencies. School Districts currently use the three tier model of intervention for academic interventions. “The Solano County Office of Education has offered Response to Intervention Training to all county schools. Participants have included schools’ representatives from Travis, Vacaville, Dixon, Benicia and Fairfield School Districts. In addition, the school-wide BEST program provides all students with research-based instruction and support in character education, anti-violence, anti-bullying, resiliency skills etc. Teachers are trained and supported in child development, supporting students through crisis and handling most adjustment difficulties.

Currently, BEST programs are in place or being implemented in nine Fairfield elementary schools serving predominantly low-income minority populations. Second Step programs are currently in a minimum of two schools in the county. To leverage funding for PEI and ensure that all elementary and middle schools in the county will be able to benefit from the program, the Solano County Office of Education has committed resources to provide training, materials and support to implement the BEST program in all interested elementary and middle schools countywide, including Rio Vista area pending coordination through Sacramento County Office of Education. Multiple BEST trainings are scheduled for fall 2008 to accommodate all interested elementary and middle schools.

Schools will also provide facilities for the interventions. School district administrators or their designees will monitor and coordinate services, ensure parent permission and collaboration, and monitor individual student outcomes.”

“Community youth services will provide parent education and support as included in the BEST and Second Step programs. Youth service counseling services is available at some middle schools and middle schools throughout the county. These services will be leveraged to include youth not involved in the juvenile justice system.

The educational liaison to the juvenile MDTs will enhance coordination of services for youth receiving their first or second police citation. The services will help ensure targeted youth have the support they need to continue in school and progress toward earning a high school diploma.

Funding for the Early Childhood PEI project will be leveraged using First 5 Solano Early Childhood Developmental Health Initiative funds (approved by First 5 Commission for joint funding opportunities as appropriate), North Bay Regional Center Early Start, Solano County Mental Health (EPSDT), and possible outreach leverage through Quality Assurance.

Youth service counseling services is available at some middle schools and middle schools throughout the county. These services will be leveraged to include youth not involved in the juvenile justice system

The program will be sustained through ongoing PEI funding, the leveraged funds identified above, and EPSDT. Training for schools also will help sustain the program. (To leverage funding for PEI and ensure that all elementary and middle schools in the county will be able to benefit from the program, the Solano County Office of Education has committed resources to provide training, materials and support to implement the BEST program in all interested elementary and middle schools countywide, including Rio Vista area pending coordination through Sacramento County Office of Education.)

During the 2008-09 fiscal year, a new MHSA advisory group will be created to monitor progress on the MHSA projects, to provide linkages with community resources, to seek ways to leverage resources across projects and provide feedback on the implementation of all components of the MHSA plan.”

## **Solano County Mental Health in Schools: Rationale and Description**

>*School-Based Targeted Student Assistance Program* – serves students in grades 4-8 providing short-term selective early intervention services for those at risk of school failure due to social/emotional issues such as loss of a parent, exposure to substance abuse or domestic violence, parental divorce, lack of social skills or emotional resiliency, or other early indicators of mental health issues.

Targeted intervention programs will focus on three levels of intervention. The work posits that 80% of the overall school population will be adequately served by services and interventions addressing all students. Currently, two school-wide, research-based intervention models are being implemented in Solano County Schools focused on this group: Second Step and BEST (Building Effective Schools Together). They focus on improving the school culture to promote healthy physical and emotional development. Both programs implement and support school-wide discipline and character development/social skills training efforts that are proven to reduce school violence, bullying, and suspension rates and increase attendance rates and student test data.

It is posited that 8% of students will require intensive services. These students are typically eligible for, and receive services through, Special Education.

The remaining 10-12% of students are considered at risk of school failure; at some point they will need targeted supplemental intervention to prevent current emotional needs from escalating to the need for more intensive treatment. Resources, however, have not been available to fund this second tier of services – short-term individual and small group prevention and early intervention services for individual children who have been identified by their student referral process (school study team) as needing additional assistance but who do not meet criteria for special education services for severe emotional disturbances. Without such services, students frequently withdraw from school through truancy, act out in class thus being suspended from class or school, become bullies or victims of bullying or develop pathological behaviors such as self-mutilation, suicidal thoughts, delinquent behavior and substance abuse.

