Enclosure 3

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

Form No. 1

MENTAL HEALTH SERVICES ACT (MHSA)
PREVENTION AND EARLY INTERVENTION COMPONENT
OF THE THREE-YEAR
PROGRAM AND EXPENDITURE PLAN
Fiscal Years 2008-09 and 2009-10

County Name: City of Berkeley	Date: 02/27/2009

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

County Mental Health Director	**Project Lead**
Name: Harvey Tureck	Name: Karen Klatt
Telephone Number: (510) 981-5213	Telephone Number: (510) 981-5222
Fax Number: (510) 981-5235	Fax Number: (510) 981-5235
E-mail: HTureck@ci.berkeley.ca.us	E-mail: KKlatt@ci.berkeley.ca.us
Mailing Address:1947 Center St., 3rd Floor Berkeley CA 94704	

AUTHORIZING SIGNATURE

I HEREBY CERTIFY that I am the official responsible for the administration of Community Mental Health Services in and for said County; that the county has complied with all pertinent regulations, laws and statutes. The county has not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and the administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2008-09, 2009-10 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief the administration budget and all related program budgets in all respects are true, correct and in accordance with the law. I have considered non-traditional mental health settings in designing the County PEI component and in selecting PEI implementation providers. I agree to conduct a local outcome evaluation for at least one PEI Project, as identified in the County PEI component (optional for "very small counties"), in accordance with state parameters and will fully participate in the State Administered Evaluation.

Signature ___________________________ ________________________

County Mental Health Director Date

Executed at Berkeley, California

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

Form No. 1

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

County: City of Berkeley **Date: 02/27/2009**

1. **The county shall ensure that the Community Program Planning Process is adequately staffed. Describe which positions and/or units assumed the following responsibilities:**

   a. The overall Community Program Planning Process

   The Mental Health Services Act (MHSA) Coordinator convened a PEI Planning Committee whose role it was to map out the PEI Community Program Planning Process. The PEI Planning Committee included a Steering Committee Member, and the following positions:
   - Consumer Liaison
   - Family Advocate
   - Mental Health Program Supervisor
   - MHSA Coordinator
   - Multicultural Outreach Coordinator

   b. Coordination and management of the Community Program Planning Process

   The following positions were responsible for the coordination and management of the Community Program Planning Process:
   - Mental Health Program Supervisor
   - MHSA Coordinator

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

   The following positions were involved in ensuring that stakeholders had the opportunity to participate in the Community Program Planning Process:
   - Consumer Liaison
   - Family Advocate
   - Mental Health Director
   - Mental Health Program Supervisor
   - MHSA Coordinator
   - Multicultural Outreach Coordinator

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

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

Prior to the PEI Community Program Planning Process, Mental Health management decided to reconstitute the ongoing MHSA Steering Committee. The MHSA Steering Committee was convened in 2004 and oversaw development of the Community Services and Supports (CSS) Plan. In order to more fully develop the Steering Committee and better reflect PEI interests, Berkeley Mental Health (BMH) worked to expand representation of unserved, underserved, and inappropriately served populations on the Steering Committee.

A PEI Planning Panel of diverse individuals was also convened, whose role it would be to narrow down PEI Populations and Priority Needs, and make service or strategy recommendations to the Steering Committee. To that end, a "PEI Planning Panel and Steering Committee Interest Form" was created as a way for community members to apply to serve on either the PEI Planning Panel or the ongoing MHSA Steering Committee.

The Interest Form was translated into three different languages, and distributed widely to obtain community participation. It was provided at various city meetings, and mailed and/or emailed to a broad base of community members, schools, organizations, consumers, and family members. To ensure inclusion, the MHSA Coordinator worked closely with the Multicultural Outreach Coordinator, the Family Advocate, and the Alcohol and Other Drugs (AOD) Coordinator to specifically outreach to, and invite participation from, individuals and family members in unserved, underserved, and inappropriately served populations.

An administrative panel that included the Mental Health Director, Family Advocate, Consumer Liaison, Multicultural Outreach Coordinator, and Training Coordinator was convened to review all Interest Forms and select PEI Panel and Steering Committee participants. Selection criteria was based on creating a diverse constituency for each group with representation from the following:

- Unserved, underserved and inappropriately served populations
- Mental health consumers and family members
- Education, health, and mental health providers
- Social service agencies
- Law enforcement

- Students
- Mental health commission members

Eight targeted Focus Groups were also convened and facilitated by an outside consultant to obtain input on PEI priority needs from specific populations. The focus groups elicited input from the following populations and/or those serving them:

- Adults/Older Adults
- African-Americans
- Asian Pacific Islanders
- Children & Youth
- LGBT (Lesbian, Gay, Bi-sexual, & Transgender)
- Mental Health Consumers
- Transition Age Youth (Family members/providers only)
- Youth/Transition Age Youth (Youth/TAY only)

The results of the Focus Groups were published and distributed or made available to stakeholders for review.

In addition to being invited to participate in Focus Groups, on the PEI Planning Panel, and/or on the MHSA Steering Committee, unserved, underserved and inappropriately served populations were solicited for the PEI Strategy Committee. The purpose of the PEI Strategy Committee was to seek further input on PEI Priority needs from individuals representing Transition Age Youth, Adults, and Older Adult populations.

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

Along with the targeted Focus Groups and vast outreach efforts to ensure a diverse representation of individuals in the PEI Process, the following opportunities for community participation were also available:

- Four “PEI Community Information and Input meetings” were held in Berkeley and Albany. Meeting announcements were placed in local newspapers, and fliers were posted in the community, and mailed and emailed to the MHSA Distribution List. Two of the meetings were held at well-known high schools in each city. A third meeting, targeting the Hispanic population in both communities was held in Berkeley and conducted in Spanish. The fourth meeting outreached to the Asian Pacific Islander population in both communities and was held in Albany. Translators were either available or on-site at each of the

meetings, and all materials and power points were translated into Spanish, Chinese, and Korean.

- Community members and stakeholders were invited to complete the PEI Survey. The survey was available both online and in three different languages in hard copy format. Surveys were handed out at various city meetings, and information on accessing the electronic link to the survey was on the MHSA website and either mailed or emailed to community members, stakeholders and the MHSA Distribution List.

- The community was invited to submit "PEI Community Strategy Reports" as another way of sharing ideas on PEI priority needs and strategies. A "PEI Community Strategy Report Outline" was created, translated into three different languages and distributed widely via mail, email, and/or hand delivery to invite feedback from community members, schools, organizations, consumers, and family members.

- Steering Committee meetings were open to the community to learn about the PEI process and register public comment.

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

Consumers who had previously participated in MHSA activities were mailed the "PEI Panel and Steering Committee Interest Forms", "Consumer Focus Group" flier, PEI Community Meeting announcements, and all other related PEI materials.

The MHSA Coordinator also attended a monthly mental health consumer Town Hall meeting to hand out "PEI Panel and Steering Committee Interest Forms" and announce and distribute fliers for the "Consumer Focus Group". Additionally, Focus Group fliers and Interest Forms were available in the Adult Clinic lobby, and Interest Forms were available at the Family, Youth and Children's clinic.

The Consumer Liaison was instrumental in convening consumer participants in the PEI process by announcing and handing out the Interest Forms and Consumer Focus Group fliers at the Wellness Recovery Task Force monthly meeting, and Mental Health Commission meeting, and by mailing/or emailing PEI documents to the Alameda County Consumer Pool of Champions.

Similarly, the Family Advocate devoted much time and energy into ensuring that Family Members were informed of opportunities and invited to participate in all PEI Community Outreach activities.

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

a. Participation of stakeholders as defined in Title 9, California Code of Regulations (CCR), Chapter 14, Article 2, Section 3200.270, including, but not limited to:
- Individuals with serious mental illness and/or serious emotional disturbance and/or their families
- Providers of mental health and/or related services such as physical health care and/or social services
- Educators and/or representatives of education
- Representatives of law enforcement
- Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families

The participation of stakeholders either in community meetings, in focus groups, on the PEI Planning Panel, on the PEI Strategy Committee and/or on the MHSA Steering Committee included the following representatives:
- A Better Way (Foster Family and Adoption Program)
- Acupuncture Detox
- Adult Services Program (Berkeley Mental Health)
- Alameda County MHSA Ongoing Planning Council
- Albany Unified School District
- BAHIA (Bay Area Hispanic Institute for Advancement, Inc.)
- Bay Area Children First (Children and Families Mental Health Agency)
- Berkeley Adult School
- Berkeley Alliance
- Berkeley Food and Housing Project
- Berkeley Organizing Congregations for Action (BOCA)
- Berkeley Police Department
- Berkeley Public Health Division
- Berkeley Unified School District
- Berkeley Youth Alternatives
- Black Infant Health
- Brothers Helping Brothas
- Building Opportunities for Self Sufficiency (B.O.S.S.)
- Center for Independent Living

- City Managers Office
- Community Members
- Family Members
- Family, Youth & Children's Services (Berkeley Mental Health)
- Fred Finch Youth Center
- Head Start Program
- Inter-City Services, Inc.
- Jewish Family and Children's Services
- Lifelong Medical Care
- Mental Health Commission
- Mental Health Consumers
- Muhsana Center for Health and Healing
- Pacific Center (LGBT Community Center)
- Progressive Missionary Baptist Church
- Satellite Housing
- Students (High School & College)
- Through the Looking Glass (Mental Health Program Serving Families with Physical Disabilities)
- Vera Casey Center (Teen Parenting Center)
- YEAH! (Youth Emergency Assistance Hostel)

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

The following opportunities for training were held for those participating in the Community Program Planning Process:

- Steering Committee members and city staff were invited to attend PEI Webcasts hosted by the Department of Mental Health (DMH).
- Sessions of the PEI Panel and reconvened MHSA Steering Committee were devoted to training participants on PEI Guidelines.
- Participants attending Focus Groups and "PEI Community Information and Input Meetings" were provided with information on PEI guiding principles.

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

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

A lesson learned in the CSS process was how difficult it is to effectively engage the community for input, without raising unrealistic expectations around programming and/or funding distributions.

As is often the case, with both the CSS and PEI components there were more community needs voiced than funding available. In order to avoid duplicating outreach efforts and raising unrealistic expectations on the use of funds, the PEI Planning Panel revisited community data gathered during CSS Program Planning that reflected PEI priority needs.
Also noted during the CSS process is how challenging it is to keep the community engaged in a meaningful way after the program planning process has concluded. During the PEI 30 day public comment period, local meetings were held to inform and seek input from the community on the draft plan. These meetings were also used as a means to continue to outreach to the community to invite individuals from unserved, under-served and inappropriately served populations to become a part of the ongoing Steering Committee. Upon Plan approval, additional outreach is planned.

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

The PEI community outreach process was successful in garnering participation from a broad representation of individuals including those from unserved, underserved and inappropriately served populations and transition age youth. Stakeholders participated in the following PEI Community Program Planning activities:

- Community Information and Input Meetings
- PEI Surveys
- Focus Groups
- PEI Planning Panel
- PEI Strategy Committee
- MHSA Steering Committee

Input from each of these vehicles was included in the data reviewed by the PEI Planning Panel and Steering Committee in order to arrive at a set of strategies that reflected MHSA guidelines, community needs and priorities, and available resources and opportunities.

While participation in planning was broad and representative overall, we did not engage as diverse a group as desired for the reconvened Steering Committee. Nonetheless, very divergent views emerged and for various reasons a fair amount of conflict characterized the group's decision-making. To that end, a Design Group was formed, with members from

Berkeley Mental Health administration and the Steering Committee. The Design Group was intended to improve the planning process and promote more cohesive work as a Steering Committee. Ultimately, the Steering Committee was able to come together to make recommendations based on relative consensus.

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

a. The date of the public hearing:

The public hearing was held on January 29, 2009 at 5:00 pm at the BMH Adult Services Clinic auditorium.

b. A description of how the PEI Component of the Three-Year Program and Expenditure Plan was circulated to representatives of stakeholders' interests, and any other interested parties who requested it.

The 30-Day Public Comment period on the PEI Component of the Three-Year Program and Expenditure Plan began on December 30th and ran through January 28th and was announced through a local Press Release. The Draft Plan was posted on the City of Berkeley MHSA website. Copies of the plan (or information directing individuals to the website) were sent via mail or email to city staff, stakeholders, community members and organizations listed on the MHSA Distribution List. Copies of the Draft Plan were available in Spanish and English in the reference section at the Public Library in downtown Berkeley. Copies of the plan were also mailed to the Mental Health Commission members. During the 30-Day Public Comment period local meetings were held to inform and seek input from the community on the draft plan.

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

The only substantive recommendations for revisions were in the Budget and Budget Narratives where funds were moved to accommodate training and professional service needs. All comments and BMH responses are outlined in Attachment B.

d. The estimated number of participants: 142

The City of Berkeley's MHSA Community Services and Supports (CSS) planning process took place over a nine-month period in 2005. During this extensive planning process, over 70 informational meetings, focus groups, and age-based work groups were held in various community settings, obtaining input from over 636 diverse participants. Surveys were distributed in three different languages, of which over 345 responses were received. Community input and survey data were reviewed and prioritized by the MHSA Steering Committee in collaboration with Berkeley Mental Health staff to inform the CSS Plan.

As part of the PEI stakeholder input and data analysis process, community data gathered during CSS Program Planning that reflected PEI priority needs was revisited. The following PEI community input activities were also conducted:

- A PEI Planning Committee was convened to design the community input process
- Four "PEI Information and Input Meetings" were held at various settings to educate the public on the PEI guidelines and obtain feedback on community needs
- A PEI Survey was created and distributed widely in two different languages
- An outside consultant was utilized to facilitate eight Focus Groups to obtain feedback from unserved, underserved and inappropriately served populations in Berkeley and Albany
- The public was invited to submit "PEI Community Strategy Reports" as a way of gaining information on program ideas that would address community PEI priority needs
- Data/information on community needs was compiled from the following sources: CSS Community Input process; PEI Survey; Mental Health and School Strategic Partnership; Berkeley and Albany Unified School Districts; Life Long Medical Center; PEI Focus Groups; PEI Community Information and Input Meetings; Public Health Division Health Disparities Project
- A PEI Planning Panel, facilitated by an outside consultant, was convened to evaluate community data and establish recommendations for PEI priority needs
- PEI Planning Panel recommendations and "Community Strategy Reports" were presented to the MHSA Steering Committee
- A PEI Strategy Committee, facilitated by an outside consultant, was convened to further develop strategies specific to TAY, Adults and Older Adults in unserved, underserved and inappropriately served populations
- Berkeley Mental Health collaborated with the MHSA Steering Committee to formalize PEI strategies and funding distributions.

Through a consultant led process, the PEI Planning Panel reviewed community data and grouped local PEI priority needs into the following five areas:

- Cultural Sensitivity & Responsiveness
- Addressing School Culture
- Promoting New Models of PEI
- Community Education
- Early Identification: Children, Youth & Families (See Attachment A)

Recommendations were made to fund strategies that addressed PEI priority needs and populations that aligned with the five topical areas. The proposed PEI Projects described herein respond to PEI Planning Panel recommended topical areas as follows:

PROPOSED PROJECT	RECOMMENDED TOPICAL AREA
Project #1: "Behavioral-Emotional Assessment, Screening, Treatment, and Referral (BE A STAR)"	• Early Identification: Children, Youth & Families • Promoting New Models of PEI • Cultural Sensitivity & Responsiveness
Project #2: "Building Educational Support Teams (BEST)"	• Addressing School Culture • Early Identification: Children, Youth & Families • Cultural Sensitivity and Responsiveness
Project #3: "PEI Community Education/Supports"	• Cultural Sensitivity & Responsiveness • Promoting New Models of PEI • Community Education
Project #4: Anti-Stigma Campaign	• Community Education

PEI PROJECT SUMMARY

Enclosure 3
Revised 08/08

Form No. 3

County: City of Berkeley **PEI Project Name: BE A STAR** (Behavioral-Emotional Assessment, Screening, Treatment, and Referral) **Date: December 26, 2008**

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☒	☒	☒	☒
3. At-Risk Children, Youth and Young Adult Populations	☒	☒		
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☐	☒	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	Transition Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☐
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☒	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒		
6. Underserved Cultural Populations	☒	☒	☒	☐

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

City of Berkeley CSS Community Program Planning identified various PEI priority needs for children and youth. Those needs along with data from targeted focus groups, community meetings, PEI Survey, city and community health reports, and local community collaborative groups working on improving the health and well-being of young children and families (including the Berkeley Integrated Resource Initiative and Birth to Five Action Team), were part of the information acquired to inform the PEI Community Program Planning process.

