

**MENTAL HEALTH SERVICES ACT (MHSA)  
PREVENTION AND EARLY INTERVENTION COMPONENT  
OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN**

**SANTA CLARA COUNTY  
Revised May 29, 2009**

**EXECUTIVE SUMMARY**

Prevention and Early Intervention (PEI) is one of five funding components through the Mental Health Services Act (MHSA). PEI funds represent approximately 20% of the County's total MHSA funding. PEI services are geared toward restructuring the mental health system to a "help-first" approach. PEI transformation concepts include: community collaboration, cultural competence, individual/family-drive programs and interventions with specific attention to individuals from underserved communities, a wellness focus which includes the concepts of resilience and recovery, integrated service experience for individuals and their families, and outcomes-based program design.

All counties' PEI plans must address the entire lifespan with 51% or more of funding utilized to serve the 0 through 25 age range. PEI plans consist of various projects (aka work plans) that are comprised of programs and supportive services to be delivered in natural community settings and which leverage other resources. Programs should be research-informed practices and target identified mental health outcomes. Each project must select/address one or more of five prescribed key community mental health needs and one or more of six priority populations. All projects must address underserved cultural populations.

Santa Clara County's PEI plan consists of four projects totaling \$12.2M annually, with another \$1.2M annually for administration, planning and evaluation. Factoring in a 3% annual increase, MHD projects at that funding level can be sustained through FY13-14. In addition, these figures do not include the County's share of the statewide PEI Training, Technical Assistance and Capacity Building project. Under this program, MHD proposes to use \$289,900 annually for four years to increase the community's ability to provide effective PEI services.

Using three general approaches, the County's PEI Plan aims to establish a network of layered services that identify mental health problems at the earliest stages, improve access to services and deliver timely and appropriate services. First, the plan establishes a county-wide base of activities that result in increased access to services by increasing awareness and reducing stigma and discrimination among underserved cultural communities. Second, the plan establishes countywide prevention and early interventions for individuals at key stages in the lifespan—early childhood, transition age youth, early adulthood/adulthood and older adulthood. Finally, the plan concentrates services within high risk areas that have demonstrated effectiveness in preventing and/or diminishing the long-term impact of mental illness across the entire lifespan and continuum of need.

### PEI Budget Summary

1. Community Engagement and Capacity Building	\$800,000
2. Strengthening Families and Children	\$6,900,000
3. Preventions and Early Interventions for Individuals Experiencing Onset of Serious Psychiatric Illness with Psychotic Features	\$1,350,000
4. Interventions for Adults and Older Adults	\$3,150,000
<b>Sub-Total</b>	<b>\$12,200,000</b>
<b>TOTAL (+ County Admin + Training /Technical Assistance)</b>	<b>\$13,690,000</b>

Project	1. Community Engagement and Capacity Building	2. Strengthening Families and Children	3. Early Onset of Serious Psychiatric Illness (with psychotic features)	4. Interventions for Adults and Older Adults
<b>Key Mental Health Need(s)</b>	<ul style="list-style-type: none"> <li>▪ Disparities in Access to Mental Health Services;</li> <li>▪ Stigma &amp; Discrimination</li> </ul>	<ul style="list-style-type: none"> <li>▪ Disparities in Access to Mental Health Services;</li> <li>▪ Psycho-Social Impact of Trauma;</li> <li>▪ At-Risk Children, Youth &amp; Young Adults</li> </ul>	<ul style="list-style-type: none"> <li>▪ Disparities in Access to Mental Health Services;</li> <li>▪ Suicide Risk</li> </ul>	<ul style="list-style-type: none"> <li>▪ Disparities in Access to Mental Health Services;</li> <li>▪ Psycho-Social Impact of Trauma</li> </ul>
<b>Priority Population(s)</b>	<ul style="list-style-type: none"> <li>▪ Underserved Cultural Populations</li> </ul>	<ul style="list-style-type: none"> <li>▪ Underserved Cultural Populations;</li> <li>▪ Children and Youth in Stressed Families;</li> <li>▪ Trauma Exposed;</li> <li>▪ Children and Youth at Risk for School Failure;</li> <li>▪ Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</li> </ul>	<ul style="list-style-type: none"> <li>▪ Individuals Experiencing Onset of Serious Psychiatric Illness;</li> <li>▪ Underserved Cultural Populations</li> </ul>	<ul style="list-style-type: none"> <li>▪ Individuals Experiencing Onset of Serious Psychiatric Illness;</li> <li>▪ Trauma Exposed</li> <li>▪ Underserved Cultural Populations,</li> </ul>
<b>Age Group(s)</b>	All	Children & Youth; TAY	All	Adults & Older Adults
<b>Estimated Unduplicated Clients</b>				
<b>Prevention:</b>	TBD	TBD	1,500	400
<b>Early Intervention:</b>	0	TBD	100	4,000

### Overview of the Santa Clara County PEI Planning Process

- Maintained inclusive and participatory process used for MHSA Community Services and Supports (CSS) planning process.
- Dr. Nancy Peña, Santa Clara County Mental Health Department (MHD) Director, provided process direction and maintained overall responsibility for PEI planning and decision-making. The day-to-day coordination and management of the PEI planning process was handled by the MHD MHSA Manager Ky Le. A PEI Planning Team met regularly, including weekly or more frequent meetings during key decision-making time periods. In addition to Dr. Peña and Ky Le, PEI Planning Team members included Jean McCorquodale, Carolyn

Verheyen, Sarah Davis, and Jorge De Luna.

