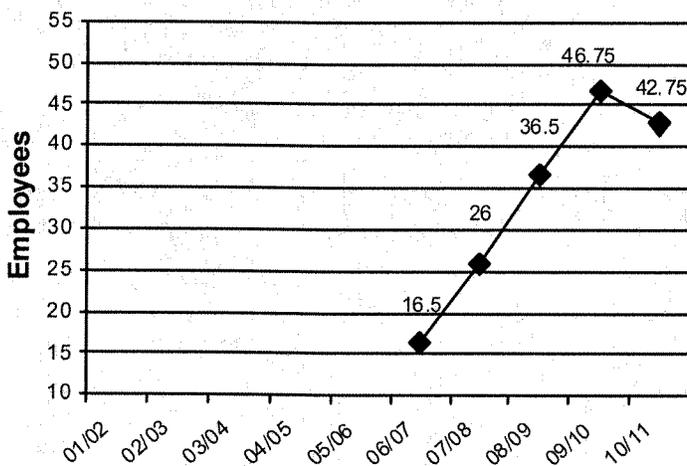


MISSION STATEMENT

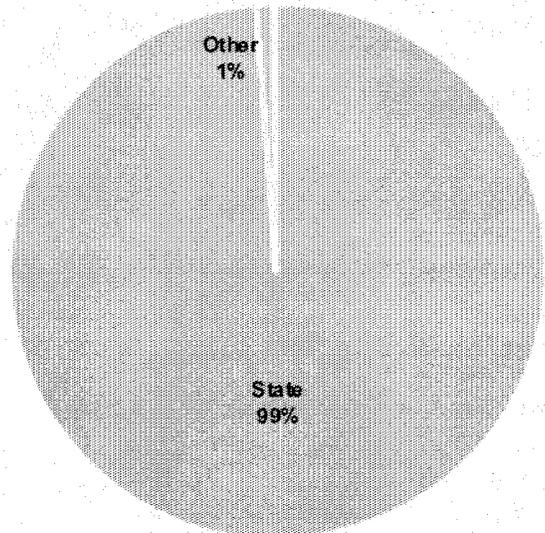
Services funded by the Mental Health Services Act are designed to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families.

Financial Summary	2009-10	2009-10	2010-11	2010-11	Change From 2009-10
	Budget	Projected	Requested	Recommended	
Revenues	\$ 10,637,311	\$ 10,475,087	\$ 12,023,633	\$ 11,902,578	\$ 1,265,267
Salary and Benefits	5,318,282	4,492,445	4,767,467	4,646,412	(671,870)
Services and Supplies	5,340,061	6,025,703	6,959,766	6,959,766	1,619,705
Other Charges	0	0	296,400	296,400	296,400
**Gross Expenditures	\$ 10,658,343	\$ 10,518,148	\$ 12,023,633	\$ 11,902,578	\$ 1,244,235
Less Intrafund Transfers	21,032	43,061	0	0	(21,032)
**Net Expenditures	\$ 10,637,311	\$ 10,475,087	\$ 12,023,633	\$ 11,902,578	\$ 1,265,267
General Fund Support (G.F.S.)	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0

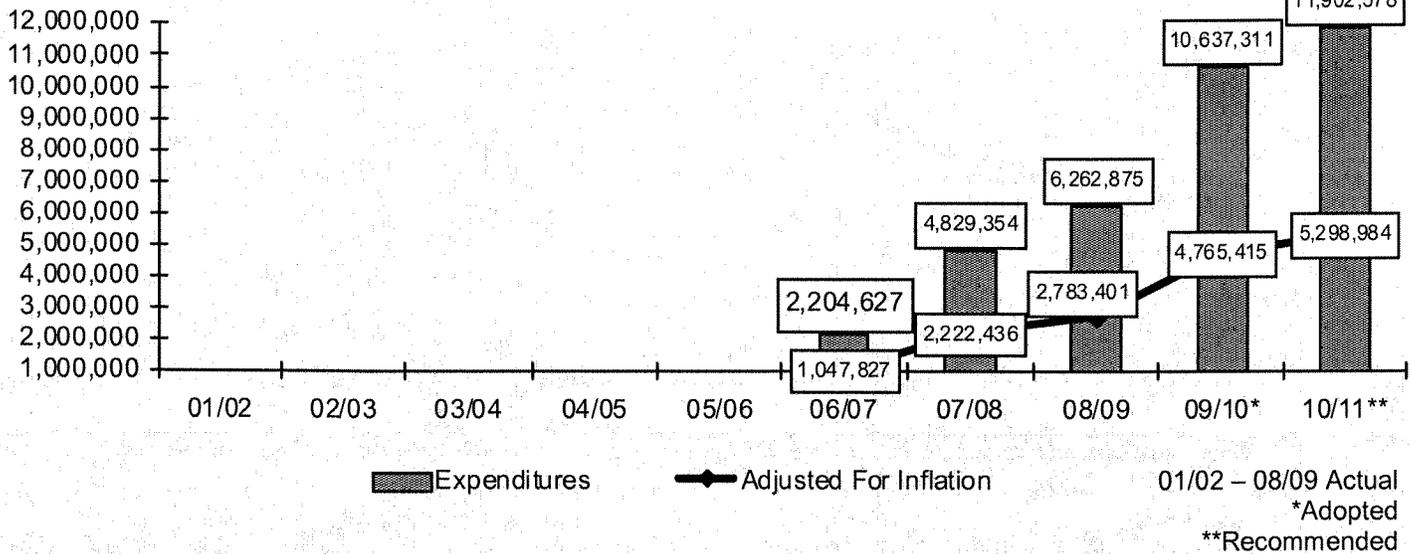
**Number of Employees
(Full Time Equivalent)**