The PEI Planning Panel that reviewed all data, identified children from birth to five and their families as one of the priority populations for funding. It was recognized that strengthening the pre-school culture through concentrated efforts to promote healthy early childhood development will support and build the resilience of young children and their family caregivers, and will have a significant impact on the elementary school climate as they enter kindergarten and beyond. Several key themes emerged across all sectors of MHSA that are pertinent to the area of early childhood development and a focus on children birth to five and their families:

- Priority populations include low-income communities, homeless families, intergenerational families, youth (including dropouts), parents with depression, uninsured, and new immigrant families
- Focusing on early intervention efforts for families with children birth to five has the potential to maximize prevention by identifying and responding to problems early, and avoiding the stigma of an eventual special education label. This was particularly important to participating representatives of communities of color
- Outreach and other interventions need to be culturally appropriate, family and community-driven, and able to serve the diverse cultures in Berkeley, particularly those found in unserved, underserved and inappropriately served communities
- Education, parent peer support and family advocacy models should be emphasized
- Services should be placed within communities so they are accessible, including childcare sites and pediatricians offices. Locating services at sites where families receive routine preventive and wellness health care or other services, rather than at mental health clinics, will also reduce stigma associated with families feeling singled out for services because they are perceived as having problems
- Policy changes and reforms to the system of services are needed to foster innovative practices and expand access for communities traditionally not served

Extensive research exists substantiating that the period from 0 – 5 years has the most important influence of any time in the life cycle on brain development and subsequent learning, behavior, and health. Adverse early child experiences can have long term effects that impact behaviors in adolescence and adulthood, increasing the risks for poor physical and mental health outcomes in adult life, reduced educational attainment, and criminal behavior. Children exposed to physical, social-emotional, and environmental trauma in these early years are at risk for developmental, cognitive, behavioral, and emotional problems that may last a lifetime. Individual and environmental risk factors for developmental delay and social emotional concerns have been delineated in the research literature. Children at greatest risk are born into families living in poverty, who experience chronic environmental stressors with significantly fewer resources within their community to help them support their child's natural resilience and healthy development. The most vulnerable children are those who have parents – that are less than twenty years old, lack high school educations, and have histories of substance abuse, domestic violence and/or mental illness.

Early identification and provision of support to children with mild to moderate problems can help them overcome these challenges and thereby decrease the likelihood of receiving a life-long diagnosis. Working with our youngest children can help prevent more serious problems, ameliorate the need for more expensive interventions later on and support better child outcomes. However, most children with developmental and behavioral concerns are not identified until well after they start elementary school. It is estimated that one out of every six children has some level of delays, yet pediatricians, for example, fail to refer 60-80% of children with developmental delays in a timely manner. Many low-income children enter school with significant cognitive deficits relative to higher-income students, placing them at risk for poor educational outcomes. These children could benefit from relatively low-cost, community-based interventions that would improve educational and health outcomes significantly, were there a system in place to identify them and link with health promotion, wellness and when necessary, intervention services. Nationally, where providers have participated in early childhood development screening, there has been a 14% reduction in special education later on and a 13% reduction in the number of those children who don't pass a grade.

Many experts recommend screening all children early for developmental, social-emotional, and behavioral concerns, including the American Academy of Pediatrics, California Blue Ribbon Autism Task Force, and Federal Child Abuse and Prevention Act. The National Academy for State Health Policy Assuring Better Child Development Project has demonstrated the feasibility of implementing universal screening for at-risk children, and the utility of such screening in improving referral and access to services. Despite the known importance of early identification for school readiness and a healthy life later on, screening and assessment is relatively rare. There is no system in Berkeley for standardized developmental screening.

Even when early identification of children occurs, current systems for assessment and treatment are complicated and confusing, and many children do not meet strict eligibility criteria for specialized tertiary systems of care such as Regional Center or mental health services for children with Serious Emotional Disturbances. The burden of finding affordable, appropriate intervention and support falls especially hard on low and moderate income communities of color, many of whom do not qualify for government supported programs but make too little to afford private pay options. Concerns about the stigma associated with labeling of their children, particularly with mental health problems, is also a significant deterrent to many parents of color seeking care.

However, there is compelling evidence that well-designed early childhood interventions show a return to society ranging from $1.80 to $17.07 dollars for every dollar spent, and that these interventions can improve school readiness, school success, mental and physical health outcomes, and economic participation. Parenting education, skill-building and support groups, wellness and health promotion education, nurse home visiting with first time mothers, developmental playgroups, mental health consultation to pediatric and child care providers, and various other interventions have been shown to be cost-effective strategies to improve healthy child development and promote positive health outcomes.

3. PEI Project Description:

BE A STAR builds on best practice approaches already implemented in many communities to institute systems to identify children with or at risk for developmental delays and ensure that these children and their families receive appropriate services and support. The overall goal is to implement a coordinated system in Berkeley for the identification of children birth to five at risk of developmental delays, physical, social-emotional, and behavioral concerns, with subsequent triage, assessment, referral, and treatment as needed to appropriate community-based or specialist services. BE A STAR is a program of Berkeley's Public Health Division that will incorporate and leverage MHSA-PEI funds to fully develop BE A STAR's mental health prevention and early intervention functions.

The program will develop the following components over the next two years:

- Develop an education strategy that builds on the strengths and resiliency of families and their community, supports positive parenting skills and emphasizes ways to achieve optimal health and wellness
- Create a coordinated system for universal screening for developmental delay and social-emotional-behavioral concerns in at-risk children ages 0-5, and for post-partum depression and peri-natal alcohol and other drug use
- Use a common standardized and validated screening instrument and train and support pediatric and childcare providers to use the tool. Initial implementation would focus on pediatric providers who serve low-income families participating in the CHDP system, and subsidized child-care providers

- Establish a triage system so that providers will be able to easily access help and consultation with managing further assessment and referral for any positive screen (to be integrated ultimately with Alameda County's SART system)
- Develop "family advocates and navigators" – recruited and trained from the community – to assist parents in accessing appropriate services and programs, and to ensure that children do not "slip through the cracks" in our complicated and fragmented systems of care
- Work with Alameda County and service agencies to augment existing assessment resources, and ensure availability of follow-up assessments after positive screens
- Develop a referral system in coordination with Alameda County and service providers so that children and family in need of services go to the right place at the right time and are not bounced from agency to agency
- Develop inter-operable data systems to track screenings, assessment, referrals, and treatments, in coordination with Alameda County
- Expand accessible and culturally competent community-based supports and therapeutic interventions for children diagnosed with developmental delays and social emotional problems, including non-intensive therapeutic options such as parent-child developmental playgroups, parent support groups, parenting classes and mental health consultation in pediatric practices and child care programs
- Identify and advocate for policy changes that can support the long-term goals for improvements in healthy early child development

The BE A STAR team will work with existing local service initiatives, collaboratives and task forces already working on healthy early childhood development, including the Berkeley Youth Collaborative, Berkeley Integrated Resources Initiative's Birth to Five Action team (that will serve as the community advisory group to this project), the Berkeley 20/20 Vision, Public Health's Vera Casey Teen Parenting Program, and Black Infant Health, the Alameda County First Five SART team, and others to ensure broad community stakeholder engagement, maximize coordination and minimize potential duplication of efforts, particularly in the planning phase.

The following strategies embedded in this project will facilitate cultural competency: use of a strength-based approach in which parents are a partner in the development and implementation; the recruitment, training and provision of stipends to parents/family navigators; and collaborative partnerships with parent and community advocacy groups. Parent advocates will be members of the communities being reached out to and will reflect the community's social, cultural and personal life experiences. They will be selected partly based on their credibility in the neighborhood, and whether they are seen as a trusted resource. Collaborations with United in Action, the Latino People's Collective parent groups, the Head Start Parent Advisory Group, Bay Area Hispano Institute for Advancement (BAHIA) and Bananas parent leadership groups will ensure a community voice is brought to the planning and is able to influence and shape the implementation of the project.

Additionally the Ages and Stages Questionnaire (ASQ) tool that will be used for screening has been standardized nationally with a large (12,000) culturally, ethnically and economically diverse population, and its use as the national "gold standard tool" is in part due to its adaptation to be relevant to culturally diverse families. It can be parent-administered, is written at a 6th grade level, and allows for parents to be directly and actively engaged in looking at their child's developmental progress along key milestones. It can also be used as a tool to educate parents on developmental stages in early childhood, what to expect, and how to support their child's healthy growth.

While the ultimate goal is to establish a universal screening and referral system for all Berkeley/Albany children birth to five, the initial pilot will focus on communities at greatest risk due to severely limited resources coupled with significant long term community or family stress and exposure to trauma. Research has shown that the children most at risk for developmental and social emotional problems and delays are those who:

- Are living in poverty
- Have a mother who (a) is less than 20 years old, (b) has less than 12 years of education, or (c) has smoked or used alcohol or used drugs during the pregnancy
- Were born pre-term or at low birth-weight
- Are victims of abuse or neglect, including malnutrition and emotional neglect
- Are living in or transitioning out of foster care
- Have a mother experiencing poor physical or mental health and/or domestic violence

Locally, families living in South West Berkeley have a lower income than other Berkeley neighborhoods, have higher rates of a number of health conditions, are exposed to more street violence and do more poorly in school. Low income, teen parent, homeless, substance abusing, maternal depression, foster care and families living in the South West Berkeley area will be the highest priority for year one of this project. Plans for future years include continuing to serve these identified at-risk populations and to focus new outreach efforts among other unserved, underserved and inappropriately served families of Berkeley and Albany. The ultimate goal is to offer universal screening to every family at key milestone stages in their child's development.

4. Programs

Program Title **BE A STAR**	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
A. Outreach and education to understand early childhood development, and how to promote health and wellness for young children, the importance of routine developmental screening, and introduction of the ASQ screening tool, will be offered to at least two childcare sites, staff and families, two pediatric providers and 2-4 additional parent groups.	Individual Children: 120 Providers: 6-10 Families: 50-75	Individuals: Families:	3 *Note: Projected annualized numbers are as follows: Children: 600 Providers: 30 Families: 250
B1. Training of providers in use and interpretation of the ASQ tool and availability of assessment and referral resources. B2. Screening of children birth to five at key developmental stages, at two subsidized childcare center and two pediatric practices that serve CHDP and Medi-Cal children. B3. Screening of moms for post-natal depression and substance abuse.	B1: Providers: 6 Individual children: 120 Families: 50-75	B2: Individual Moms: 25-30 Families: 25-30	3 *Note: Projected annualized numbers are as follows: <u>Prevention:</u> Children: 600 Providers: 20-30 Families: 250 <u>Intervention:</u> Individual Moms: 30-60 Families: 50-75
C. Recruitment and training of Family Advocates/Navi-gators to work with at least ten identified families to ensure receipt of needed services.	Individuals: Families:	Children: 28 Families: 10	3 *Note: Projected annualized numbers are as follows: Children: 112 Families: 40
D1. More extensive assessment, including mental health consultation, of an estimated 10-20% of those screened.	Individuals: Families:	D1 & D2: Individual children:	3

	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		
D2. Referral for either monitoring, community-based or more intensive intervention programs, in partnership with Family Advocate/Navigators. Referrals will be based on the triage system and the mapping of existing community resources (both developed within the first six months of program implementation).		25-35 Families: 8-12	*Note: Projected annualized numbers are as follows: Children: 100-125 Families: 32-48
E. Ongoing consultation and periodic training with pre-school classroom teachers, parents and pediatricians to assist with appropriate assessment, referral and strategies for classroom interventions.	Children: 120 Families: 50 Providers: 8-10	Individuals: Families:	3 *Note: Projected annualized numbers are as follows: Children: 300 Families: 125-150 Providers: 24-40
F. Intensive assessment, referral and case management for children and, as needed parents, to address developmental problems and delays.	Individuals: Families:	Individual children: 10-15 Families: 5	3 *Note: Projected annualized numbers are as follows: Children: 40-60 Families: 20
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	Providers: 6-10 Children: 120 Families: 50-75	Individual moms: 25-35 Individual children: 25-35 Families: 25-35 (all a subset of Prevention #s)	3 *Note: Projected annualized unduplicated numbers are as follows: Prevention: Children: 600 Families: 250 Providers: 30 Intervention:

	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		
			Children: 100-125 Families: 32-48 Individual Moms: 30-60

Note: Reflected above is a gross estimate of the numbers of individuals and families that will be served thru the prospective timeframe. Actual numbers will be dependant on start-up time, etc.

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

BE A STAR will create a coordinated system and infrastructure for screening and referral that will reach a larger portion of the community than is currently served, and will enhance the ability of low income and chronically stressed families to access prevention and early intervention services. The project will offer prevention and early intervention services in local settings already used by these families (pediatricians and childcare sites). The incorporation of family advocates and peer navigators will encourage and facilitate families to get needed assistance and will create a broad cadre of culturally diverse workers outreaching within their own communities. The potential to leverage additional funds is high, through matching with existing funding streams available to public health and mental health. This will allow for significant improvement in services to families and children who might previously not have qualified for reimbursement.

6. Collaboration and System Enhancements

BE A STAR will operate out of the City of Berkeley's Public Health Division and will coordinate with the Mental Health Division's Family, Youth and Children's (FYC) Program for consultation and referrals. The following other collaborations, partnerships or arrangements will be developed with the implementation of BE A STAR:

- ***Berkeley-Albany Head Start and Early Head Start***, operated by the Berkeley Albany YMCA, will continue to provide screening for enrolled children, and will utilize BE A STAR for referrals for children identified as at-risk or in need of further assessment and services. Their Parent Advisory Board will serve as a resource for input in developing the program and ensuring it is accessible and culturally relevant.
- ***Berkeley Integrated Resources Initiative Birth to Five Action team*** will be expanded and will serve as advisory team for BE A STAR program implementation and policy development. Community groups (e.g. BAHIA, United in

Action) will be asked to serve to ensure that the voice of families is heard throughout program development and implementation.

- ***Berkeley Public Health Division*** programs will be fully coordinated with BE A STAR, including Public Health Nursing, Black Infant Health, CHDP (Child Health and Disability Prevention) and Vera Casey program for pregnant and parenting teens.
- ***Alameda County First Five:*** BE A STAR will work closely with First Five to ensure that BE A STAR is fully and completely integrated with the Alameda County SART system as the County system is implemented over the next several years. It is anticipated that the County will eventually provide a 1-800 triage line, and will provide additional resources for in-depth assessments.
- ***Alameda Alliance*** managed care organization will facilitate work with providers and referrals for medically necessary services.
- ***Lifelong Medical Center*** will be approached as a screening site; BE A STAR will collaborate closely with Centering Pregnancy and Centering Parenting programs at Lifelong.
- Additional referral agencies including ***Children's Hospital Early Childhood Mental Health Program and Behavior Disorders Program, Regional Center of the East Bay, Through the Looking Glass, Brighter Beginnings, Seneca, other Alameda County agencies, Berkeley Unified School District (BUSD) Special Education, East Bay Agency for Children Therapeutic Nursery School, Family Paths, Jewish Family and Children's Services, La Familia, The Link to Children,*** and many others.
- ***Pediatric providers*** will be trained in and provided assistance with the use of standardized screening tools and referral protocols.
- ***Additional subsidized Childcare providers*** will be recruited, trained in and provided assistance with the use of standardized screening tools and referral protocols, including BUSD early childhood education sites (over two years).