- Key MHD staff support was provided by Bruce Copley, Deputy Director; Tiffany Ho, M.D., Medical Director; Deane Wiley, Learning Partnership Director; Pat Garcia, Director of Administration; Thuhien Nguyen, Cultural Competency Coordinator; Jennifer Jones, Consumer Affairs Manager; Sheila Yuter, Older Adult Services Manager; Monique Jimenez, MHSA TAY Coordinator; Louise Hill, MHSA Full Service Partnership Coordinator; Marilyn Cornier, Program Manager; Martha Paine, Director of General Fund Services; Emma Ramirez, Executive Assistant to the Director; and Loraine Girard, Wes Girard, Lien Doung, Michelle, Sortillon, Pat Cala, Linda Rodriguez, Patricia Medina and Lolanda Ulloa, who provided valuable administrative support.
- Five well attended MHSA PEI Forums were held over a one and a half-year period to solicit broad input on the lifespan needs of each of the six targeted groups that were identified by the State Department of Mental Health in their PEI Guidelines.
- The MHD Director Nancy Peña commissioned the development and production of three reports on PEI needs and perspectives from three key community venues: education, governmental systems serving stressed children and families, and primary health care. The reports were entitled:
  1. "Every Child Has a Story, Perspectives of Santa Clara County Schools on the Need for Mental Health Prevention and Early Intervention Services," (Carla Holtzclaw: author)
  2. "Children and Youth in Stressed Families: Creating the Risk and Reality of Juvenile Dependency System Involvement, Juvenile Justice System Involvement, and School Failure. The Perfect Storm: Economic Insufficiency, Substance Abuse, Family Violence, Mental Illness, Immigration and Language Barriers, Cultural Misconceptions and Biases," (Jean McCorquodale: author)
  3. "Health Care System Assessment Report for Prevention and Early Intervention Programs," (Jorge De Luna: author)
- Each report was the centerpiece of discussion at a major PEI forum.
- Forums were augmented by 36 focus groups, conducted by trained facilitators in all of the county's five threshold languages. The focus groups were aimed at underserved populations, many with direct involvement in the dependency and justice systems. In addition, these focus groups were held in geographic locations throughout Santa Clara County.
- Additional presentations and discussions were held with various consumer, family, provider and service groups.
- A survey also was developed and sent to the police chiefs representing all law enforcement agencies within Santa Clara County.
- After the findings from all of the above-described sources were analyzed and summarized, along with a summary of comments and recommendations relevant to PEI that were culled from the input into the previous MHSA Community Services and Supports (CSS) planning process, the resulting information was put into forms (summary reports and a matrix) designed to be useful and usable by the participants in the next stage of PEI planning—members of the Strategy Work Groups (SWGs).
- An invitation and an explanation of the application process were widely publicized for individuals interested in serving on the PEI SWGs. Applications were received and reviewed and 57 SWG members were appointed, including 17 whose participation was

supported through stipends from the MHD. It included representation of consumers and family members, education, law and justice, organizations representing the interests of children and families, parents and caregivers of children and youth, representatives of physical health services, providers of mental health services, providers of social and other services, and representatives of unserved and underserved populations. The SWGs were charged with identifying PEI initiatives that address the needs and populations prioritized by the community and developing recommendations for PEI approaches and projects. They met weekly over a two-month period.

- California Institute of Mental Health (CIMH) consultants worked with the SWG members to further refine their project plan objectives and align them with potential best practices.
- Another step in PEI planning was a Town Hall at which SWG members were joined by a broad cross-section of other interested individuals and group representatives to:
  - Hear a review of the PEI planning process and planning parameters,
  - Receive the findings from the various PEI input-gathering methodologies utilized to date,
  - Review the decisions on the most critical concerns and key mental health needs as determined by the SWG members, and
  - Provide their input.
- The SWG members endorsed the concept of countywide projects, along with significant geographically oriented initiatives. The geographically based projects would represent investment plans by the MHD into the affected communities.