PEI will fund second tier supplemental services to students in elementary and middle schools, using either the unfunded tier 2 supplemental services components of Second Step or other intervention strategies (anger regression therapy, grief counseling, post traumatic stress counseling) which offer research based methodologies for intervening early and preventing more prolonged and/or intensive mental health needs. The work will include:

- Student interventions, including anger management; handling stressful emotions; problem solving; resolving conflict; dealing with rumors, peer pressure and bullying; and communication skills. Additional targeted support groups for grief counseling, divorce groups, and social skills will be incorporated.
- Parent education and support through collaboration and consultation with the parent to support the strategies being learned in counseling.
- Teacher education and support through collaboration and consultation with the teacher to support the strategies being learned in counseling.
- Outreach and information through existing school information venues, and existing community partnership referral networks, and school district information and referral processes.
- Training for schools so that they can sustain the program.

SOLANO (cont.)

Individual students will be referred by teachers, parents or administrators to the school's Student Study Team (SST), a school-based prevention and early intervention process composed of the student, his/her parents, teachers, a school administrator and community-based organizations including foster care and family support agencies, as appropriate. The SST will identify the student's strengths, assets and obstacles to student success, and develop and implement a practical improvement plan (including these supplemental services) that all school, caregiver and community team members agree to follow. Follow-up meetings provide a continuous casework management strategy to maximize the student's achievement and school experience.

Supplemental services programs funded by PEI will be made available only to schools which have already implemented the first-tier school-wide BEST or Second Step Programs. During the first two years, priority will be given to elementary schools (that have received this training) with highest numbers of ethnic minority students and schools which can demonstrate that they have implemented and made progress on plans to reduce average suspension/expulsion rates.

It is estimated that approximately 10% of students (an average of 60) students in each of the nine schools with existing BEST programs will be served during the first school year, for a total of 540 students, and an additional 900 students in 15 schools will be served during the second school year. As additional schools implement the school-wide programs, they will be offered the supplemental programs, again prioritized by school and student need. When fully implemented we estimate that the project will serve 40 of the 61 elementary schools and at least five of the sixteen middle schools in the county and provide services for up to 4000 students per year.

Tier 2 Second Step/supplemental services programs will be operated through contracts with community-based organizations, the county office of education or by school districts directly (either in-house or through agency partnerships). All staff and materials will be sensitive to special needs and culturally and linguistically appropriate. All services will be provided at the student's school of attendance.

>*Educational Liaison to Juvenile Probation Multi-Disciplinary Teams (MDTs)*. The second strategy in the school-aged project will serve secondary students who are at risk of or who have had a first contact with the juvenile justice system. Solano County criminal justice representatives on the workgroup report that the best time to reach these youth is before they have committed a serious offense landing them in juvenile hall. Once a youth is in juvenile hall, they report, the focus is on addressing criminal behavior rather than addressing early signs of mental illness.

Within the last three months, the Vacaville Police Youth Services Department has begun initial implementation of an unfunded pilot program to convene a multidisciplinary team composed of police officers, probation officers, school district staff, family support services, child protective services and mental health staff to review cases of youth referred for criminal citations. Most of these youth have been cited for misdemeanors including drug related violations, vandalism, battery, theft, etc. A range of five to ten youth are referred to the team each week. The team works with the youth and his/her family to collaborate on addressing community, family and school related issues, so that the youth can get back on track and lead a productive, non-criminal life.

SOLANO (cont.)

Juvenile justice teams in the other two large cities of Solano County, Vallejo and Fairfield are limited to police and juvenile probation officers. Missing from these teams are county social services, mental health and school district representatives who could provide crucial mental health and school-related information on academic achievement, attendance and disciplinary issues. Absent this participation, this crucial information remains confidential, and police and probation staff report that the youth frequently do not receive the necessary support to reenter the educational setting, or become involved in healthy community activities or employment. Instead, these teams typically invoke punitive rather than preventive or rehabilitative measures, leaving youth at greater risk of future police involvement.

This PEI project would fund the multi-disciplinary team pilot program in Vacaville and expand it to Fairfield and Vallejo, the three communities with the highest youth crime and youth gang involvement. Referrals from other areas in the county will be coordinated on a case by case basis. PEI funding will be used to support school district involvement in multi-disciplinary teams in the three cities. Specifically, it will fund one position, divided among the Vacaville, Vallejo and Fairfield/Suisun Unified School Districts, to attend the meetings and develop school-based interventions to address the needs of these youth. The school representative(s) will be responsible for identifying appropriate educational settings for these youth and monitoring their attendance, behavior and academic progress. To address the social/emotional needs of these youth, they will also direct students to appropriate school-related or school-based youth services and counseling groups. Further, they will be responsible for monitoring all school-related activities and progress towards high school graduation.