Leveraging existing community and financial resources will be integral to achieving the overall goal of the BE A Star program. Berkeley Public Health plans to leverage state and federal Maternal, Child, and Adolescent Health funding with MHSA-PEI dollars. Through this funding component, it is anticipated that the match to PEI dollars will be on a 1:1 basis. Additional potential funding streams/financial resources include: EPSDT for provision of mental health consultation and treatment; First 5 of Alameda County for county SART system potentially to include triage and assessment services; Medi-Cal Administrative Activities (MAA); Targeted Case Management (TCM); Medi-Cal (e.g. family advocates will help eligible families enroll in Medi-Cal so that they can access services and providers can be reimbursed); and grant funds to support innovative community-based interventions to support healthy child development.

Implementing standardized screening during pediatric visits and in subsidized childcare will facilitate this program in several ways. Nearly all children (excluding those born in another country) are eligible for free pediatric care through Public Health's Child Health and Disability program, and all children are required to get certain immunizations to attend either licensed day care or enter kindergarten. Offering screening through CHDP pediatric practices will make it more convenient for families to receive this service as their children already utilize this "common gateway service". Likewise, many low-income families already use subsidized childcare centers and have trusting relationships with the staff there, making it more likely they will feel comfortable participating in screening that happens for all families at their childcare site. Once children are identified as at-risk, there are a variety of assessment, referral, and treatment services for children ages 0-5 in Berkeley that can be leveraged as part of BE A STAR.

7. Intended Outcomes

The long-term goal of BE A STAR is "a healthy start for every child", so that **all** children can achieve their potential. The program's vision is that this effort will ultimately lead to reduced inequities in health and education outcomes and will enhance children's future life and health. The overall intended outcome in the first three years of BE A STAR is to establish a coordinated system for screening, assessment, referral, and treatment of children who have or are at risk for developmental delay and/or social-emotional-behavioral concerns. Specific intended individual and system level outcomes of BE A STAR are to:

- Increase awareness of the importance of healthy early childhood development, and the efficacy of identifying early any developmental delays or social, emotional and behavioral concerns among parents, providers and community agencies
- Increase the number of children who are routinely screened for developmental/social-emotional concerns using a validated and standardized screening tool
- Increase the proportion of children with possible concerns who are assessed, referred, and receive appropriate services and/or treatment early, so more serious problems can be prevented
- Improve coordination of screening, assessment, treatment, and referral for young children and their families so that children do not slip through the cracks
- Improve coordination between Berkeley and Alameda County systems
- Expand services that treat children with developmental delays and social emotional concerns, through increasing capacity of existing services and leveraging existing resources to expand services
- Prevent more serious developmental delays and social emotional concerns that affect children's school readiness

8. Coordination with Other MHSA Components

BE A STAR will potentially coordinate with multiple MHSA components. Children, youth and families who meet the criteria will be referred to Berkeley's MHSA/CSS Intensive Support Services program. Project administrators and community partners may receive training offered through the WET component. Additionally, collaboration and referrals will occur between other proposed PEI projects, particularly the BEST Project in order to strengthen the transition of children from pre-school or family care to kindergarten. As appropriate, parents may also be referred to support group services that are implemented through the Community Education/Supports Project.

9. Additional Comments (optional)

Literature shows that the most important life stage in terms of prevention and early intervention is the period from birth to five. Recognition that promotion of healthy early childhood development can support and build the resilience of young children in ways that carry into adulthood makes this project an essential component of Berkeley's mental health prevention and early intervention efforts. The potential for early intervention among our youngest children to strengthen not only the pre-school culture, but to have a significant impact on the elementary school climate as these young children enter kindergarten is compelling. This project offers Berkeley a unique opportunity to build bridges across the entire life course and across generations, by incorporating early childhood development efforts with school-linked prevention activities and strategies that serve at-risk teens and other parent caregivers, including grandparents who are caring for many of these at-risk children.

PEI PROJECT SUMMARY

Enclosure 3
Revised 08/08

Form No. 3

County: **City of Berkeley** **PEI Project Name:** **Building Effective Schools Together (BEST)**
Date: **December 26, 2008**

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☐	☐
2. Psycho-Social Impact of Trauma	☒	☒	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	☒	☒		
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☒	☒	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	Transition Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☐	☐
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☒	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒		
6. Underserved Cultural Populations	☒	☒	☒	☒

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).
City of Berkeley CSS Community Program Planning identified various PEI priority needs for children and youth. Those needs along with data from targeted focus groups, community meetings, a PEI Survey, and local community collaborative groups including the Schools-Mental Health Partnership (SMHP)[1], were part of the information acquired to inform the PEI Community Program Planning process. The PEI Planning Panel who reviewed all data, determined children and youth to be priority populations for funding.

Data revealed achievement gaps, perceptions of culturally uninformed or unwelcoming school environments, and other social and environmental inequities that make children and youth in underserved cultural populations at risk for school failure and juvenile justice involvement, among other things. Research suggests that children begin to fail in school before other mental health problems begin to emerge and that early school failure is at least partially causative of other risk behaviors. For this reason, schools are a critical context for providing prevention and early intervention mental health services (CA Department of Mental Health, MHSA Web cast, May 20, 2005).

The Berkeley and Albany communities have long recognized the inequities that exist and the importance of the school context in providing mental health services to children, youth and families. Over the past several years, significant work has been done in both communities to enhance school-based services and cultural competence. The SMHP was created in 2005 as a multi-agency, cross-jurisdictional collaboration committed to building a comprehensive system of school-based and school-linked mental health care in the pre-K through 12 schools. The SMHP completed a comprehensive, community-wide resource assessment of the mental health needs of children, youth and families, which served as the basis for the Berkeley Schools-Mental Health Strategic Plan (2007).[2] This plan, which establishes a service delivery infrastructure and a continuum of school-based services from prevention to intensive interventions, is currently under implementation.

After the first year of implementing the Schools-Mental Health Strategic Plan, mental health providers have been placed in every school in Berkeley and interdisciplinary service coordination teams called "Universal Learning Support System (ULSS) Teams" have been established at every school site. These teams receive referrals of students with academic and

[1] Members include Berkeley Alliance, Berkeley Unified School District, Birth-to-Five Action Team, Berkeley Mental Health Family, Youth & Children's Services, Berkeley Public Health (School-Linked Services Program), School Mental Health Providers, Alameda County Behavioral Health.
[2] Schear, T. & Warhuus, L. (2007). Berkeley Integrated Resources Initiative: Schools Mental Health Partnership Strategic Plan. Berkeley Alliance, Berkeley, CA.

behavioral health needs, and link students and their families to school-based and school-linked health and behavioral health services.

Following the suicides of two Albany students within a year period, in 2006 Albany voters passed a parcel tax that included dedicated funding for school-based mental health services. The parcel tax was used to hire a full-time mental health professional for Albany High School and a part-time clinician contracted with City of Berkeley Mental Health. Through use of EPSDT revenues, the second position was increased to full-time and serves Medi-Cal eligible and uninsured elementary and middle school students. Based on voter support for mental health services for children and youth, advocacy by Mental Health Commissioners, Albany elected and school district officials, this new partnership between Albany and Berkeley Mental Health was forged. The missing link has been sufficient resources to offer a more comprehensive approach that expands prevention services in addition to the current crisis and treatment oriented services.

While efforts to enhance school-based mental health services in Berkeley and Albany have increased as a result of these community-wide efforts, effectively serving all students with needs remains a challenge. While service availability is steadily improving, the number of new referrals continues to exceed the number of students who can be served. One important reason for this service gap is the lack of a prevention program in place to build protective factors and strengthen resiliency. A second cause is the lack of sufficient resources to serve students who are not Medi-Cal eligible, such as undocumented students, in early intervention programs. Several of the school sites bear the costs of providing limited services to these students, however there are inequities from school-to-school, with no clear baseline for even a minimal level of service. While this is less of an issue in the middle schools and high schools, where district staff is often the service provider, the elementary schools are especially affected by this problem, as they rely heavily on Medi-Cal billing to provide services.

3. PEI Project Description:

This project is entitled *BEST or "Building Effective Schools Together"*. The project emphasizes the implementation of an effective mental health prevention strategy in the Albany and Berkeley public school systems, and also helps fill some of the resource gaps inherent in the current system of early intervention services. The prevention component will support all students, although the underserved and inappropriately served are expected to benefit more, as these students are more likely to suffer from the absence of a prevention system. Enhancements to the early intervention system will primarily benefit the underserved, particularly low-income students without Medi-Cal (i.e. undocumented and uninsured students), as these students frequently do not receive needed services.

As one of the efforts to implement the SMHP Strategic Plan, work has already begun towards the implementation of the BEST program in the Berkeley Schools. BEST is a prescribed model of *Positive Behavioral Supports* (PBS), which is one of the most effective evidence-based models of mental health prevention and early intervention utilized in schools.

Positive Behavioral Supports (PBS) is a systems-oriented, data driven approach for establishing the social culture and behavioral norms needed for a school to be an effective learning environment for all students. PBS is based upon the reality that schools typically deal with problem behavior by over-relying on the use of aversive and exclusionary consequences. Teachers, staff and administrators respond to student displays of chronic behavior problems by increasing their use of verbal reprimands, exclusionary consequences (i.e. detention and suspensions) and loss of privileges and rewards. Most frequently, the students affected by such actions are those in the most "at risk" groups, with lower academic results and weaker support resources in their homes and neighborhoods. In other words, the students who are typically underserved or inappropriately served by the educational and mental health systems. Rather than building upon protective factors and resiliency as expected, the school environment and feelings of failure experienced by students with behavioral challenges becomes a causal factor in the emergence of mental health problems.

The goal of PBS is to achieve effective behavior support for all members of the school community. PBS implementation transforms the culture of a school from one that takes a reactive and aversive approach to managing problem behavior to one that takes a preventive, positive, and supportive approach. Rather than relying on a "blame and punish" approach, schools learn to assess, analyze, and address how their own culture and climate contribute to negative behavior. The initial goal is to achieve effective behavior support for the entire school community by clearly defining, explicitly teaching, and encouraging school-wide behavioral expectations in all contexts of the school (i.e. school-wide, classroom, and non-classroom/non-instructional settings). Once this universal approach is achieved (at which time research shows significant reductions in behavioral problems in the school), schools focus on providing affirmative, yet effective, early intervention strategies for the few students who continue to struggle with behavior despite improvements in the school environment. A substantial body of research demonstrates that PBS can be effectively implemented in schools and that implementation leads to transformative outcomes for students and schools. (Horner, R.H., & Sugai, G., 2005). [3]

BEST (developed at the Institute for Violence and Destructive Behavior, University of Oregon) is one of the most well-known and researched models of PBS. Successful BEST implementation is a three-to-five year process of systems

[3] Horner, R.H., & Sugai, G., (2005). School-wide positive behavior support: An alternative approach to discipline in schools. (pp. 359-390). In L.Bambara & L. Kern (Eds.) Positive Behavior Support. New York: Guilford Press.

transformation in a school. The first year focuses on a systematic, data-driven effort to improve school climate. Through the BEST model, program implementation at a school site involves the creation of a 6-12 member school site implementation team (often termed a BEST Team or school climate team) that minimally consists of an administrative leader, teachers and staff, mental health/other service providers, and parents. The team works with a BEST coach and interacts periodically with the rest of the school staff to review existing behavioral information/data and identify clear behavioral outcomes. The team then works to accomplish the following: analyze, describe and prioritize the issues that need to be addressed within the school context; work with school staff and parents to define and teach behavioral expectations; implement explicit and systematic ways of acknowledging positive behavior among students; ensure on-going collection and use of data for decision-making and continued progress toward meeting outcomes; and modify practice implementation based on the analysis of progress data. In the second and third years, the site implementation team focuses on continued, data and outcome driven improvements to school climate, as well as on identifying and implementing concrete, evidence-based practices to support the students who continue to struggle behaviorally despite school climate improvements. In subsequent years progress continues to be monitored carefully based on data, interventions are refined and improved, and new staff members receive a thorough orientation and training as needed. Once BEST has been fully implemented, the team continues to meet regularly to monitor and review the program, and ensure that outcomes continue to be met.

As part of the monthly evaluations of BEST, each school site will be considering the ethnic/racial breakdown of student's receiving/not receiving discipline referrals. The over-representation of a particular ethnic/cultural group as having behavioral problems will be seen as a sign that the program is not effectively serving that particular group and adjustments will be made to ensure that the school culture is effectively supporting all of its students. Feedback about the project will also be sought from parents, with an emphasis on ensuring that the cultural groups of all students are well represented in the feedback. All communications about the project will be provided to families in languages used by the school population. In Berkeley, in an effort to better serve all of its students, principals and several teachers have been participating in ongoing training in culturally responsive pedagogy. The tools learned in this training will help ensure that each site's BEST program is relevant and meaningful to all student cultural populations.

Consistent with the most successful models of PBS in communities, implementation will involve roll out at a few schools at a time (Institute for Violence and Destructive Behavior, University of Oregon). With much success, BEST has been rolled out in two Berkeley schools over the past couple of years with good initial success. Additional local measures towards the implementation of BEST have included:

- May 2007, Berkeley City Council and the Berkeley Board of Education entered into a formal agreement to ratify the Schools-Mental Health Partnership, which included an agreement to jointly implement a mental health prevention program in the schools
- In honor of that agreement, the FYC Program assigned a senior-level clinician to serve as the School Based Services Coordinator. A portion of her time will go toward supporting BEST implementation
- The Manager of Family and Community Partnerships was appointed to lead BEST roll out in BUSD
- April 2008, the SMHP sponsored a full day of cross training for all BUSD school sites and all school-based mental health providers on the BEST model with one of the founders, Dr. Jeffrey Sprague

Leveraging MHSA monies will provide the additional resources needed to ensure full implementation of BEST in all targeted Berkeley and Albany schools.

With the combination of BEST implementation and the early intervention services implemented by the Schools-Mental Health Partnership, the Berkeley and Albany Public Schools will be much more equipped to build protective factors and resiliency in students, and to address mental health problems when they do emerge. Despite this strong combination of a prevention and early intervention approach, there are still resource gaps in the system. One significant gap is the ability of the Berkeley elementary schools to provide early intervention services to students who do not have Medi-Cal or other mental health insurance coverage. This gap exists because providers cannot recapture the costs of providing services to these students, and the elementary schools frequently do not have the funds to pay for them. To strengthen the capacity to serve these students, especially during BEST implementation, this project will provide some funding for the provision of early intervention services to non-Medi-Cal students who need them. Such services will include group intervention, teacher consultation, referrals to outside agencies, and parenting support. The Berkeley elementary schools and the school districts will also be encouraged to add additional funding to the system to further enhance service levels.

The Health Center at Berkeley High School was established in 1993 and offers a range of excellent public and mental health services, demand, however, outpaces capacity for mental health services and the more traditional individual therapy model in place is currently being re-designed to respond to a range of unmet needs. These gaps involve effective prevention, assessment, referral and treatment for high school students who are experiencing and/or are at-risk of substance abuse, co-occurring and other unaddressed mental health problems. Building on programs and relationships already implemented through the SMHP, this project will collaborate with the High School Health Center at Berkeley High and provide resources to begin to create strategies to address these and other emerging and longstanding needs. As described previously, Albany Unified School District (AUSD) has more recently begun to address the mental health needs

of its students. The BEST project will help increase the effectiveness of the already existing prevention efforts at Albany High School.