### **Approach and Identification of High Risk Areas**

- Another way in which the Santa Clara County PEI planning approach was closely modeled after its CSS approach was that it incorporated a lifespan perspective within a public health model of prevention, early intervention, and intervention strategies. A primary PEI planning parameter was the necessity to utilize PEI funding to build upon the CSS system of care and tie into existing CSS programs and services.
- A strong group consensus developed among SWG members, particularly those who met as a “stressed families and education work group” that while some PEI projects should focus on “horizontal” targets across the entire county, the major portion of PEI funding should be devoted to “deep, intensive, vertical” population targets that are selected based on criteria demonstrating geographic areas of highest need. Moreover, to ensure that individuals and families have access to coordinated services, the MHD’s implementation approach will emphasize strong and stable linkages between programs and services, particularly in Project 2 (children and youth) and Project 4 (adults and older adults).
- The SWG members suggested the following guidance for the target area collaboratives:
  - Must integrate and engage all key partners.
  - Must have a school-linked presence.
  - Must collaborate with community clinics.
  - Must strive for sustainable costs and personnel.
  - Must be culturally appropriate and adaptable.
  - Must create skills that can be applied across life domains.
  - Must be tied to the targeted populations and outcomes.

- Must stay true to the principles underlying the model or practice.
- Must produce outcome data that goes beyond self-reporting and is linked to goals.
- Criteria for highest need areas (by zip code) included such things as:
  - Residence of Mental Health Department clients, and
  - Occurrence of suicide attempts, along with proxies for stress and trauma, which research reveals may contribute to reactive and situational mental illnesses
  - Entrants into the juvenile justice system,
  - Sustained cases of child abuse and neglect and entry into foster care,
  - Substance abuse,
  - Occurrence of domestic violence,
  - Felony arrests
  - Teen pregnancies,
  - Low birth weight
  - Poor school performance,
  - School drop-out rates, and
  - Low income.
- Intended outcomes include improvements in mental wellness and reduction in environmentally and developmentally influenced conditions such as attachment disorders, grief reactions, mood/self-regulatory problems, conduct disorders, anxiety, depression and post-traumatic stress disorder.
- In addition, secondary benefits are expected to include such things as reduced levels of child maltreatment and foster care placements, reduced serious juvenile crime, improved school performance, improved social-emotional functioning (as measured by one or more standardized measures), and improved family functioning (as measured by one or more standardized measures).
- The four areas demonstrating the highest needs as measured by incidence of the factors cited above are zip codes within East San Jose, Central San Jose, North County, and South County.

### **Alternative and/or Additional Practices**

For each strategy, the MHD has identified a recommended practice. The practices were selected in consultation with the PEI SWGs, CIMH and MHD staff. However, if requested by the collaboratives formed within the High Risk Areas (HRA), the MHD will initiate a process through which other practices are considered as alternatives or additions. The MHD will utilize professional expertise and draw from the experience of other counties to review and analyze alternative practices for possible PEI implementation. The criteria utilized in this consideration will include the following:

1. The practice must have an evidence (outcome evaluation or research) basis, with a demonstrable level of effectiveness in producing the intended outcomes with the targeted population/s.
2. The practice must be sufficiently well articulated that it can be replicated, for example, it must have a written manual and training protocols and/or a written curriculum.

3. If the MHD agrees that the practice has an evidence basis that is equivalent to or better than the recommended practice, it may be substituted for or implemented along with the recommended practice. However, if the practice meets criteria one and two above but has less well documented outcomes, for consideration by the MHD it must have been locally developed, or must already be in use in the HRA, or the HRA must be about to implement the practice through other funding sources, or the practice must leverage significant other resources, or there must be some other compelling rationale for why it should be utilized in place of or in addition to the selected practice.

### **Summary of the Four Proposed Projects**

#### **Project 1: Community Engagement and Capacity Building for the Reduction of Stigma and Discrimination**

- The primary goal of this project is to reduce disparities in access to mental health interventions among underserved cultural populations due to stigma, discrimination, and lack of knowledge about mental health services. Programs under this project will target all age ranges and will be implemented countywide over time.
- Stakeholders in all sectors and stages of the PEI planning process expressed common critical concerns relating to the prevention, early intervention and mental health needs of the community. These concerns dovetailed the findings of the County's MHSA CSS planning process and were entirely consistent with and supported by the report and recommendations of the MHD's Ethnic and Cultural Community Advisory Committees (ECCACs), "Ethnic Communities of Santa Clara County, Seeking to Help Persons Struggling with Mental Illness, Their Families and Communities, and to Help Fulfill the Promise of MHSA—System Transformation."
- Consistent with the PEI guidelines, stakeholders strongly supported the need to focus PEI services on underserved cultural populations as an overarching strategy with the goals of reduction of stigma, discrimination and disparities in access to services. There was consensus that resources need to be devoted to the development and implementation of specific strategies to reach, involve and influence underserved cultural populations. It was agreed that cultural competency is not based solely on linguistic ability and that service providers, even those that currently target particular ethnic communities, need to improve their cultural competency. Moreover, evidence-based practices need to be framed in culturally relevant contexts.
- Multiple factors contribute to maintaining disparities in access to services for underserved cultural populations. Barriers, including discrimination, biases and misconceptions, exist at all levels—individual, program, institution and community. Therefore, persistent and robust public awareness and education strategies must be initiated countywide and sustained over a long period of time to significantly reduce barriers at all levels.
- Project One's supplementary goal is to develop, within and/or among underserved cultural populations, a robust network and infrastructure capable of developing and sustaining ongoing PEI and related services. Therefore, as an overarching strategy, consumers or family members from underserved cultural communities will play a significant role in project development and implementation.