## Solana County Demographics

As of the 2000 census:

- >Population = 394,542 people (population density averages 476 people per sq. mile)
- >Households and Families = 130,403 households and 97,411 families
  - (39.9% of households had children under the age of 18 living within them;  
55.7% married couples living together; 13.8% had a female householder with no husband present; 25.3% were non-families; 19.6% of all households were made up of individuals and 6.5% had someone living alone who was 65 years of age or older. The average household size was 2.9 and the average family size was 3.33.)
- >Median age = 34 years
  - (With respect to age spread, 28.3% are under the age of 18; 9.2% from 18 to 24; 31.3% from 25 to 44; 21.7% from 45 to 64; and 9.5% who were 65 years of age or older.)
  
- >Per capita income for county = \$21,731
- >Median income
  - >>household = \$54,099
  - >>family = \$60,597
  - >>Males = \$41,787
  - >>Females = \$31,916
- >Number below poverty line
  - >> 8.3% of the population
  - >> 6.1% of families
  - >>10.3% of those under age 18
  - >> 6.3% of those age 65 or over

According to Census 2000, the racial makeup of the county was 56.37% White, 14.91% Black or African American, 0.79% Native American, 12.75% Asian, 0.78% Pacific Islander, 8.01% from other races, and 6.39% from two or more races. 17.64% of the population were Hispanic or Latino of any race. 8.5% were of German, 6.4% Irish and 6.0% English ancestry. 75.7% spoke English, 12.1% Spanish and 6.6% Tagalog as their first language.

## Concluding Comments

As the above summaries indicate, the County PEI plans vary widely in their focus on the role schools play in a mental health system. For the most part, the PEI plans reviewed and the data from schools underscore that a focus on mental health in schools is a reality. At the same time, the PEI plans highlight the point that policy makers generally have not specified a clear and formal role for schools with respect to mental health, except with respect to mandated special education services and as part of a few ad hoc initiatives.

That remains the situation even though the 1999 *National Action Agenda* stemming from the Surgeon General's Conference on Children's Mental Health called for promoting "cost-effective, proactive systems of behavior support at the school level." The report from the conference stated: "These systems of behavior support should emphasize universal, primary prevention methods that recognize the unique differences of all children and youth, but should include selective individual student supports for those who have more intense and long-term needs." The report also stressed the importance of strengthening "the resource capacity of schools to serve as a key link to a comprehensive, seamless system of school- and community-based identification, assessment and treatment services to meet the needs of youth and their families where they are."

(<http://www.hhs.gov/surgeongeneral/topics/cmh/childreport.htm> )

Reflecting earlier calls for mental health in schools, Goal 4 of *Achieving the Promise: Transforming Mental Health Care in America* prepared in 2003 by the President's New Freedom Commission on Mental Health specifically calls for schools to play a role in a transformed mental health system.

(<http://www.mentalhealthcommission.gov/reports/reports.htm> )

As our Center has stressed in previous reports: At present, mental health activity is going on in schools with competing agenda vying for the same dwindling resources. Diverse school and community stakeholders are attempting to address complex, multifaceted, and overlapping psychosocial and mental health concerns in highly fragmented and marginalized ways. This has led to inappropriate competition for sparse resources and inadequate results.

Enhancing MH in schools clearly is not an easy task. The bottom line is that limited efficacy seems inevitable as long as the full continuum of necessary programs is unavailable and staff development remains deficient; limited cost effectiveness seems inevitable as long as related interventions are carried out in isolation of each other; limited systemic change is likely as long as the entire enterprise is marginalized in policy and practice.

The present state of affairs calls for realigning policy and practice around a unifying and cohesive framework based on well-conceived models and the best available scholarship. Initiatives for MH in schools can help transform mental health systems. But, they must be connected in major ways with the mission of schools and integrated into a restructured system of education support programs and services. This means braiding resources and interventions with a view to ensuring there is a *comprehensive system of student and learning supports*, rather than separate programs and services. Coordinated efforts naturally are part of this, but the key is development of a *system* that meets overlapping needs and does so by fully integrating mental health agenda into school improvement planning at school and district levels.

Related reports from the Center at UCLA:

- >*Mental Health in School & School Improvement: Current Status, Concerns, and New Directions*  
<http://smhp.psych.ucla.edu/mhbook/mhbookintro.htm>
- >*Building Collaboration for Mental Health Services in California Schools: What Will be Built?*  
<http://smhp.psych.ucla.edu/pdfdocs/buildingcollabformhrfpanalysis.pdf>
- >*Frameworks for Systemic Transformation of Student and Learning Supports*  
<http://smhp.psych.ucla.edu/pdfdocs/systemic/frameworksforsystemictransformation.pdf>

*School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge.*

Carnegie Council Task Force  
on Education of Young Adolescents (1989)