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
BEST in Berkeley and Albany	Individuals: 1,650 Families:	Individuals: 125 Families: 65	3 Note: Projected annualized numbers are as follows: Prevention: Individuals: 2,650 Families: 1,000 Intervention: Individuals: 150 Families: 75
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 1,650 **Families**:	**Individuals:** 125 **Families**: 65	3 Note: Projected annualized unduplicated numbers are as follows: Prevention: Individuals: 2,650 Families: 1,000 Intervention: Individuals: 150 Families: 75

Note: Reflected above is a gross estimate of the numbers of individuals and families that will be served thru the prospective timeframe. Actual numbers will be dependant on start-up time, etc.

Separate from the public schools, questions also exist around the level of PEI resource needs in the many private schools that exist in Berkeley and Albany. This is of particular concern because scholarships exist for low-income youth to attend local private schools that may or may not have access to the mental health resources they need. Therefore, resources

will be utilized for the FYC Program to begin to assess and create strategies to address any gaps in services and needs that exist among students attending local private schools.

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

Berkeley and Albany schools will collaborate with the FYC Program for the delivery of services. BUSD has a "Universal Learning Support System (ULSS)"policy that mandates all schools to have interdisciplinary ULSS teams at their schools sites to receive referrals, assess students, and link them directly to services. Each school site has a mental health provider that sits on its ULSS team and is responsible to link students to behavioral health services. School-based mental health providers come from either BUSD (Middle Schools Only), Berkeley Mental Health, or one of the following three local nonprofit mental health agencies: Bay Area Children First, Bay Area Community Resources, and Rosa Parks Family Resource Center.

Implementation in the Albany and Berkeley schools will involve outside technical assistance to the school sites, along with capacity building within the system so that on-going support and technical assistance can be provided to the schools over time.

The school districts will provide full training to school psychologists and program supervisors, such that they can serve BEST coaches as part of their regular capacity. Additionally the schools and/or district will pay some of the costs for teacher/staff release time and substitutes.

6. Collaboration and System Enhancements

The Berkeley Schools-Mental Health Partnership is an interagency collaboration of Berkeley Mental Health, Berkeley Public Health, BUSD, and nonprofit agencies. The partnership is committed to building a comprehensive system of school-based and school-linked mental health care, for the purpose of ensuring that all Berkeley students have access to the social and emotional support they need for healthy development and school success. The Schools-Mental Health Partnership is part of the Berkeley Integrated Resources Initiative (BIRI), a community wide endeavor launched in 2005 to integrate school and community resources in policy and practice, with a common goal of promoting healthy child and youth development and breaking down barriers to learning. BIRI builds on a longstanding partnership between BUSD, City of Berkeley, and University of California at Berkeley (UCB), and weaves together existing institutional change efforts into a single coordinated and unified process. Most recently, BIRI merged with a grass roots effort organized by

community members concerned with achievement and health inequities in Berkeley to become the Berkeley 2020 Vision for Children and Youth.

The implementation of BEST will strengthen the Schools-Mental Health Partnership by bringing a unified prevention strategy into the schools and by increasing the number of adults promoting social emotional wellness with children and youth (teachers, after school providers, mental health providers). While most school districts implementing BEST rely solely on educators to do the work, the strength of existing partnerships in Albany and Berkeley put us in a superior position to leverage existing resources with MHSA-PEI funds. Working collaboratively on BEST implementation will be transformative for both school districts and the mental health system. The culture of the schools will become more inclusive and positive; far more conducive to student learning and social/emotional development. Mental health providers will expand their current practice into the prevention and early intervention realms and become increasingly integrated into the functioning of the schools. The strength of existing partnerships means that the BEST coaches and most other resources needed for BEST implementation can be housed either in the schools or a mental health agency, depending upon which of the organizations is in the best position to leverage funds. With key point people already appointed by all of the partners, the ingredients for success are in place.

7. Intended Outcomes

Research has shown that rigorously implemented prevention programs in schools result in fewer students developing problems that require more substantial attention (Institute for Violence and Destructive and Behavior, University of Oregon). The ability to rigorously implement prevention and early intervention supports would fill a significant gap in the broader service continuum. Because the prevention effort reduces the number of students in need of mental health services, the current mental health service resources in the Albany and Berkeley Schools will be less stretched, and better able to meet referral needs. This is indeed why a key priority of the Berkeley SMHP Strategic Plan is the implementation of an effective model of mental health prevention in the pre-K through 12 schools.

<u>Individual Outcomes</u>

- Improvements in the perception of school safety and school “health” through the following:
    1.) Decreases in risk factors including: difficulties in school; negative attitudes towards school/low bonding/low school attachment/low commitment to school; aggressive behaviors or other anti-social behaviors, etc.

2.) Increases in protective factors" including: school motivation/positive attitude toward school; student bonding, commitment and connectedness to school; prosocial school involvement.

- Decreases in the number of students needing intensive behavioral supports.
- 20-60% reduction in office discipline referrals for students.
- Increases in the time students spend in instruction.

As noted above, successful implementation of BEST in the Berkeley/Albany Schools will reduce the number of students referred for more extensive mental health services, such that the current system can more effectively meet student mental health needs.

<u>System and Program Outcomes</u>

- Schools will become a more welcoming place for children, youth and families through the following:
  1.) Decreases in negative labeling by teachers and school staff.
  2.) Decreases in the amount of time administrators and teachers spend addressing problem behaviors.
  3.) Increases in the presence and involvement of caring, supportive adults who consistently provide and adhere to clear standards and rules.
  4.) Provision of opportunities and rewards for students who engage in prosocial school involvement.

- Through the provision of sufficient technical support, Berkeley/Albany schools will successfully adopt PBS to fidelity.
- Longitudinal studies indicate that PBS practices have sustained up to 10 years following implementation, even with turnover in administrators and core team members.

8. Coordination with Other MHSA Components

The BEST project will potentially refer individuals and families to various CSS funded programs including: Intensive Support Services; Family Advocacy Services; Transition Age Youth Support Team, etc. Ideally BEST will also coordinate with and refer parents and individuals to the following other PEI proposed projects: "BE A STAR" and PEI Community Education/Supports.

9. Additional Comments (optional)

In contrast to the typical mental health clinic, schools are a real-life context frequented by most children, youth and families in a community. As such, appropriately structured school-based services have the potential to reduce stigma and address state identified Key PEI Community Mental Health Needs. The BEST program implements prevention and early intervention services that target children and youth at risk of school failure, provides early identification and intervention for students with emerging mental health challenges and enhances protective factors and resiliency for all students.

PEI PROJECT SUMMARY

Enclosure 3
Revised 08/08

Form No. 3

County: City of Berkeley PEI Project Name: PEI Community Education/Supports
Date: December 26, 2008

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☐	☒	☒	☒
2. Psycho-Social Impact of Trauma	☐	☒	☒	☒
3. At-Risk Children, Youth and Young Adult Populations	☒	☒		
4. Stigma and Discrimination	☐	☒	☒	☒
5. Suicide Risk	☐	☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
B. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☐	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☐
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☐	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒		
6. Underserved Cultural Populations	☐	☒	☒	☒

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

CSS Community Program Planning identified the following populations to be unserved or underserved by the mental health system: Asian Pacific Islanders; Latinos; Seniors, and Transition Age Youth (TAY). Although African Americans were found to be overrepresented in the mental health system, the cultural appropriateness of the services they receive remains questionable. Furthermore, it is unclear on the number of LGBTQQI community members accessing mental health services and, as with the African American population, how appropriate the services are.

Throughout the PEI community data gathering process, gaps in the availability of, and access to, services providing support for individuals experiencing trauma and everyday stressors were frequently identified. Focus Group and community input data revealed the following traumatic experiences, social inequities, and mental health related stressors in each unserved, underserved or inappropriately served population:

African Americans:

- Trauma of racism (historically and in everyday experiences)
- Disparities in access to appropriate mental health services
- Lack of service providers that are culturally competent and linguistically astute
- Inappropriate labeling and stereo-typing of children/youth
- Unwelcoming school environments
- Suicide risk
- Substance Abuse

Asian Pacific Islanders:

- High incidence of Domestic Violence
- High depression rates among women and transition age youth (16-25)
- High parental expectations for academic achievement and success, which often leads to a secondary or nonexistent focus on the well-being of youth
- Multi-generations of families caught between two cultures: the country of origin and America
- Cultural stress around immigration and integrating into a new culture

- Stigma of mental illness and receiving mental health treatment
- Lack of service providers that are culturally competent and language proficient
- Disparities in access to appropriate mental health services
- Gambling, substance abuse and eating disorders

Latinos:

- Lack of access to service providers that are bilingual and culturally competent
- Experience of children/youth being discriminated against and incorrectly labeled due to poor language proficiency
- Multi-generations of families caught between two cultures: the country of origin and America
- Experience of culture shock and stress related to immigration and integrating into a new culture
- Lack of services/supports for everyday stresses and problems
- Domestic Violence
- Substance Abuse
- Stigma and fear of accessing mental health services
- Trauma around racism and discrimination

LGBTQQI:

- Stigma and discrimination related to sexual orientation (which can cause anxiety, fear and depression)
- Isolation, marginalization and invisibility
- Suicide Risk
- Substance Abuse
- Lack of service providers who are competent in LGBTQQI issues
- Discrimination directed at youth who have parents who are LGBTQQI
- Shortage of appropriate services

Seniors:

- Grief due to increasing losses of family, friends, mobility and self-determination
- Increased physical illnesses
- Isolation
- Loss of independence and autonomy
- Elder Abuse
- Prescription medication misuse or abuse
- Suicide Risk
- Stigma of mental illness and accessing mental health services
- Negative feelings about self-worth and usefulness
- Depression

Transition Age Youth:

- Family economic stressors
- School stressors
- School failure or drop out
- Substance Abuse
- Stigma of mental illness and accessing mental health services
- Suicide Risk
- Verbally, mentally, physically or sexually abusive family or personal relationships
- Risk of criminal or gang involvement

Common themes across each underserved cultural population include: a lack of service providers that are culturally competent and language proficient; stigma of mental illness and accessing mental health services; disparities in access to appropriate mental health services; and a lack of support services and education for trauma exposed individuals and those experiencing everyday stressors.

A PEI Planning Panel that was convened during the Community Program Planning process to evaluate community data and identify key PEI priority needs, made recommendations to implement programs that: provide community education and supports; are culturally sensitive and appropriate; and are community based. Similar recommendations from the PEI Strategy Committee, which was convened to develop strategies to address TAY, Adults and Older Adults in underserved cultural populations, was to implement community based, culturally competent, support services for trauma exposed individuals and/or those in need of coping strategies to deal with social inequities or stressful life situations.

Trauma in the broadest sense, related to domestic violence, child or elder abuse, the enduring effects of poverty, racism, stigma and discrimination, lack of access to health care, wars and civil strife, etc., all can contribute to the onset of post traumatic stress disorder, depression, anxiety and other mental health problems. The resulting psychological anguish caused by exposure to traumatic experiences, social inequities, and everyday life stressors can contribute to increased substance abuse, community and family violence, school dropout and failure, suicide risk and the perpetuation of trauma across multi-generations.

3. PEI Project Description:

By partnering with community groups to implement culturally appropriate support services to individuals in underserved cultural populations, this project will address needs identified in the PEI Community Program Planning Process. Community based organizations, social service agencies, faith based venues, recreational entities, neighborhood groups, etc. currently serving underserved cultural populations in Berkeley and Albany will be provided with financial resources and technical assistance to implement support groups and community educational strategies to address trauma and other identified PEI priority needs.

In collaboration with Berkeley Mental Health, each program will be flexibly designed to meet the needs of the targeted population. Funding recipients will be able to creatively design services based on the priority needs of the population they serve. Programs will outreach to the communities they serve and implement support structures based on priority needs. At the minimum programs will provide: outreach and engagement, targeted support groups, and community education. Flexibility will also be provided to include the following additional capacity building strategies:

- **Building Leaders** = Interested community participants will undergo a training on the provision of prevention and early intervention services and resource acquisition. Graduates will become paid trainers and mentors while continuing to develop skills for further employment in the human service field.

- **Consultation/Training** = Professional staff and/or contracted consultants will provide training and follow-up consultation to other city and community based organizations in order to ensure the delivery of culturally competent services and to develop rudimentary skills across the service provider network on mental health screening, assessment, intervention and referral. Culturally specific interventions and follow-up will be a central part of this capacity building strategy.

All programs will be required to adhere to the following PEI Panel recommendations:

- Service providers will be trained and can demonstrate they use culturally appropriate tools and resources
- Services offered will be strength-based and recognize the socio-cultural context of the individual's and group's needs and will "normalize" (de-stigmatize) services and education
- Service providers will have the capacity or be expected to develop the capacity to identify and refer individuals who may need more formal mental health services
- Service providers will be knowledgeable about and capable of successfully referring and linking individuals to other community resources

This project is influenced by theories behind the following two programs listed on "SAMHSA's National Registry of Evidenced-based Programs and Practices": "Trauma Affect Regulation:

- Guide for Education and Therapy (TARGET)",[4]
- "Seeking Safety"[5]

Targeting TAY and Adults in underserved cultural populations, both programs implement skill building and support for those who have experienced trauma.

For purposes of initial planning, funding will be equally distributed across programs serving TAY, Adults and Older Adults in the following unserved, underserved and inappropriately served populations: African Americans, Asian Pacific Islanders, Latinos, LGBTQQI, Senior Citizens, and Transition Age Youth. As services and leveraging opportunities

---

[4] Ford, J., & Ford, J. (2007). Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
[5] Najavits, L. (2000). Seeking Safety therapy for PTSD and Substance Abuse

develop, resource allocation will be adjusted according to changing needs. While this project will target TAY, Adults and Older Adults, children and youth residing in families where individuals access services, will also directly benefit. Furthermore, educational activities and outreach strategies provided under these programs will target the whole family.

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
African American	Individuals: 30 Families: 15	Individuals: Families:	3 *Projected annualized numbers are as follows: Individuals: 60 Families: 25
Asian Pacific Islander	Individuals: 10 Families: 5	Individuals: Families:	3 *Projected annualized numbers are as follows: Individuals: 40 Families: 15
Latino	Individuals: 30 Families: 20	Individuals: Families:	3 *Projected annualized numbers are as follows: Individuals: 60 Families: 40
LGBTQQI	Individuals: 30 Families: 10	Individuals: Families:	3 *Projected annualized numbers are as follows: Individuals: 60 Families: 25

	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		
Senior Citizens	Individuals: 20 Families: 5	Individuals: Families:	3 *Projected annualized numbers are as follows: Individuals: 60 Families: 25
Transition Aged Youth	Individuals: 20 Families: 5	Individuals: Families:	3 *Projected annualized numbers are as follows: Individuals: 50 Families: 10
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 170** **Families: 60**	**Individuals:** **Families:**	3 *Projected annualized unduplicated numbers are as follows: Individuals: 500 Families: 120

Note: Numbers are based on receiving PEI Plan approval by mid-February 2009 and conducting an RFP process with contract awards by mid-March. Figures include those individuals accessing outreach and engagement and support services. Projected numbers reflect a gross estimate of individuals and families that will be served during the prospective timeframe. Actual numbers will be dependant on the contracting process, start-up time, etc.

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

The project emphasizes engaging individuals and families in a range of prevention, early intervention and other community services, and therefore increases the capacity for screening, early identification and successful referrals for more serious mental health problems.

6. Collaboration and System Enhancements

Funding recipients will provide space to hold support groups/community meetings; develop/distribute promotional materials to inform the public about the support groups/community meetings; provide culturally competent trained staff who will either solely lead or co-lead support groups and/or educational sessions.

Berkeley Mental Health will provide financial resources, program coordination and staff or consultants who will work with agencies on planning and implementing support groups/community education.