- *The goals of this project will have significant overlap with the goals and objectives of the other three projects. When appropriate, resources and programming will be leveraged, shared and not duplicated. The MHD envisions that programs under this project will significantly enhance or advance the prevention efforts of the other projects.*
- This project will initially focus on four strategies to meet its primary and secondary objectives.
  1. Expand outreach and engagement activities being conducted by the ECCACs and currently funded under CSS. Per DMH guidelines, CSS outreach and engagement activities are directed at reducing barriers to services for individuals who would otherwise qualify for CSS mental health services. Many of the current activities, such as outreach and education to community centers, are more closely related to PEI goals. These community engagement and education activities often vary in scope and frequency based on the size and needs of the cultural group. Therefore, the MHD intends to enhance this strategy by working with all cultural groups to develop and implement one consistent education campaign using a tool such as Mental Health First Aid, an emerging program developed in Australia that has demonstrated positive preliminary outcomes on improved attitudes towards mental illness.
  2. Recognizing that culturally specific education and awareness campaigns will still be vital, the MHD will engage and support individual communities to develop tailored campaigns such as, for example, popular theater.
  3. This project also will sponsor the development or expansion of a community-based organization or association dedicated to reducing ethnic and cultural disparities in access to services.
  4. Coordination with and implementation of strategies that complement the statewide initiatives, in particular Stigma and Discrimination Reduction and Ethnically and Culturally Specific Programs and Interventions, will fall under the auspices of this project.

## **Project 2: Strengthening Families and Children**

- This project prioritizes children, youth and their families from underserved cultural populations with increased prevention efforts and responses to early signs of emotional and behavioral health problems. This project will focus on children and youth (0-15), but the project's programs and services will be available, when warranted, to young adults.
- This project is divided into two components. Component One: County-wide practices supporting parents of young children that will be implemented in conjunction with Component Two: a continuum of services targeting four geographic regions of high need based on a combination of the most relevant risk factors. Table 1 provides a summary of the project's programs.
- Since this project consists of multiple programs and services, intended individual outcomes will be specific to the project component/s in which the individual or family participates. However, taken as a whole this project is intended to produce the following community-level outcomes:
  - Reduction of juvenile justice involvement (countywide and in High Risk Areas)
  - Reduced levels of child maltreatment and child removals/foster care placements (countywide and in High Risk Areas)
  - Increase in high school graduation rates (in High Risk Areas)

- Decrease in number or rate of individuals from these communities entering the mental health system (in High Risk Areas)

Project 2: Table 1

	Program and/or Practice	Region Specific?	Age / Population	Prevention / Early Intervention	Purpose
<b>Countywide</b>	Parenting Support – Triple P Levels One/Two-Three	No	Parents of Children (ages 0 – 6)	<input checked="" type="checkbox"/> Prevention - Universal <input type="checkbox"/> Prevention - Selective <input type="checkbox"/> Early Intervention	Improve parents' skills and capacity for building protective factors in their children.
	Reach Out and Read	No	0 – 5	<input checked="" type="checkbox"/> Prevention - Universal <input type="checkbox"/> Prevention - Selective <input type="checkbox"/> Early Intervention	Promote the development of protective factors in young children and their parents, and screen for early indications of developmental delays.
	Nurse Family Partnership	No	New, low-income mothers at-risk of or involved with the criminal justice or child welfare systems.	<input type="checkbox"/> Prevention - Universal <input checked="" type="checkbox"/> Prevention - Selective <input checked="" type="checkbox"/> Early Intervention	Provide relatively intensive and relatively long-term support to high risk single mothers.
<b>High Risk Areas</b>	Parenting Support – Triple P Levels Four and Five	Yes	Parents of Young Children and pre-teens exhibiting more severe behavioral problems	<input type="checkbox"/> Prevention - Universal <input type="checkbox"/> Prevention - Selective <input checked="" type="checkbox"/> Early Intervention	Provide parents with more intensive support in dealing with emerging behavioral problems.
	Multi-Level School Based – Strengthening Families	Yes	Children and youth 3-16 years old and their families	<input type="checkbox"/> Prevention - Universal <input checked="" type="checkbox"/> Prevention - Selective <input type="checkbox"/> Early Intervention	Provide focused prevention strategies to parents, teachers and students in school settings to enhance protective factors and decrease risk factors.
	Family Therapy – Brief Strategic Family Therapy	Yes	Families of youth 10-18 with substance use and conduct problems	<input checked="" type="checkbox"/> Prevention - Universal <input checked="" type="checkbox"/> Prevention - Selective <input checked="" type="checkbox"/> Early Intervention	Provide intensive, direct interventions to parents and children to address severe emerging behavioral / emotional problems.

	<b>Program and/or Practice</b>	<b>Region Specific?</b>	<b>Age / Population</b>	<b>Prevention / Early Intervention</b>	<b>Purpose</b>
	Child/Skills Therapy – Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Depression Treatment Quality Improvement (DTQI)	Yes	Trauma exposed children (ages 3 to 18) and their caregivers who also may be exhibiting symptoms of depression	<input type="checkbox"/> Prevention - Universal <input type="checkbox"/> Prevention - Selective <input checked="" type="checkbox"/> Early Intervention	Provide intensive, direct interventions to parents and children to address severe emerging behavioral / emotional problems and depression resulting from trauma.

- For each of the four High Risk Area (HRAs), the MHD will establish or build upon an existing "collaborative," consisting of school administrators, educators, community-based organizations providing mental health, social and other services, primary care providers, faith-based organizations, law enforcement and social service agencies, and leaders/representatives of neighborhoods and ethnic communities. The collaboratives will play a critical role in implementing, leveraging and the sustaining the project's strategies.
- The collaboratives will play a more active role in implementing the project's second component. In each HRA, the MHD and the collaboratives will implement four strategies in order to achieve specific mental health outcomes for program participants and to reduce critical risk factors in their community. In each HRA, the MHD intends to implement 1) an early intervention parenting program, 2) a multi-level school-based prevention and/or early intervention program, 3) a family therapy intervention, and 4) early interventions to address the signs and symptoms of trauma and depression. The strategies were chosen in consultation with the PEI SWGs and consultants from CIMH. The strategies, along with programs under the first component, were selected to meet the range of needs identified by stakeholders during the planning process.
- Although each strategy is prescribed, collaboratives will be able to determine the level, or quantity, of each intervention category based the strengths and needs of the community. It is conceivable that an HRA may implement all strategies but not use PEI funds for all of them.
- For each strategy, the MHD has identified a recommended practice. The practices were selected in consultation with the PEI SWGs, CIMH and the MHD staff. Collaboratives may choose alternative or additional practices, if the practices meet the criteria established by the MHD and explained in the Executive Summary section, Alternative and/or Additional Practices.
- Anticipated Numbers Served: The MHD will provide an estimate of clients served once implementation plans have been developed for each HRA. The MHD anticipates providing these estimates no later than 60 days after the PEI project is approved by the DMH/OAC. As described, individual communities will have a significant input into the level of service for each strategy/intervention category.

**Project 3: Prevention and Early Intervention for Individuals Experiencing the Onset of Serious Psychiatric Illness with Psychotic Features**

- The project is intended to result in a focused continuum of primary and selective prevention and early intervention services to address the onset of serious psychiatric illness with

psychotic features, with the goals of improving mental health and functioning in all life domains and reducing suicide risk. This project primarily focuses on children and transition age youth (TAY) because this age range is associated with the onset of serious psychiatric illness with psychosis. However, although outreach, education and intervention practices will focus on children, adolescents and young adults, services will be available to any individual experiencing the onset of serious psychiatric illness with psychotic features, regardless of age. The selection of this priority population reflects stakeholder input throughout the PEI and the CSS planning processes.

- The project's intended outcomes for individuals relate to the mental health and social functioning of individuals, while program and community level outcomes are targeted at the undesired consequences of delayed or no access to interventions. Individual outcomes include:
  - Preventing psychotic episodes by individuals experiencing at-risk mental state (ARMS);
  - Preventing subsequent psychotic episodes for individuals who have experienced an initial psychotic episode;
  - Improving levels of functioning in regard to living situation and participation in rewarding vocational and social/recreational activities; and
  - Decreasing the incidence of suicide attempts or suicide ideation.
- This project is predicated on the research-supported premise that early and intensive services before, at the time of, or immediately following first onset can significantly alter the trajectory of an individual's illness and help ensure that they are able to lead productive lives.
- This project will utilize the *Early Detection and Intervention for the Prevention of Psychosis* (EDIPP) program, which is currently being funded as a replication study in six sites nationwide, to build the research evidence on the effectiveness of this model at preventing onset and disability. The CIMH rates EDIPP's level of evidence as promising. Initial evidence indicates that the EDIPP program reduces hospitalizations and reduces relapse after first break as well as initial onset for individuals at risk. The EPPIC program is listed in the DMH Resource Materials guide. The County selected EDIPP as its preferred practice because it consists of robust support services and seems to represent the most up-to-date model for treatment of ARMS or First Onset. In their review of early psychosis programs, the County's PEI Strategy Work Groups recommended that the County implement a program similar to Oregon's EAST (Early Assessment and Support Team), which is one of the EDIPP replication sites.
- This project will have several strategies.
  - A. Universal community education. This strategy is intended to increase the community's overall awareness of the needs of young adults experiencing ARMS or first onset in order to decrease stigma and discrimination which may be obstacles to seeking treatment.
  - B. Targeted multicultural outreach and training. This strategy teams professional clinical staff with consumers and family members for the purpose of engaging and educating individuals who come into contact with young adults and training those individuals to recognize the signs and symptoms ARMS and First Onset. Although efforts will be directed at professionals who might encounter young persons in the early stages of deterioration toward psychosis, this component will extend to others such as first responders (e.g., police) and parents of at-risk populations.
  - C. Community-based interventions: assessment, individual support, clinical interventions.