Due to size and scale, the project will need to build on existing PEI related efforts in Berkeley and Albany which may include health care, social services, ATOD, faith-based, educational, recreational or other governmental or non-governmental service organizations. The overall project has potential to fill in gaps at the "front door" of the mental health system and is viewed as an integrative service approach within the larger system of care. A few examples of existing programs that could either be replicated or expanded through this initiative in order to reach a larger population include but are not limited to the following:

- **Brothers Supporting Brothas** is a culturally specific intergenerational program designed to provide young African American men with access to positive African American mentors/role models from the community. Over a six-month timeframe, young adults meet on a weekly basis with a diverse group of African American male facilitators from varying age groups and life experiences, to address individual and collective culturally specific struggles and problems faced by African American men. Topics encourage, enlighten, educate, and support participants by providing them with life skills that enhance the thinking process, increase the ability to make positive decisions, and raise self-esteem. The program also focuses on leadership development skills, community service, "rites of passage", and building support within the African American community, which increases self-esteem, and community bonding.

- **Latino Families in Action** provides culturally competent psycho-educational support services and referrals to Latino individuals and families who are experiencing social, emotional, psychiatric, physical, and/or spiritual problems. With a goal of reducing the stigma of mental illness, the program coordinates with various city and community resources to educate, inform and support the Latino community. Individuals and families can participate in informational forums and/or become involved in one of several targeted psycho-educational support groups.

- **Seniors Caring for Seniors** helps to ease the burden and build community among senior care providers. Many older adults provide care for either their ailing parent or some other elderly individual. This can cause stress and isolation on the part of the caretaker. "Seniors Caring for Seniors" meets once a month and provides information and support for elderly caretakers. Operated through the Berkeley Division on Aging, this support group program links with respite care services for those providing care for an elderly individual.

- **Lesbians of Color (LOC) Support Group** provides a safe environment for women to support one another, share experiences, find issue resolution, and discuss cultural similarities, differences and the reality of racism within the LGBTQQI community. Convened by the Pacific Center, this group meets once a week, serving 10-15 participants.

This project will fill a gap in services by providing ongoing resources that aren't currently available for community based support services, particularly in underserved cultural populations. It could also provide capacity building by increasing the potential for reciprocal consulting and training opportunities between community-based organizations, and mentoring leaders within the community. Additionally, this project will partner with the Community Health Worker Pipeline, a collaborative project between Berkeley's Public and Mental Health Divisions and Berkeley Community College to provide community health workers with skills in case management, AOD services, public health and social service intervention and related skills.

7. Intended Outcomes

An intended individual outcome will be to prevent the onset or reduce the severity of, depression, anxiety, post-traumatic stress disorder or other mental health problems. Other individual outcomes include promoting resilience by providing resources, experiences and information to support those who have suffered or are at-risk for suffering various traumatic experiences, including the enduring effects of poverty, disenfranchisement, racism, stigma and discrimination. Intended system and program outcomes are as follows:

- Increased community awareness of the link between trauma and mental health problems
- Reduced stigma around mental health services
- Increased access to education and support for mild to moderate mental health problems
- Increased capacity for screening and successful referral for more intensive mental health services
  Berkeley Mental Health staff will collaborate with each funding recipient on the creation of measurable outcomes that are specific to the given population

8. Coordination with Other MHSA Components

This project will coordinate with the CSS component by referring individuals in need to CSS funded services including: Full Service Partnerships; Family Advocacy services; Employment services, TAY outreach and engagement, etc. Programs choosing to implement training, consultation and/or mentoring components will also potentially coordinate with the Workforce, Education and Training (WET) initiative. Additionally, CSS and WET funds may ultimately be leveraged to support this project in the future, helping to create a continuum of services in the development of an integrated MHSA Plan. Services will also coordinate with the other proposed PEI Projects as appropriate.

9. Additional Comments (optional)

PEI PROJECT SUMMARY

Enclosure 3
Revised 08/08

Form No. 3

County: **City of Berkeley** **PEI Project Name:** **Social Inclusion Project**
Date: **December 26,2008**

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☐	☒	☒	☒
2. Psycho-Social Impact of Trauma	☐	☒	☒	☒
3. At-Risk Children, Youth and Young Adult Populations	☒	☒		
4. Stigma and Discrimination	☐	☒	☒	☒
5. Suicide Risk	☐	☒	☒	☒

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	Transition Age Youth	Adult	Older Adult
C. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☐	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☐	☐
3. Children and Youth in Stressed Families	☐	☐		
4. Children and Youth at Risk for School Failure	☐	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒		
6. Underserved Cultural Populations	☒	☒	☒	☒

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

CSS and PEI Community Program Planning identified stigma and discrimination as a key issue for current and would be mental health consumers that should be a priority need for funding. Data gathered in the Community Program Process, including input from a focus group of mental health consumers, identified the following potential results of being exposed to stigma and discrimination:

- Feelings of alienation, marginalization and/or isolation
- Internalized oppression, suffering and trauma
- Distrust of others
- Anger and indignation
- Post traumatic stress disorder
- Increased risk for suicide

Stigma regarding mental health problems and discrimination against mental health consumers are rampant in our culture. Mass media venues contribute by perpetuating stereotypes and using language (such as “crazy”, “nuts”) that connotes negative labels and caste individuals in an undesirable, even dangerous light. Those accessing mental health services often feel shamed, feared and/or disregarded by others. Others in need of mental health services often avoid seeking help for fear of being labeled or discriminated against.

3. PEI Project Description:

This project will work with Alameda County to ensure a coordinated effort around Anti-Stigma Campaigns and programming. The City of Berkeley’s Consumer Liaison participates on Alameda County’s MHSA Ongoing Planning Council which developed and approved the County’s PEI Plan. It will be vital for Berkeley to interface with the County’s newly proposed Stigma and Discrimination Liaison regarding the coordination of Anti-Stigma efforts. The proposed Berkeley and Albany local efforts will be twofold:

First, a group of Berkeley and Albany consumers & family members will be convened to develop local strategies for combating stigma and discrimination in conjunction with Alameda County’s proposed Action Committees. Berkeley

Mental Health will then coordinate with Alameda County, schools, consumers, family members, and local communities and agencies on the implementation of chosen strategies.

Secondly, in conjunction with Berkeley Mental Health's CSS Employment Specialist, consumers will be trained and hired to conduct presentations to programs serving underserved cultural populations, as well as schools and other community organizations in order to dispel myths, attitudes and discrimination around mental health clients and issues. Having the venue to share stories around recovery and healing will ideally reduce stigmatizing attitudes, while empowering those consumers and family members who are providing the presentations. An important aspect of this component will be the convening of a Peer Supervision/Technical Assistance group for consumers and family members around stigma and discrimination issues. This will provide a supportive, exploratory, safe space for consumers and family members to come together to share information, seek assistance and provide mutual support.

4. Programs

PEI PROJECT SUMMARY

Enclosure 3
Revised 08/08

Form No. 3

Program Title **Berkeley Anti-Stigma Program**	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Convening of consumers and family members to develop local strategies for combating stigma and discrimination.	Individuals: 15 Families:	Individuals: Families:	3 *Projected annualized numbers are as follows: Individuals: 15
Working with Alameda County on implementing locally chosen Anti-Stigma and Discrimination strategies. (Note: This goal will mostly be accomplished after the projected June 2009 timeframe).	Individuals: Families:	Individuals: Families:	3 *Projected annualized numbers are as follows: Individuals: 15
Training and hiring of consumers to conduct Anti-Stigma presentations in public venues.	Individuals: 7 Families:	Individuals: Families:	3 *Projected annualized numbers are as follows: Individuals: 10
Peer Supervision/Technical Assistance group participation.	Individuals: 5 Families:	Individuals: Families:	3 *Projected annualized numbers are as follows: Individuals: 7
Community Presentations (Note: This goal will mostly be accomplished after the projected June 2009 timeframe).	Individuals: Families:	Individuals: Families:	3 *Projected annualized numbers are as follows: Individuals: 200 Families: 75

TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** **27** **Families**:	**Individuals:** **Families:**	3 *Projected annualized unduplicated numbers are as follows: Individuals: 215 Families: 75

Note: Projected numbers reflect a gross estimate of individuals and families that will be served during the prospective timeframe. Actual numbers will be dependant on the contracting process, start-up time, etc.

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

One element of Berkeley's Anti-Stigma Project will be to improve community knowledge and use of local mental health resources. These include both city and county programs and private sector resources. Individuals providing services will be trained in resource acquisition and referral/linkage skills.

6. Collaboration and System Enhancements

As described above, Berkeley's MHSA Anti-Stigma campaign will be closely tied to the much larger county-wide initiative in Alameda County's PEI Plan. The Berkeley Anti-Stigma Program will provide enhanced anti-stigma efforts in Berkeley and Albany than would otherwise be available through the county program. The Anti-Stigma Program also offers additional opportunities for consumers and family members to gain employment and other skills that may be incorporated into Berkeley's workforce development activities.

Collaborations with the following entities will be an integral part of this project:

- Alameda County Behavioral Health Care Services (BHCS) Stigma and Discrimination Liaison
- BHCS "Pool of Champions"
- National Association of the Mentally Ill (NAMI) local chapter
- Berkeley Drop In Center
- BHCS BestNow Program
- Berkeley and Albany Schools
- Community based organizations

Berkeley Mental Health will leverage resources with the identified collaborative partners. Local schools and community-based agencies will provide the meeting space and opportunities for consumers and family members to provide presentations to assembled groups of people.

7. Intended Outcomes

Intended individual outcomes will be to prevent the onset or reduce the severity of, depression, anxiety, post-traumatic stress disorder or other mental health problems that are associated with the exposure to stigma and discrimination. Other individual outcomes include promoting resilience by empowering, supporting and partnering with those who have suffered or are at-risk for suffering stigma and discrimination.

Intended program outcomes are to:

- Increase public knowledge on the detrimental effects of stigma and discrimination
- Decrease the incidence of stigma and discrimination
- Reduce stigma around mental health services
- Provide community awareness presentations around mental health stigma and discrimination to various unserved, underserved and inappropriately served populations.

Outcomes will be measured through some of the following:

- Numbers of presentations conducted to general public
- Numbers of presentations conducted specifically to unserved, underserved and inappropriately served populations
- Numbers of attendees at presentations
- Increases in the referrals/or use of Mental Heath services following public presentations.

8. Coordination with Other MHSA Components

This project will coordinate with the Community Services and Supports (CSS) component by referring individuals in need to CSS funded services including: Full Service Partnerships; Family Advocacy services; employment services, Transition Aged Youth services, etc. Programs will also potentially coordinate with the Workforce, Education and Training (WET) initiative around hiring consumers in the workplace. Additionally, it is envisioned that this project will provide presentations to the programs funded under the proposed PEI Community Education/Supports project.

9. Additional Comments (optional)

Form No. 4

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

County Name:	**City of Berkeley**	Date:	02/27/2009
PEI Project Name:	**Behavioral-Emotional Assessment, Screening, Treatment & Referral (BE A STAR)**		

Provider Name (if known):

Intended Provider Category:

Proposed Total Number of Individuals/Families to be served:	FY 08-09	38	FY 09-10	117
Total Number of Individuals/Families currently being served:	FY 08-09	0	FY 09-10	0
Total Number of Individuals/Families to be served through PEI Expansion:	FY 08-09	9	FY 09-10	26
Months of Operation:	FY 08-09	3	FY 09-10	9

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
0.30 Sr Hlth Svcs Pgm Specialist	5,902	17,706	23,608
0.80 Psychiatric Social Worker I	13,867	41,602	55,469
0.50 Comm Hlth Worker Specialist	6,711	20,133	26,844
0.30 Public Health Nurse	5,207	15,622	20,829
0.05 Clinical Psychologist	1,136	3,410	4,546
0.05 MH Program Supervisor	1,025	3,076	4,101
b. Total Salaries, Wages	33,848	101,549	135,397
c. Benefits and Taxes @ 54%	18,278	54,836	73,114
d. Total Personnel Expenditures	52,126	156,385	208,511
2. Operating Expenditures			
a. Facility Cost	3,854	11,561	15,415
b. Other Operating Expenses	10,000	28,325	28,325
c. Total Operating Expenses	13,854	39,886	53,740
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Prevention Services		15,000	15,000
Program Evaluation		30,000	30,000
a. Total Subcontracts		45,000	45,000
4. Total Proposed PEI Project Budget	65,980	241,271	307,251
B. Revenues (list/itemize by fund source)			
MAA		25,000	25,000
1. Total Revenue		25,000	25,000
5. Total Funding Requested for PEI Project	56,402	196,976	253,378
6. Total In-Kind Contributions	9,578	25,545	28,873

Form No. 4

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

County Name: **City of Berkeley** Date: 02/27/2009

PEI Project Name: **Building Educational Support Teams (BEST)**

Provider Name (if known):

Intended Provider Category:

Proposed Total Number of Individuals/Families to be served:	FY 08-09	412	FY 09-10	1,238
Total Number of Individuals/Families currently being served:	FY 08-09	0	FY 09-10	0
Total Number of Individuals/Families to be served through PEI Expansion:	FY 08-09	48	FY 09-10	142
Months of Operation:	FY 08-09	3	FY 09-10	9

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
1.75 Psychiatric Social Worker I	30,335	91,003	121,338
0.15 Clinical Psychologist	3,410	10,229	13,639
0.10 MH Program Supervisor	2,050	6,152	8,202
0.05 Office Specialist II	665	1,997	2,662
b. Total Salaries, Wages	36,460	109,381	145,841
c. Benefits and Taxes @ 54%	19,688	59,066	78,754
d. Total Personnel Expenditures	56,148	168,447	224,595
2. Operating Expenditures			
a. Facility Cost		0	0
b. Other Operating Expenses	8,950	36,875	85,825
c. Total Operating Expenses	8,950	36,875	85,825
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
School Site Service Providers		55,000	55,000
Training & technical assistance		40,000	40,000
a. Total Subcontracts		95,000	95,000
4. Total Proposed PEI Project Budget	65,098	300,322	365,420
B. Revenues (list/itemize by fund source)			
MAA		25,000	25,000
1. Total Revenue		25,000	25,000
5. Total Funding Requested for PEI Project	49,416	247,896	297,312
6. Total In-Kind Contributions	15,682	33,676	43,108

Form No. 4

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

County Name:	**City of Berkeley**			Date:	02/27/2009
PEI Project Name:	**Community Education/Supports**				
Provider Name (if known):					
Intended Provider Category:					
Proposed Total Number of Individuals/Families to be served:		FY 08-09	0	FY 09-10	230
Total Number of Individuals/Families currently being served:		FY 08-09	0	FY 09-10	0
Total No. of Individuals/Families to be served through PEI Expansion:		FY 08-09	0	FY 09-10	0
Months of Operation:		FY 08-09	3	FY 09-10	9

Proposed Expenses and Revenues		Total Program/PEI Project Budget		
		FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
MHSA Supervisor	0.10 Comm Svcs Specialist III	2,393	7,179	9,572
Multi-Cultural Svcs Coordinator	0.15 Comm Svcs Specialist II	2,950	8,849	11,799
Vocational Coordinator	0.10 Comm Svcs Specialist I	1,640	4,921	6,561
	0.20 Assistant Management Analyst	3,073	9,218	12,291
b. Total Salaries, Wages		10,056	30,167	40,223
c. Benefits and Taxes @ 54 %		5,430	16,290	21,720
d. Total Personnel Expenditures		15,486	46,457	61,943
2. Operating Expenditures (See below in Subcontracts)				
a. Facility Cost				
b. Other Operating Expenses		28,325	80,000	108,325
c. Total Operating Expenses		28,325	80,000	108,325
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
	African-American		26,520	26,520
	Asian Pacific Islander		26,520	26,520
	Latino		26,520	26,520
	LGBTQQI		26,520	26,520
	Senior Citizens		26,520	26,520
	Transition Aged Youth		26,520	26,520
a. Total Subcontracts			159,120	159,120
4. Total Proposed PEI Project Budget		43,811	285,577	329,388
B. Revenues (list/itemize by fund source)				
1. Total Revenue			0	0
5. Total Funding Requested for PEI Project		28,325	239,120	267,445
6. Total In-Kind Contributions		15,486	46,457	61,943