skill-building and medication as needed. This strategy is to be conducted by clinical professionals trained in the EDIPP model and forms the core interventions aimed at achieving the project's outcomes for individuals.

- D. Multi-family support groups. This strategy establishes long-term support structures for families and increases their capacity to support their loved ones.
- E. Peer support services. This strategy allows individuals to connect with and build a network of support that is attuned to their experiences and culture. This component, along with the multi-family support groups, adheres to the input provided by stakeholders and is consistent with the MHSA General Standards.
- F. Supported employment and supported education. This strategy provides additional and specialized support to young persons to continue their educational and/or employment activities while maintaining their recovery. This component is critical in enabling individuals to lead productive lives and to have success in all life domains.
- G. Benefits Assistance and Social Services Navigation. This strategy assists individuals and families in accessing the supportive services they need in order to achieve and sustain long-term recovery. Equally important, this component ensures that an individual's recovery is supported by or coordinated with any other systems or institutions with which the young person may be involved. This component ensures that individuals do not "fall through the cracks."

#### **Project 4: Primary Care / Behavioral Health Integration for Adults and Older Adults**

- This project's primary goal is to improve underserved populations' access to suitable, non-stigmatizing and low intensity mental health interventions to effectively address the onset of serious psychiatric illness and reduce suicide risks among individuals 26 years of age and older (adults and older adults).<sup>1</sup> The project is intended to result in a continuum of selective prevention and early intervention services, including early identification and treatment, integrated into primary health care clinics with the goal of reducing stigma and increasing access to timely interventions targeting disorders such as depression and anxiety. Intended outcomes include improved physical and emotional health, early identification and treatment of disorders resulting in improvements in mood and participation in rewarding personal, vocational and social/recreational activities, and a decrease in the incidence of suicide attempts.
- Particular attention will be given to address the higher risks experienced by older adults and refugees. The project's primary goals are:
  - Improve the coordination between and integration of primary and behavioral health;
  - Improve the capacity of primary care providers to identify, prevent and treat emerging mental health problems as part the patient's overall health care;
  - Increase early identification of emerging mental health problems, especially in older adults;
  - Improve timely access to services;
  - Improve mood, enjoyment and life functioning among individuals experiencing the

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<sup>1</sup> Community health clinics serve patients of all ages. Although the project focuses on adults (as defined by the guidelines) and older adults, the project team will not withhold appropriate interventions for treating depression and anxiety disorders from children, youth and TAY. For children and youth, the project teams' involvement may primarily involve consultative services to parents and primary care providers; however, young adults (TAY) will be provided access to the whole continuum of developed services as appropriate.

onset of depressive and anxiety disorders; in addition,

- For individuals experiencing more severe symptoms related to trauma, provide appropriate interventions in order to reduce symptoms and improve social functioning; finally,
- Prevent suicide ideation and attempts among patients.
- This project will consist of two components. Some programs and services will be offered countywide, while others will be implemented in the identified, specific “High Risk Areas” (HRAs) of the county. Table 2 provides a summary of the project components and programs.

**Project 4: Table 2**

	<b>Program and/or Practice</b>	<b>Region Specific?</b>	<b>Age / Population</b>	<b>Prevention / Early Intervention</b>	<b>Purpose</b>
<b>Countywide</b>	Increase psycho-education for all patients in primary care settings.	No	All	<input checked="" type="checkbox"/> Prevention - Universal <input type="checkbox"/> Prevention - Selective <input type="checkbox"/> Early Intervention	Improve patients' understanding of factors contributing to mental wellness and encourage patients to seek assistance.
	Gatekeepers Case-Finding Model and Community Outreach	No	Older Adults	<input checked="" type="checkbox"/> Prevention - Universal <input checked="" type="checkbox"/> Prevention - Selective <input type="checkbox"/> Early Intervention	Increase identification of older adults in need of mental health, health, and/or social services.
	Prolonged Exposure (PE) Therapy for Post-Traumatic Stress Disorders (+cross training in modified IMPACT model)	No	18+	<input type="checkbox"/> Prevention - Universal <input type="checkbox"/> Prevention - Selective <input checked="" type="checkbox"/> Early Intervention	Provide early interventions to address depression, anxiety and/or PTSD in refugees and patients referred by primary care clinics.
<b>High Risk Areas</b>	Modified IMPACT and PE for adults and older adults in primary care settings	Yes	18+	<input type="checkbox"/> Prevention - Universal <input type="checkbox"/> Prevention - Selective <input checked="" type="checkbox"/> Early Intervention	Intervene at the earliest possible stage of depression or anxiety to decrease symptoms, improve mood, and increase participation in meaningful life activities.



# Prevention and Early Intervention Plan Summary

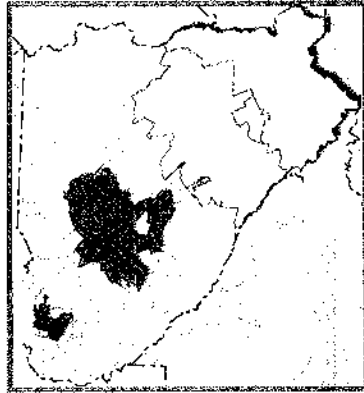
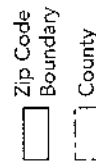
SANTA CLARA COUNTY MENTAL HEALTH SERVICES ACT

**SUMMARY OF PREVENTION AND EARLY INTERVENTION STRATEGIES**  
Prevention and Early Intervention strategies will create a continuum of services to help people avoid mental illness; provide services during the earliest phases of mental illness, and target key age groups. Some PEI services will be concentrated in high risk areas, while others will be implemented countywide.

## COUNTYWIDE PEI STRATEGIES

These strategies will be implemented throughout Santa Clara County.

- **Older Adults**  
Early identification and linkages to services for older adults in need of mental health, health or social services, who may otherwise go unrecognized and untreated. (Project 4)
- **New Refugees**  
Early identification and services for newly resettled refugees who have signs of depression, anxiety or post-traumatic stress disorder, delivered in conjunction with primary care providers. (Project 4)
- **People Experiencing First Onset**  
A continuum of prevention and early intervention services for those experiencing the first onset of serious mental illness with psychosis; program will focus on adolescents and transition-age youth. (Project 3)
- **At-Risk New Mothers**  
Intensive and longer-term parenting support for high risk, first-time single mothers whose children are at the greatest risk of developing behavioral problems. (Project 2)
- **Parents and Guardians of Young Children**  
Support services to improve parent and guardian skills and capacity to build protective factors in their children. (Project 2)
- **Underserved Communities**  
Education campaigns, outreach and engagement strategies to reduce stigmas and discrimination, and increase knowledge of mental health services. This project will increase access to services in underserved communities. (Project 1)



Data Source:  
ESRI USA and TIGER



May 2009

## HIGH RISK AREA PEI STRATEGIES

These strategies will be implemented in high risk areas of Santa Clara County.

- **Early Identification**  
Identification and early intervention to treat depression, anxiety and post-traumatic stress disorder in adults who are experiencing the first signs of mental illness. (Project 4)  
**Client Age: 18+**
- **Child/Skills Therapy**  
Intensive, direct interventions for parents and children to address severe, emerging behavioral and emotional problems and depression resulting from trauma. (Project 2)  
**Client Age: 3 to 18**
- **Family Support**  
Intense, direct therapy and support for the whole family when a child is experiencing severe emerging behavioral and emotional problems. (Project 2)  
**Client Age: 3 to 16**
- **School-Based PEI**  
Focused prevention and early intervention strategies for parents, teachers and students in school settings to enhance protective factors and decrease risk factors. (Project 2)  
**Client Age: 4 to 12**
- **Parental Support Program**  
A program for parents and guardians of young children and pre-teens to improve parenting skills and provide support for emerging behavioral problems. (Project 2)  
**Client Age: 0 to 12**

### North High Risk Area

Population = 27,877  
Includes zip code 94043.

### South High Risk Area

Population = 111,151  
Includes zip codes 95020, 95037 and 95046.

### Central and East High Risk Areas

Population = 732,285  
Includes zip codes 95008, 95110, 95111, 95112, 95113, 95116, 95117, 95118, 95119, 95121, 95122, 96123, 95125, 95126, 95127, 95128, 95133 and 95148.