Form No. 4

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

County Name: **City of Berkeley** Date: 02/27/2009

PEI Project Name: **Social Inclusion**

Provider Name (if known):

Intended Provider Category:

	FY 08-09	FY 09-10
Proposed Total Number of Individuals/Families to be served:	7	20
Total Number of Individuals/Families currently being served:	0	0
Total Number of Individuals/Families to be served through PEI Expansion:	0	0
Months of Operation:	3	9

Proposed Expenses and Revenues		Total Program/PEI Project Budget FY 08-09	FY 09-10	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
Consumer Liaison	0.15 Comm Svcs Specialist II	2,689	8,065	10,754
Vocational Coordinator	0.10 Comm Svcs Specialist I	1,640	4,921	6,561
	0.10 Office Specialist II	1,340	4,022	5,362
b. Total Salaries, Wages		5,669	17,008	22,677
c. Benefits and Taxes @ 54 %		3,037	9,111	12,148
d. Total Personnel Expenditures		8,706	26,119	34,825
2. Operating Expenditures				
a. Facility Cost				
b. Other Operating Expenses		$4,165	6,660	10,825
c. Total Operating Expenses		$4,165	6,660	10,825
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
	Consumers & family members		7,500	7,500
a. Total Subcontracts			7,500	7,500
4. Total Proposed PEI Project Budget		$12,871	40,279	53,150
B. Revenues (list/itemize by fund source)				
1. Total Revenue				
5. Total Funding Requested for PEI Project		$4,165	14,160	18,325
6. Total In-Kind Contributions		$8,706	26,119	34,825

PEI Administration Budget Worksheet

Form No.5

County: **City of Berkeley** Date: 02/27/09

		Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2008-09	Budgeted Expenditure FY 2009-10	Total
A. Expenditures						
1. Personnel Expenditures						
a. MHSA Coordinator	Hlth Svcs Pgm Spec		0.35	8,288	24,863	33,151
b. PEI Support Staff	Office Specialist II		0.25	3,352	10,055	13,407
c. MHSA Supervisor	Comm Svcs Spec III		0.25	5,920	17,759	23,679
d. Assistant Management Analyst			0.10	1,620	4,863	6,483
e. Health Administrative Financial Specialist			0.05	1,185	3,556	4,741
f. Manager of Mental Health Services			0.05	1,640	4,919	6,559
Sub-Total	Salaries/Wages		1.05	22,005	66,015	88,020
g. Employee Benefits	@ 54%			11,882	35,648	47,530
h. Total Personnel Expenditures				33,887	101,663	135,550
2. Operating Expenditures						
a. Facility Costs				2,500	7,500	10,000
b. Other Operating Expenditures				3,750	31,250	35,000
c. Total Operating Expenditures				6,250	38,750	45,000
3.County Allocated Administration						
a. Total County Administration Cost				$40,137	140,413	180,550
4. Total PEI Funding Request for County Administration Budget				$27,560	$102,680	$130,240
B. Revenue						
1. Total Revenue						
C. Total Funding Requirements				$40,137	$140,413	$180,550
D. Total In-Kind Contributions				$12,577	$37,733	$50,310

Form No. 6

Instruction: Please provide a listing of all PEI projects submitted for which PEI funding is being requested. This form provides a PEI project number and name that will be used consistently on all related PEI project documents. It identifies the funding being requested for each PEI project from Form No. 4 for each PEI project by the age group to be served, and the total PEI funding request. Also insert the Administration funding being requested from Form No.5 (line C).

County:	City of Berkeley
Date:	02/27/2009

		Fiscal Year			**Funds Requested by Age Group**			
#	List each PEI Project	FY 08/09	FY 09/10	**Total**	*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
1	BE A STAR	$56,402	$196,976	$253,378	$253,378			
2	BEST	$49,416	$247,896	$297,312	$297,312			
3	Community Education/Supports	$28,325	$239,120	$267,445		$89,148	$89,148	$89,149
4	Social Inclusion	$4,165	$14,160	$18,325			$18,325	
	Administration	$27,560	$102,680	$130,240	$32,560	$32,560	$32,560	$32,560
	Total PEI Funds Requested:	$165,868	$800,832	$966,700	$583,250	$121,708	$140,033	$121,709

*A minimum of 51 percent of the overall PEI component budget must be dedicated to individuals who are between the ages of 0 and 25 ("small counties" are excluded from this requirement).

City of Berkeley PEI Plan
Budget Narratives

Budgets for each project show a full year of implementation and associated "one-time" costs. It is anticipated that in Budget Year 08-09, 25% of the funds will be utilized for program implementation.

City of Berkeley Project #1
Behavioral-Emotional Assessment, Screening, Treatment & Referral (BE A STAR)

Brief Program Description

BE A STAR will implement a coordinated system in the cities of Berkeley and Albany for the identification of children birth to five at risk of developmental delays, physical, social-emotional, and behavioral concerns, with subsequent triage, assessment, referral, and treatment as needed to appropriate community-based or specialist services. It is anticipated that a Senior Health Services Program Specialist will oversee the project on the Public Health side and supervise a Community Health Worker Specialist who will provide training, coordination and collaboration with community agencies, childcare providers, and pediatricians. The Mental Health Program Supervisor at Berkeley Mental Health Family, Youth and Children's Services will oversee the staff work of the Psychiatric Social Worker and Clinical Psychologist whose roles will be to provide consultation and clinical supervision of staff.

Budget Year 08-09

A. Expenditures

1) Personnel Expenditures: $52,126

   Salaries are reflective of City of Berkeley job classifications, and benefit rate for City of Berkeley is 54% inclusive of workers compensation costs:

   Lines "a" & "b", $33,848 reflects staff salaries.
   Line "c", $18,278 represents staff benefits.

   Positions include:
   - Senior Health Services Program Specialist - 0.30 FTE
   - Psychiatric Social Worker I - 0.80 FTE
   - Community Health Worker Specialist - 0.50 FTE
   - Public Health Nurse – 0.30 FTE
   - Clinical Psychologist - 0.05 FTE
   - Mental Health Program Supervisor - 0.05 FTE

2) Operating Expenditures: $13,854

   Line a - $3,854 for facility costs including rent and utilities.
   Line b - $10,000 for operating expenses including basic office supplies, training, and stipends.

3) Subcontracts/Professional Services: N/A
4) Total Proposed PEI Project Budget: $65,980

Revenue

Total Revenue – N/A

5) Total Funding Request for PEI Project: $56,402
6) Total In-Kind Contributions: $9,578

Budget Year 09-10

A. Expenditures

1) Personnel Expenditures: $156,385

Salaries are reflective of City of Berkeley job classifications, and benefit rate for City of Berkeley is 54% inclusive of workers compensation costs:

Lines “a” & “b”, $101,549 reflects staff salaries.
Line “c”, $54,836 represents staff benefits.

Positions include:

- Senior Health Services Program Specialist - 0.30 FTE
- Psychiatric Social Worker I - 0.80 FTE
- Community Health Worker Specialist - 0.50 FTE
- Public Health Nurse – 0.30 FTE
- Clinical Psychologist - 0.05 FTE
- Mental Health Program Supervisor - 0.05 FTE

2) Operating Expenditures: $39,886

Line a - $11,561 for facility costs including rent and utilities.
Line b - $28,325 for other operating expenses including basic office supplies, promotional materials, and vehicle/maintenance costs on a car to provide transportation for program staff.

3) Subcontracts/Professional Services: $45,000
    - Program Evaluation - $30,000 for costs associated with evaluating the BE A STAR program
    - Prevention services - $15,000

4) Total Proposed PEI Project Budget: $241,271

Revenue

Total Revenue - $25,000 reflects estimates of MAA revenues that will be generated by the new program.

5) Total Funding Request for PEI Project: $196,976
6) Total In-Kind Contributions: $25,545

City of Berkeley Project #2
Building Effective Schools Together (BEST)

Brief Program Description

The project will implement an effective mental health prevention strategy in the Albany and Berkeley public school systems, and help fill resource gaps inherent in the current system of early intervention services. It is anticipated that the Mental Health Program Supervisor, from Berkeley Mental Health Family, Youth and Children's Services will supervise the staff work of the Psychiatric Social Workers, Clinical Psychologist, and Office Specialist. The Psychiatric Social Workers will be trained in BEST practices and Become "BEST coaches". They will provide services across schools/districts. The role of the Clinical Psychologist will be for consultation and referrals. The Office Specialist will provide administrative support for project staff.

Budget Year 08-09

A. Expenditures

1) Personnel Expenditures: $56,148
   Salaries are reflective of City of Berkeley job classifications, and benefit rate for City of Berkeley is 54% inclusive of workers compensation costs:

   Lines "a" & "b", $36,460 reflects staff salaries.
   Line "c", $19,688 represents staff benefits.

   Positions include:
   - Psychiatric Social Worker I - 1.75 FTE
   - Clinical Psychologist - 0.15 FTE
   - Mental Health Program Supervisor - 0.10 FTE
   - Office Specialist II- 0.05 FTE

2) Operating Expenditures: $8,950
   Promotional materials and website improvements; computers, peripherals, software, etc.; miscellaneous supplies, equipment, services.

3) Subcontracts/Professional Services: N/A

4) Total Proposed PEI Project Budget: $65,098

B. Revenue
   Total Revenue – N/A

5) Total Funding Request for PEI Project: $49,416

6) Total In-Kind Contributions: $15,682

Budget Year 09-10

A. Expenditures

1) Personnel Expenditures: $168,447
   Salaries are reflective of City of Berkeley job classifications, and benefit rate for City of Berkeley is 54% inclusive of workers compensation costs:

Lines “a” & “b”, $109,381 reflects staff salaries.
Line “c”, $59,066 represents staff benefits.

Positions include:

- Psychiatric Social Worker I - 1.75 FTE
- Clinical Psychologist - 0.15 FTE
- Mental Health Program Supervisor - 0.10 FTE
- Office Specialist II- 0.05 FTE

2) <u>Operating Expenditures:</u> $36,875
    - Vision 2020 - $20,000 to be used towards augmenting funding for the City of Berkeley/Berkeley Unified School District Vision 2020 Initiative, which aims to eliminate disparities and achievement gaps in the Berkeley schools by the year 2020. Funding is part of City contribution for consulting, development and partnerships with community stakeholders for Vision 2020.
    - Vehicle/maintenance costs - $15,000 toward purchase and maintenance on a car to provide transportation for program staff. Vehicle will be shared among staff across PEI programs.
    - Basic office supplies - $1,875

3) <u>Subcontracts/Professional Services:</u> $95,000
    - School Site Service Providers - $55,000 to provide early intervention services to non-Medi-Cal students who need them. Services will include group intervention, teacher consultation, referrals to outside agencies, and parenting support.
    - Training and Technical Assistance - $40,000 for training and technical assistance for BEST coaches (35,000), and co-occurring and AOD disorders among adolescents ($5,000).
4) <u>Total Proposed PEI Project Budget:</u> $300,322

B. Revenue

Total Revenue - $25,000 reflects estimates of MAA revenues that will be generated by the new program.

5) <u>Total Funding Request for PEI Project:</u> $247,896

6) <u>Total In-Kind Contributions:</u> $33,676

City of Berkeley Project #3
Community Education/Supports

Brief Program Description

This project will implement culturally appropriate support services to individuals in underserved cultural populations. At the administrative level, it is anticipated that various duties of project coordination, implementation and oversight will be split among the following Berkeley Mental Health MHSA positions: MHSA Supervisor, Multi-Cultural Outreach Coordinator, and the Vocational Coordinator. An Assistant Management Analyst will also provide administrative support on contract development and management, data collection and evaluation of contracts.

Budget Year 08-09

A. Expenditures

1) Personnel Expenditures: $15,486
   Salaries are reflective of City of Berkeley job classifications, and benefit rate for City of Berkeley is 54% inclusive of workers compensation costs:

   Lines "a" & "b", $10,056 reflects staff salaries.
   Line "c", $5,430 represents staff benefits.

   Positions include:
   - MHSA Supervisor - Community Services Specialist III - 0.10 FTE
   - Multi-Cultural Services Coordinator - Community Services Specialist II – 0.15 FTE
   - Vocational Coordinator - Community Services Specialist I - 0.10 FTE
   - Assistant Management Analyst - 0.20 FTE

2) Operating Expenditures: $28,325
   - Grant writing - $10,000 to write grants to leverage and expand Community Education/Supports services.
   - Target training - $10,000 to provide prevention-oriented training for caregivers for seniors on loss, grief, and how to access support resources; and training on gender violence.
   - Miscellaneous - $8,325 for promotional materials and website improvements; computers, peripherals, software, etc.; miscellaneous supplies, equipment, services.

3) Subcontracts/Professional Services: N/A

4) Total Proposed PEI Project Budget: $43,811

B. Revenue
   Total Revenue – N/A

5) Total Funding Request for PEI Project: $28,325
6) Total In-Kind Contributions: $15,486

Budget Year 09-10

A. Expenditures

1) Personnel Expenditures: $46,457
   Salaries are reflective of City of Berkeley job classifications, and benefit rate for City of Berkeley is 54% inclusive of workers compensation costs:

   Lines “a” & “b”, $30,167 reflects staff salaries.
   Line “c”, $16,290 represents staff benefits.

   Positions include:
   - MHSA Supervisor - Community Services Specialist III - 0.10 FTE
   - Multi-Cultural Services Coordinator - Community Services Specialist II – 0.15 FTE
   - Vocational Coordinator - Community Services Specialist I - 0.10 FTE
   - Assistant Management Analyst - 0.20 FTE

2) Operating Expenditures: $80,000
   - Conference on Trauma - $15,000 to provide a city or countywide conference on trauma.
   - Training and technical assistance - $25,000 for engaging underserved populations, defining, understanding and modifying culturally inappropriate service practices; and collaboration with juvenile justice to identify at-risk youth and service development.
   - Pilot projects - $40,000 to implement community education and supports pilot projects

3) Subcontracts/Professional Services: $119,340
   - Consultants - $119,340 to implement community-based psycho-educational support services to unserved, underserved or inappropriately served populations: African-Americans, Asian Pacific Islander, Latinos, LGBTQQI, Senior Citizens, and Transition-Aged Youth.

4) Total Proposed PEI Project Budget: $285,577

C. Revenue
Total Revenue – N/A

5) Total Funding Request for PEI Project: $238,120

6) Total In-Kind Contributions: $46,457

City of Berkeley Project #4
Social Inclusion

Brief Program Description
This project will collaborate with Alameda County to ensure a coordinated effort around Anti-Stigma Campaigns and programming. It is anticipated that the Berkeley Mental Health Consumer Liaison will provide coordination with Alameda County and oversight on the project. The Vocational Coordinator will work closely with the Consumer Liaison to coordinate the work of the consumers and Family Members. An Office Specialist will provide logistical support.

Budget Year 08-09
A. Expenditures

1) Personnel Expenditures: $8,706
Salaries are reflective of City of Berkeley job classifications, and benefit rate for City of Berkeley is 54% inclusive of workers compensation costs:

Lines "a" & "b", $5,669 reflects staff salaries.
Line "c", $3,037 represents staff benefits.

Positions include:
- Consumer Liaison - Community Services Specialist II - 0.15 FTE
- Vocational Coordinator - Community Services Specialist I - 0.10 FTE
- Office Specialist II- 0.10 FTE

2) Operating Expenditures: $4,165
Promotional materials and website improvements; computers, peripherals, software, etc.; miscellaneous supplies, equipment, services.

3) Subcontracts/Professional Services: N/A

4) Total Proposed PEI Project Budget: $12,871

B. Revenue
Total Revenue – N/A

5) Total Funding Request for PEI Project: $4,165

6) Total In-Kind Contributions: $8,706

Budget Year 09-10
A. Expenditures

1) Personnel Expenditures: $26,119
Salaries are reflective of City of Berkeley job classifications, and benefit rate for City of Berkeley is 54% inclusive of workers compensation costs:

Lines "a" & "b", $17,008 reflects staff salaries.
Line "c", $9,111 represents staff benefits.

Positions include:

- Consumer Liaison - Community Services Specialist II - 0.15 FTE
- Vocational Coordinator - Community Services Specialist I - 0.10 FTE
- Office Specialist II- 0.10 FTE

2) Operating Expenditures: $6,660
Promotional materials and website improvements; computers, peripherals, software, etc.; miscellaneous supplies, equipment, services.

3) Subcontracts/Professional Services: $7,500
Funds will be used to hire consumers and family members on an hourly basis who will provide Anti-Stigma oriented presentations in local venues.

4) Total Proposed PEI Project Budget: $40,279

B. Revenue
Total Revenue – N/A

5) Total Funding Request for PEI Project: $14,160

6) Total In-Kind Contributions: $26,119

City of Berkeley
MHSA PEI Administration

Budget Year 08-09
A. Expenditures

1) Personnel Expenditures: $33,887
   Salaries are reflective of City of Berkeley job classifications, and benefit rate for City of Berkeley is 54% inclusive of workers compensation costs:

   Lines “a” & “b”, $22,005 reflects staff salaries.
   Line “c”, $11,882 represents staff benefits.

   Positions include:
   - PEI Coordinator - Health Services Program Specialist - 0.35 FTE
   - PEI Support Staff - Office Specialist II - 0.25
   - MHSA Supervisor - Community Services Specialist III - 0.25 FTE
   - Assistant Management Analyst - 0.10 FTE
   - Health Administrative Financial Specialist - 0.05 FTE
   - Manager of Mental Health Services – 0.05 FTE

2) Operating Expenditures: $6,250
   Line a - $2,500 for facility costs including rent and utilities.
   Line b - $3,750 for basic office supplies, etc.

3) County Allocated Administration
   a) Total County Administration Cost: $40,137

4) Total PEI Funding Request for County Administration Budget: $27,560

B. Revenue
   1) Total Revenue - N/A

C. Total Funding Requirements: $40,137

D. Total In-Kind Contributions: $12,577

Budget Year 09-10
A. Expenditures

1) Personnel Expenditures: $101,663
   Salaries are reflective of City of Berkeley job classifications, and benefit rate for City of Berkeley is 54% inclusive of workers compensation costs:

   Lines “a” & “b”, $66,015 reflects staff salaries.
   Line “c”, $35,648 represents staff benefits.

   Positions include:
   - MHSA Supervisor - Community Services Specialist III - 0.25 FTE
   - PEI Coordinator - Health Services Program Specialist - 0.35 FTE

- Support Staff - Office Specialist II - 0.25
- Assistant Management Analyst - 0.10 FTE
- Health Administrative Financial Specialist - 0.05 FTE
- Manager of Mental Health Services – 0.05 FTE

2) Operating Expenditures: $38,750
   Line a - $7,500 for facility costs including rent and utilities.
   Line b - Other Operating Expenditures: $31,250
   - Homeless Prevention Fund: $20,000 to be used to augment the City's Homeless Prevention Program by providing financial assistance to eligible individuals and families who are housed to prevent them from becoming homeless.
   - First Break of Mental Illness Project: $5,625 to be used to collaborate with Alameda County on a First Break of Mental Illness project.
   - TAY Prevention Project: $5,625 to be used to facilitate the development of a set of strategies for serving TAY who are at risk of homelessness.

3) County Allocated Administration
   a) Total County Administration Cost: $140,413

4) Total PEI Funding Request for County Administration Budget: $102,680

B. Revenue
   1) Total Revenue - N/A

C. Total Funding Requirements: $140,413

D. Total In-Kind Contributions: $37,733

County: City of Berkeley **Date: 12/26/08**

PEI Project Name: BE A STAR: *Healthy Child Development Project*

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

The City of Berkeley will evaluate the BE A STAR: *Healthy Child Development Project.*

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

The BE A STAR project was selected for evaluation for the following reasons:

- During the PEI planning process, community stakeholders identified this project as serving one of the most critical target groups in Berkeley and Albany.
- The project has the capacity to yield measurable results.
- This project has the potential to evaluate a population and intervention strategy that has yet to be researched in the Berkeley community.
- The interventions in this project have shown to be effective in serving people from diverse cultures.
- If shown to be effective, this project has the potential to leverage additional resources, through matching with existing funding streams available to public health and mental health.

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

<u>Person and family-level outcomes</u>

- Increased proportion of children aged 0-5 living in high-risk conditions who are screened for developmental/social-emotional concerns using the Ages & Stages Questionnaire (ASQ), a validated and standardized screening tool.
- Increased proportion of these children identified with possible concerns who are:
  (a) Assessed by trained healthcare providers for social/emotional concerns and developmental delay.
  (b) Referred to appropriate service providers.
  (c) Receive appropriate services and/or treatment.
- Increased number of mothers who are screened and referred for post-partum depression or substance abuse.
- Improved knowledge among parents of children 0-5 living in high-risk conditions in the following areas:
  (a) Infant and early childhood development; specifically, the importance of the first five years on future learning, behavior, and health outcomes.
  (b) Importance of early screening for developmental, social-emotional, and behavioral concerns.
  (c) The community mental health resources and services available to their children and themselves

- Increased awareness of the importance of early childhood development and the problem of developmental delays and social, emotional and behavioral concerns, among pediatricians, childcare providers, and community agencies.
- Increased number of providers and parents who are trained to administer the screening tool.
- Improved knowledge among natural leaders in the parent community (family advocates/navigators) of importance of early childhood development and early recognition of social, emotional and developmental concerns.

<u>Program/system level outcomes</u>

- Improved coordination of screening, assessment, treatment, and referral for children 0-5 and their families who are living in high-risk conditions.
- Improved coordination between Berkeley and Alameda County provider networks, specifically through collaboration with Alameda County Public Health Perinatal SART to ensure appropriate referrals and tracking for children whose mothers screen positive for substance use.
- Expanded services that treat children with developmental delay and social emotional concerns, through increasing capacity of existing services and leveraging existing resources to expand services.
- Establishment of a triage system that will enable providers to easily access support in assessing and referring children who screen positive.
- Prevention of more serious developmental delays and social emotional concerns that affect children's school readiness and lifelong physical and mental health.
- Identification of policy changes that can support long-term goals for improvements in healthy early child development, and advocacy efforts to enact such policies.

3. Describe the numbers and demographics of individuals participating in this intervention.

The following table presents an estimate for the number of children and families that will be served by this project.

PERSONS TO RECEIVE INTERVENTION

POPULATION DEMOGRAPHICS Families with children 0-5	PRIORITY POPULATIONS						
	Trauma[2]	First Onset	Child/ Youth in Stressed Families[3]	Child/ Youth School Failure[4]	Child/ Youth Juvenile Justice	Suicide Prevention	Stigma/ Discrimination
ETHNICITY/ CULTURE			**Total: 706 children/ 247 families**				
African American			**276/92**	**20**			
Asian Pacific Islander			**38/12**				
Latino			**157/51**	**20**			
Native American			**N/A**				
Caucasian			**102/34**	**5**			
Other (Indicate if possible)							
AGE GROUPS							
Children & Youth (0-5)	**Less than 143**		**706**				
Transition Age Youth (16-25)			**45**	**45**			
Adult: new moms (18-59)			**50**				
Older Adult; Grandparent caregivers			**10 (Vera Casey)**				

[2] Defined as children who are in the welfare system/foster care. Data currently available only at Ala County level; figure is estimated based on 2040 children in Alameda, of which Berkeley represents 7%. Age breakdown of children is not known at this time.

[3] Defined as families living in poverty. It is assumed that many of the "stressed families" that are involved in situations such as out of home placements, parental substance abuse, exposure to family or community violence, and suffering parental post-partum depression are those families living in poverty. A significant subset of this number includes families in South West Berkeley, which has higher poverty rates, disproportionate rates of health problems and lower school success rates than other neighborhoods. This number is for TOTAL number of families and children; program will reach a % of them.

[4] Families with teen parents, including Vera Casey Teen Parenting Program participants. Figure is an estimate based on previous years participants.

(>60)							
TOTAL	**140**		**706/247**	**45**			
Total PEI project estimated ***unduplicated*** count of individuals to be served: Approx. 850							

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

All collaborative partners will be required to continuously track data, and provide annual written reports on outcomes. Once baseline measures are established, the following data elements will be used to evaluate the project:

Person and family-level outcomes

- Number of children aged 0-5 living in high-risk conditions screened, as reported by pediatricians, childcare providers, and family advocates/navigators.
- Number of providers who are trained in administering ASQ screening tool, as reported by trainers.
- Number of referrals made to health care providers, as reported by collaborative partners.
- Number of providers who are able to access assessment and referral services, as reported by collaborative partners.
- Number of children aged 0-5 living in high-risk conditions that are screened positive in this program who receive further services (as reported by providers of referral source).
- Pre and post-test of questionnaire measuring parents' and providers' knowledge of infant and early childhood development.

System level outcomes

- Comparison of service network map at baseline (before program implementation) to service network map at year three of the program.
- Number of meetings held among collaborative partners.
- Memoranda of Agreements among collaborative partners.
- Documentation describing system and procedures of triage system.
- Comparison of percent of high-risk children 0-5 in Berkeley who are diagnosed with social and emotional concerns and developmental delay, at baseline, vs. year three of program.
- Number of referrals and receipt of services from collaborative partners.
- Documentation of strategies, actions taken, and outcomes of policy advocacy efforts.
- Development of an algorithm to describe a system of assessment, screening and referral, that complements and interfaces with the Alameda County Children's SART model.

5. How will data be collected and analyzed?

Collaborative partners participating in the project will collect data on an ongoing basis. An independent evaluator will analyze the data provided by the project partners. Collection of data will include, but is not limited to, the following strategies:

- Tracking number of events and activities, and number of parents and families

participating in outreach and education events and activities, through sign-in sheets at presentations, trainings, and parent group meetings.

- Tracking the number of children who are screened through this program for early developmental delays and social, emotional problems, at pediatric offices and childcare centers located throughout Berkeley.
- Tracking the number of children 0-5 living in high-risk conditions who are referred for further assessment or services.
- Tracking the number of children 0-5 living in high-risk conditions who receive services, as well as the number who are unable to receive services due to waiting lists, programs that don't exist, or other factors.
- Documentation of efforts to identify and braid or leverage funding streams to support/augment needed community-based programs or clinical interventions, through meeting minutes, memos and other sources.

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

Two of the strategies embedded in this project will facilitate cultural competency: (1) The recruitment, training and provision of stipends to parent advocates/family navigators; and (2) Collaborative partnerships with parent and community advocacy groups. The parent advocates will be members of the communities we are reaching out to and will reflect the community's social, cultural and personal life experiences. They will be selected partly based on their credibility in the neighborhood, and whether they are seen as a trusted resource. The collaboration with United in Action, the Latino People's Collective parent groups, the Head Start Parent Advisory Group, BAHIA and Bananas parent leadership groups will ensure that a diverse community voice is brought to the planning and is able to influence and shape implementation of the project.

In addition, the ASQ screening tool has been tested and shown to be effective in working with populations of diverse race, ethnicity, and socio-economic status.

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

There will be written descriptions of the policies and procedures of components related to the project model. Training and continuous technical assistance will be provided to collaborative partners. Written agreements will be developed with pilot sites about roles, expectations, and accountability.

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

The evaluation report will be shared with the following key collaborators in Berkeley and Albany:

- Berkeley/Albany Head Start and Early Head Start
- Berkeley Integrated Resources Initiative Birth to Five Action Team
- Alameda County First Five
- Alameda Alliance

- Berkeley Vision 20/20
- Lifelong Medical Center
- Referral agencies throughout the East Bay (Children's Hospital, Berkeley Unified School District, Regional Center for the East Bay, etc)
- Pediatric providers throughout Berkeley and Albany
- Subsidized childcare providers throughout Berkeley and Albany
- Berkeley Health and Human Services Department
- Berkeley City Manager's Department
- Faith-based organizations
- Berkeley and Albany City Councils
- Berkeley and Albany Unified School Districts' School Boards

In addition, evaluation reports will be discussed on at minimum an annual basis with the PEI steering committee. The final outcome evaluation report will be provided to the California Department of Mental Health.

ATTACHMENT A
PEI PANEL DATA REVIEW/RECOMMENDATIONS FOR PRIORITY NEEDS

CULTURAL SENSITIVITY & RESPONSIVENESS ****	ADDRESSING SCHOOL CULTURE ***	PROMOTING NEW MODELS OF PEI *******	COMMUNITY EDUCATION *****	EARLY ID: CHILDREN, YOUTH & FAMILIES ***
• Support groups for all ages • Peer counseling youth specific. * • Cultural outreach. • More Bi-lingual bi-cultural clinicians. * • Cultural Competency: Training; Hiring; Screening & Assessment tools • Give MH support to new immigrant families • More effective outreach to underserved cultures and minorities (to encourage use of services)* • Culturally appropriate services: Training/staff; spectrum; mental health programs should have tangible resources too*	• Numbers of suspensions increase exponentially from K to Middle School-indicate need for behavioral prevention/early intervention • Children feel unsafe at school-kids not connected to adults (school climate)* • High rates in special education need for early intervention 0-5 and higher rates for A African American students in special ed.* • Need to address higher suspension rates for African American students. Pre-11th grade. * • Create more positive school environment (keeping in mind oppression, racism, homophobia, and needs of children who have English as a second language	• Overhauling the medical model* • Incorporate behavioral health svcs as natural progression of MH svcs (include in physicals)* • Barrier Free Access • No $$ for Co-Payment/Prescriptions services for undocumented people, transportation, & everyone who needs svcs & have no $ • Place services in community (schools, com. orgs., doctors/ clinics)* • No spectrum of service in Non-Traditional settings (com. of color)* • Substance use prevention • Early intervention for trauma abuse—all ages* • Break the cycle services: special programs for TAY (18-25); special programs (0-5) * • New models: example housing for TAY to come “home” when they “fail” * • Use peer counselors as facilitators offering on-going support groups-use diverse, grad students, etc. • Services in non traditional settings • Support for all kinds of families • More inclusive of LGBT	• Collaboration (training, accessibility)-having liaisons between the police dept. & com. organizations. • Socio-emotional education for youth dropping out of school. • Social/emotional classes for youth to prevent trauma & suicide (middle and high schools)* • Community Education around MH issues * • Educate parents, children, youth re: trauma/abuse impact. * • Education of public to reduce stigma that is culturally appropriate • Diverse multi-cultural/lingual providers for community outreach, education & support groups* • Bring diverse enhanced services to community existing sites ie AmeriCorp grad students* • Community Education including providing Educ., homeless, families /intergenerational, schools • Increased media PSA’s using diverse everyday folks providing info and community referrals	• Services for parents who have a trauma/depression related diagnosis. * • Prevention groups to reduce incarceration rates for youths. * • Early behavioral & learning problems begin early become exponentially worse.* • Early identification of school problems • Early childhood issues: Parenting education, culturally appropriate services • Culturally responsive services to infants, children & families with disabilities • MH Services in low income areas for preschool and early grades • In-home intervention for ethnically diverse expectant or parenting families (0-5) who are at risk or have trauma or disability issues • Early intervention in trauma* • Eating Disorders/Body Image

NOTE: Each small group (5 total) was asked to asterisk their the top three most important pressing need. Asterisked items are noted and summarized in heading.