SAN JOAQUIN COUNTY MENTAL HEALTH SERVICES ACT

# Prevention and Early Intervention Planning

## MAP 1: RISK RATING AVERAGE BY ZIP CODE

Zip Code Risk Indicator Score

- 1 - 1.99
- 2 - 2.99
- 3 - 3.99
- 4 - 4.99
- 5 - 5.99

High Risk Areas (with zip code risk rating 4.00 and above)

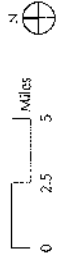
zip code boundaries do not align with jurisdictional boundaries

Zip Code Boundary

County

Water

Interstate/Highway

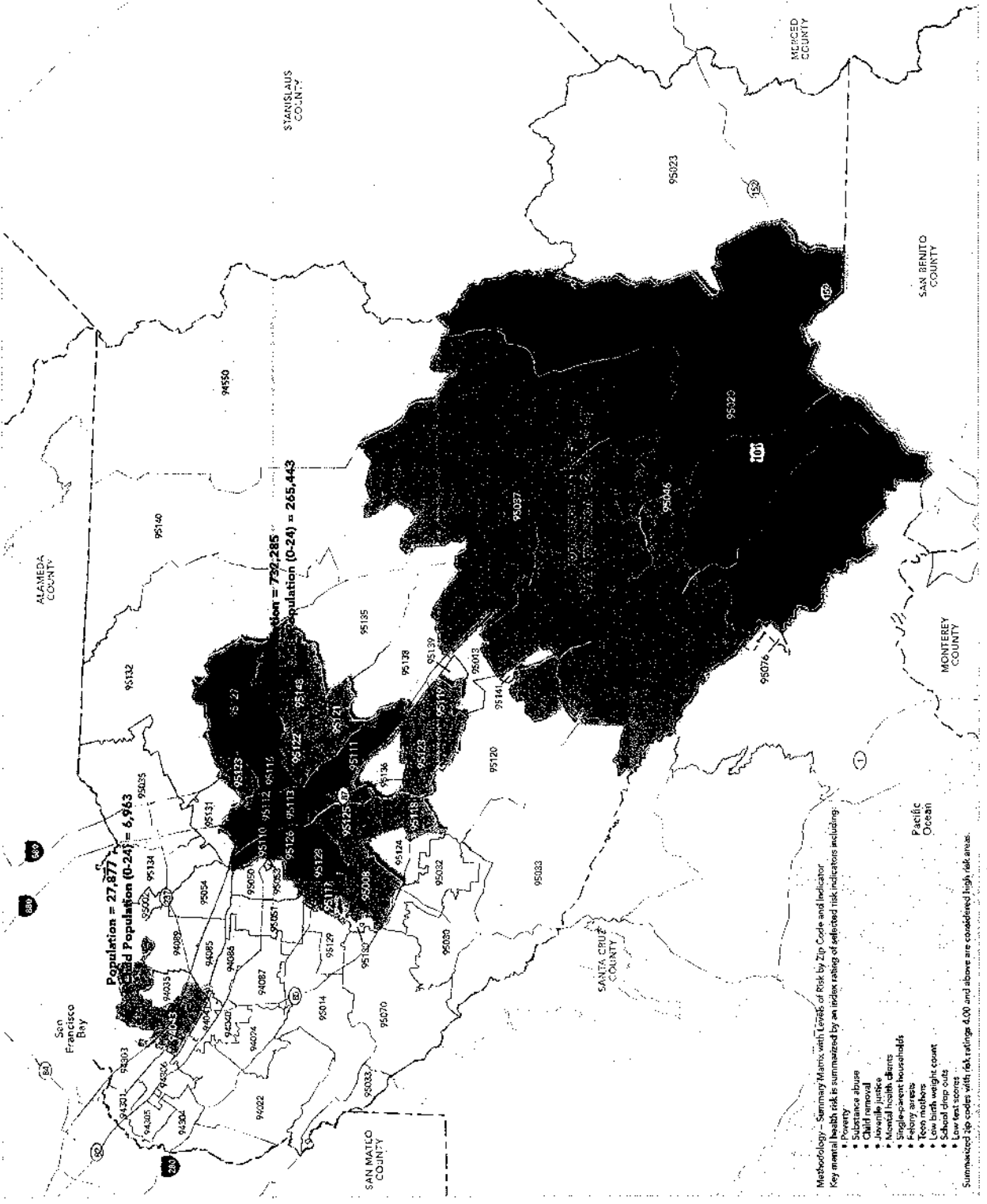


For each risk indicator, the zip code that falls within the highest bracket of incident numbers (the top 1/6 of those listed) are identified with the number six (6) and the zip code that falls within the lowest bracket (the bottom 1/6 of those listed) are identified with the number one (1). The average risk indicator for each zip code was calculated by totaling the indicator scores and dividing the total by the number of indicators with available data (which ranges from four to ten). Average risk ranges from 1.11 to 5.55. Zip codes that have a risk rating average of 4.0 or higher are shaded in dark shades of green and these zip code borders are outlined. Identifying zip areas with a risk rating average of 4.0 or higher as potential high areas in the county.



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May 2009  
Data Source: ESRI USA and TIGER



**Methodology:** Summary Maps with Levels of Risk by Zip Code and Indicator  
Key mental health risk is summarized by an index rating of selected risk indicators including:

- Substance abuse
- Child removal
- Juvenile justice
- Mental health clients
- Single-parent households
- Felony arrests
- Teen mothers
- School dropouts
- Low test scores

Summarized zip codes with risk ratings 4.00 and above are considered high risk areas.