ATTACHMENT B

PEI DRAFT PLAN
Public Comments & Berkeley Mental Health (BMH) Responses

Overall Process

Comments:

- This is an amazing body of work. I just wanted to give you huge kudos for piecing it all together so well. I love the project on Social Inclusion.
- The process was very cumbersome, costly, very frustrating and did not produce any new, innovative or exciting ideas—it's just rehashing of the same old tired ideas that haven't worked in the past. It is laughable if BMH thinks there is going to be any notable improvement over the dismal results in the schools as far as prevention/intervention in the past five years. Most of my colleagues that spent time in the community engagement process have the same negative feelings.
- I sat through a lot of meetings in the process, and saw a lot of competing priorities and demands, and you've balanced the competing priorities. I think it's hard to capture in a plan what the reality is going to be once you get going. It's not enough money to do any one of those things. It's going to be difficult to meet all the goals of the plan the way they are figured. The services are more expensive and families more in need. There's the 80/20 rule…20% of the population takes up 80% of the services. It's very optimistic, in being able to accomplish so much. I'm thrilled to see there is a 0-5 component as you get more bang for your buck when you start that young, when the women are pregnant.

Response:

The comments above did not warrant a change to the Draft PEI Plan.

BE A STAR Project

Comments:

- Want to see wellness articulated.
- Don't want problems to be focused on, but rather a healthy positive wellness approach with children and families.
- I suggest a guidebook be developed to train the Family Advocates/Navigators.
- Spanish speakers should be recruited to be Family Advocates/Navigators.

Response:

Each of the comments above speaks to the implementation of the proposed program and will be revisited for the appropriateness of inclusion if program approval is granted.

BEST Project

Comment:

- Why do we keep throwing money at the schools when they keep doing the same old thing?

Response:

The BEST Project is based on a nationally known model program that has demonstrated proven effectiveness in changing a school climate into a positive, supportive environment. BEST has a comprehensive approach and is very different than other programs previously implemented in the schools.

Comment:

- As a member of the MHSA Steering Committee and Design Team and full participant in the PEI planning process I wish to make comment on the City of Berkeley MHSA Draft PEI Plan which has been posted on the City of Berkeley MHSA website for a 30-Day Public Review and Comment period. My comment concerns Project #2 BEST, specifically expenditures of $73,325 in one time funds listed as other operating expenditures. The expenditures are described in the budget narrative as consisting of a) $30,000 to purchase and provide maintenance on a car to provide transportation for program staff and b) Vision 2020: $20,000 to be used towards augmenting funding for the City of Berkeley's Vision 2020 program which aims to reduce achievement gaps in the schools. Regarding the $20,000 allocated to the City of Berkeley's funding for Vision 2020. Vision 2020 is a program of the Berkeley Alliance—a partnership of the City of Berkeley, the Berkeley Unified School District and the University of California, Berkeley. Vision 2020 is a joint initiative on the part of the City of Berkeley and the Berkeley Unified School District. Recent discussions between partners took place regarding funding Vision 2020 resulting in pledges from the Berkeley Unified School District and the City of Berkeley for $50,000 each. Such pledges are commendable given the terrible budget crisis in the State of California and the significant cuts we are facing in State funding for Health, Education and Welfare. While there is wide support within the Steering Committee for using one time MHSA PEI funding for the 2020 initiative, I believe that the funding should be allocated to the Berkeley Alliance to underwrite the costs of the initiative, thereby lowering the costs for all partners. I find it improper that the City of Berkeley recommend funding be allocated to itself only. Regarding the $30,000 allocation for a car, I find the justification for one time allocation to the City of Berkeley for $30,000 to purchase and provide maintenance on a car to provide transportation for program staff to be entirely lacking. Neither was the expense or need ever discussed by the Steering Committee prior to its insertion in the final draft. There is no other similar request in any other proposal although all programs have such a need. It seems to me that the City of Berkeley can pay mileage to employees or continue to utilize the City's car share program at a significantly reduced cost. I question why the cost of transportation is not met under operating expenses which would free up these funds to be allocated to the significant needs that were reviewed and discussed by the Steering Committee. I object to the approval of this significant expense of one time funds without additional justification and review by the Steering Committee.

Response:

As originally indicated BMH will be requesting $20,000 to fund part of the City of Berkeley commitment to the Vision 2020 Initiative (a program aimed to close the achievement gap among all students by the year 2020). Regarding the car, it was always envisioned that the proposed purchase would be utilized by both the BEST and Be A Star projects as BMH staff will be traveling to schools and city based organizations on a daily basis for each project. Originally the cost to purchase the car was shown under one component (the BEST project). Costs for the purchase and maintenance of a car are now shown under both the BEST and Be A Star Projects.

Comment:

- The presentation of the plan is well done and for the most part, the program meets the identified community needs. However, when looking at the budget section in particular, there are a couple of issues that we need to correct/address. For the first budget year, it states outright that FYC will develop staff trained as BEST coaches. Assuming that the originally discussed RFP process won't happen, this training for FYC staff is critical as there are presently no FYC staff who have been trained as trainers, and only one to my knowledge who has a rudimentary understanding of what BEST is. At the same time, there is zero funding attached to this item. In other words training has been left out of that budget year, which certainly won't work as we move to expand the program! I estimate we can work with $5,000, added to BUSD's current $10,000 for the first budget year. Second, while we don't have training, you have set aside 30K for vehicle purchase or maintenance. Perhaps some of these funds are better used for training to get the program off the ground (staff won't need a car until they get trained). Whatever the reason for the use of the funds in this way, I at least hope that vehicle is going to FYC as the presumed BEST trainers since they currently don't have one. For the following budget year, unfortunately, training costs are again absent. There is no way that even with some initial training of trainers that we can do this spring, that staff will be fully trained next year. The training of trainers consists of coaches participating in the full training of a school site (4 full day sessions, plus direct work with the schools between sessions, followed by some additional coaching and training. We will need to continue to work with external coaches for at least next year. Estimated cost for training for the following fiscal year are: $15,000 (not including staff time, though that's ok, since their time will be reallocated in this model). I recommend reducing personnel to make this work. Reducing personnel makes some sense since BUSD is also adding trainers to the pot and we will slowly build up capacity in the system so that we don't have to do as much training in subsequent years (which is another reason why training is a better use of one time funds than, say vehicle purchase). Finally, I am glad that we were able to add the subcontracts/professional services as we discussed. I think, though, though there was a slight miscalculation. We agreed that 5,000 would be the lowest meaningful baseline. Unfortunately we have 11 rather than 10 elementary schools so we need to find an additional 5,000.

Response:

Funding for initial training has been added into the revised BEST project budget. Sufficient subsequent training money is available in PEI growth funds. BMH has also increased the subcontracts/professional services allocation by $5,000.

Comment:

- Based on my own experience as a parent trying to receive academic justice I don't see those needs reflected in this project. None of the issues I have raised have been addressed in this project in terms of the academic achievement gap. If you are just targeting kids to see if they can perform and have them behave in ways that are acceptable…if you are choosing people to survive in a system that is basically unhealthy and you are not dealing with those health disparities then it's not where I wanted to see the emphasis.
- What about basic physiology and sleep and how that ties in to how a child is doing in school? There's strong evidence of the need for sleep and none of this takes this into account. There could be a problem with homework, expecting kids to not be able to move or play. A good Mental Health program might be getting kids out to play and in playgroups. I'm wanting to see a support of health. Schools are not really healthy and systems are not healthy, so it's easy to be unhealthy in those systems.

Response:

One of the primary elements of the proposed "BEST" Project is to create a shift in the school climate to one that is more healthy, positive and supportive of youth. BEST and Vision 2020 are long-term initiatives that are designed to provide a comprehensive and holistic approach to improving school climate and the health and academic performance of students.

Comments:

- I would like to see more transparency around ways for parents and family members to be involved.
- Parent Navigators would be helpful to have on the BEST Team's.
- Will students be involved on some of the BEST Teams that are being convened?

Response:

Each of these comments speaks to the implementation of the proposed program and will be revisited for the appropriateness of inclusion if program approval is granted.

Comment:

- I'm familiar with the BEST Program as I lived in Oregon for several years. Given that Native American youth have the highest rate of suicide, is there any specific outreach to them?

Response:

At this time, BMH has not chosen to implement any services that specifically outreach to Native American Youth; however, our cultural competence initiatives strive to address the needs of all underserved populations in Berkeley and Albany. While census and prevalence data do not identify Native Americans as a population with significant numbers in Berkeley or Albany, Oakland has a very large urban Native American population. Our intent is to partner with Alameda County and the Native American Health Center as appropriate to provide culturally responsive services as the needs of this population are identified.

Community Education/Supports Project

Comments:

- The programs look at people based on race, instead of a more global inclusive approach. When we look at priority populations, underserved cultural populations, my understanding would be more looking for common human denominators inclusive of how we approach health and how we unite people and how we even get people here. "The programs are not wellness oriented. I would really like to see that we are looking at and supporting people's participation in healthy practices.
- Single Moms are not a Target Group, they're all too busy, but if they were a focus they would say "Help Me".
- It seems that a lot of what we are talking about is accountability. I think we all know that we have CBO's that every time there is a contract job, those same people seem to get the contracts. Encourage new people in new agencies to come in and do some of this work for us. This goes to accountability and issues with ground rules.
- The Conference on Trauma should really focus on educating people about the roots of trauma and educating providers on how in a therapy session to not separate something like Domestic Violence (and the trauma of that) from the mental illness and the therapy session.
- I am in support of community forums. I participated in some of them, as a member of the community I find them to be a good idea. I think approaching some of these issues socially is a good use of prevention money and a way to be inclusive. I think there are issues of violence which are phenomenally hitting our community right now to the point that you might consider us a warzone. So I think the more ways we have to respond to this community and build capacity for health and mental health and respond to crisis then that's good.

Response:

Each of these comments speaks to the implementation of the proposed program and will be revisited for the appropriateness of inclusion if program approval is granted.

Comment:

- As we work to serve the public (in our community of Berkeley) to provide Mental Health and Public Health Services; given the Cultural, Social, Economic and Environmental deterioration faced by the families we try to help, it is imperative to help the helper. Professional burn out prevention through regularly scheduled Clinical Supervision and support groups that can help motivate, inform and educate workers and providers to identify true (suicide or other) risk from counter-transference, indifference, frustration, annoyance etc. This could be built into the Quality Assurance process as well. This is a cornerstone of excellent, clinical practice.

Response:

Although this comment didn't warrant a change to the Draft PEI Plan, it is a concept that will be revisited in future discussions around increases to the PEI and CSS funding allocations.

Comment:

- If we can specifically deal with the mental health challenges facing the kids on the streets. They are not in the YEAH program and I am really concerned about the kids that I am seeing out in the streets. Inter-generational aspect.

Response:

It is envisioned that supportive services to address some of the mental health concerns of TAY will be put in place under the proposed Community Education/Supports Project.

Comment:

- I've come into a real concern about sexual abuse and women of color. It appears to be intergenerational. We're having a lot of women, now young women intravenous drug use and sexual behavior, the issue is trauma. Sexual abuse is trauma, community they live in is trauma, One concern is how it depresses, trauma. Not just women but all community. Since 9/11 we have failed to understand the effect of trauma on individuals. If you take New York, there's been increasing substance abuse and exhausted mental health services, still dealing not only with mental health trauma, but also physical trauma. The area between Oakland and Richmond is also a trauma zone, issues of food clothing, access, 1) access of providers, culturally competent providers, not necessarily of color, but understanding the culture; 2) lack of patient-centered services, wrap around services. These kinds of issues where these take place, lack of acute access care. If you're not suicidal or going to shoot someone you can't access the mental health system in a reasonable fashion. So we have issues of access and health disparities, economics, and the weight on the economy. Mental health issues get pushed to the side, I find the issues that are starting to dominate and in terms of mood disorder and heart disease, sexual abuse, substance abuse, cancer, we tend to continue to underfund human capital particularly mental health capital and there in lies the problem. This is going to be a consistent issue, we have aging populations and family, family is extended family, and the nuclear family does not exist. The number one family is "single head of household, female, with kids" We continue to use the white-Freud model for people of color or etc problems. I'm seeing a lot of women with intergenerational abuse and trauma and in denial about it. The whole community is in denial about it; it's a sore subject. One of the things that happens in these plans is that intentions are good but in real life it just doesn't happen. A lot of adolescent treatment is peer focused, so how we get those folks into the mix, that's going to solve the problem. It's a great climate to start, Berkeley is always innovative for that stuff, we happened to have some real changes for in the way we provide and model things here, don't know if it is wrap-around or individualized program, understanding culture, to make this work, to reduce suicide rates, untreated mental illness that predominates itself in homelessness and incarceration.

Response:

The reoccurring issue in this comment is "trauma" and its enduring effects. The proposed Community Education/Supports Project will provide education/support services to the African American population among other unserved, underserved and inappropriately served populations. Referrals to Mental Health Treatment and other ancillary services will be provided to those in need.

Social Inclusion Project

Comments:

- I really like the inclusion of consumer and family members. I wonder how we are going to work on local strategies for combating stigma. I'm interested in the whole process and am looking for it to be more artistic and open.
- Measures should be put in place to protect both and students to safeguard the confidentiality of those who hear the presentations in schools and may want to self-reveal that they have a mental illness.
- An interesting way to use some of the funding under this component is to have a "Mad Pride Celebration" where mental illness is focused on in a positive way (displaying artwork, music, crafts, dance etc at a street fair or some other fashion) that have been created by those individuals who have a mental illness.
- A suggestion of programs that are prevention oriented and could be both supportive and anti-stigmatizing are "Listening Clubs", "Hiking Clubs", etc.

Response:

Each of these comments speaks to the implementation of the proposed program and will be revisited for the appropriateness of inclusion if program approval is granted.

***Across Projects**

Comments:

- I sense high standards for the four programs. I'm concerned that Quality Assurance be comparable to or far, far, far better than the Adult Program. So have you thought about the Continuity of Care, Access, Availability, Implementing a Treatment Plan, how children and families will be tracked?

Response:

Each proposed project will be aligned with appropriate agencies where individuals who are in need of a more intensive level of services will be referred. Mechanisms for each program will be developed to monitor and track individuals, children and families. Additionally, a comprehensive evaluation will be conducted on the Be A Star project..

Comments:

- This is an extremely thoughtful, formidable, comprehensive plan and I am very impressed by it. My concern is that matching same culture, same race, same ethnicity, same sexual orientation, same gender isn't sufficient for what you see in Southwest Berkeley and what you see in the world these days. There is a huge social, psychosocial, socioeconomic, systemic problem you see among African Americans called "Therapeutic Alienation". It isn't sufficient to my thinking as a lay person to bring in an African American person who can relate to the situation as it is. I'm concerned that there be people who are attuned to the systemic problems who can address the social illnesses which to me are very pervasive, much more insidious and much more hard to address. The distinction between social illnesses and psychological illnesses is anybody's guess, but it is not going to be sufficient to bring in traditional Western models of therapy even if they are positive. So what are we going to do about that?
- For the two programs, BEST & BE A STAR, is there going to be some sort of provision to be sure that staff is going to be diverse, as recruitment will be done for people who will be staffing these programs so that staff is reflective of the populations they serve?

Response:

The issues expressed in these comments speak to cultural competency which is a strong value at BMH and a core value in MHSA. Each proposed program will need to demonstrate the use of culturally appropriate screening tools and the employment of staff who have been trained and are culturally competent. Cultural Competence is a developmental process and cannot be taken for granted simply by reference in the plan and thus will be a major implementation challenge.

Comment:

- I assumed that in the paper when you referred to the word "family" that includes moms/dads or two moms or two dads, but what about grandparents? Thinking more in terms of the nuclear family being more than just mom/dad/kids but also the involvement of grandparents?

Response:

In the proposed projects, Grandparents are considered to be a part of the definition of family.