Source of Funds



10 Year Expenditures Adjusted For Inflation



SERVICE PROGRAMS

Community Services and Supports

Community Services and Supports (CSS) programs are designed to enhance mental health services for children and youth with serious emotional disturbances and for transition age youth, adults, and older adults with serious mental illness. Programming for this Mental Health Services Act (MHSA) component is comprised of Full Service Partnerships (FSP) which focus on providing intensive mental health services 24 hours a day, 7 days a week for individuals with severe mental illness. The Full Service Partnerships are intended to provide “whatever it takes” to help clients and family members achieve their goals. CSS also includes system development programs such as Latino Services, Crisis Services, Community School mental health services and Behavioral Health Treatment Court services. These programs offer services and supports to the entire population of persons with severe and persistent mental illness.

Total Expenditures: \$7,457,206 Total Staffing (FTE): 33.75

Prevention and Early Intervention

Prevention and Early Intervention (PEI) programming includes community-based projects which promote wellness and increase resiliency. These projects include stigma reduction campaigns, outreach and education for targeted universal and selective populations, school-based student assistance programming and youth development activities, mentoring and peer-based services for high-risk populations, and increased counseling services for individuals and families seeking brief, short-term interventions. The overall goal of PEI is to build community capacity to increase resiliency. This is done using strategies which decrease risk factors and increase the protective factors that promote positive mental health and reduce the negative impact of mental illness.

Total Expenditures: \$2,543,688 Total Staffing (FTE): 8.00

Capital Facilities and Technology

The Capital Facilities and Technology (CFT) component of MHSA is looking to improve delivery of its behavioral health services and the efficiency of the associated business and financial processes through improved information technology. The San Luis Obispo County Health Agency is procuring a commercial off-the-shelf (COTS) electronic health record (EHR) system to support practice management and provide an electronic health record for clients.

Total Expenditures: \$657,113 Total Staffing (FTE): 1.00

Workforce Education and Training

The Workforce Education and Training (WET) component of MHPA provides funding to develop and maintain a mental health workforce capable of providing client and family-driven, culturally competent services using effective methods that promote wellness, recovery and resilience and increased involvement in the transformation of the mental health system. This component provides culturally competent and recovery oriented staff development; peer advisory, mentoring and advocacy, law enforcement and first responders training, online learning; internships and stipends, scholarships and grants, and collaboration with the local community college in creating educational programs related to the mental health field.

Total Expenditures: \$430,271 Total Staffing (FTE): 0.00

Innovation

The Innovation (INN) component is less specific in its directives than other components of MHPA forming an environment for the development of new and effective practices/approaches in the field of mental health. Projects are novel, creative, and/or ingenious mental health methods that contribute to learning, and that are developed within communities through a process that is inclusive of unserved, underserved and inappropriately served individuals.

Total Expenditures: \$814,300 Total Staffing (FTE): 0.00

DEPARTMENT COMMENTS

Key Accomplishments of Mental Health Service Act (MHPA) for FY 2009-10

Customer Service

- A Behavioral Health Treatment Court was developed and implemented in FY 2009-10. This was a collaborative effort, with the Courts, Probation and the Public Defender participating in the process.
- An FSP team was developed for inmates with a mental illness who are being released from jail. The FSP team conducts a "reach-in" engagement prior to the inmate being released. Upon release the team then works with the client in accessing behavioral health services.
- Created a Child and Adolescent Full Service Partnership Team in the South County.
- The Full Service Partnership teams have allowed clients to remain in the community, maintain housing, decrease the number of inpatient hospitalizations and increase social contacts.
- A bilingual Family Advocate was added to the Client and Family Partners program.
- Implementation of the Prevention and Early Intervention (PEI) services component of MHPA began in FY 2009-10. PEI programs aim to reduce the negative impact of mental illness and to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for un-served and underserved populations.
- Work was begun with Transitions Mental Health Association (TMHA) to develop community housing through the MHPA Housing program.

Improved Business Practice

- Due to the intense 24/7 services offered by the Full Services Partnership program, the number of inpatient hospitalizations and incarcerations have been reduced.
- An after-hour crisis worker was added to provide crisis intervention services to the public after 5 P.M. Previously this function was provided by the staff at the psychiatric inpatient unit.
- Improved coordination between Forensic Coordination Team, Behavioral Health Treatment Court, Forensic Re-entry Services and County Behavioral Health Services.
- A Geriatric Specialist is now participating in various policy making committees in the county.

Finances

- A productivity report is now produced by fiscal staff each quarter, indicating the amount billed versus available hours for every direct care staff member.
- Funded required prudent reserve with unspent MHPA monies.

Learning & Growth

- The Full Service Partnership teams are a collaborative effort between County Behavioral Health Services and other Community Based Providers. Regularly scheduled meetings are conducted with management staff from Mental Health and the Community Based Organizations in order to ensure clear communication and a consensus on mission and service delivery.
- Behavioral Health facilitated several training opportunities for staff and community partners, including a seminar on Co-Occurring Disorders conducted by Dr. Mee-Lee; training on cultural competency with the Lesbian, Bisexual, Gay, Transgender, Questioning (LBGTQ) population; and seminars on Suicide Prevention, smoking cessation, sexual abuse, and law and ethics.
- The Workforce Education and Training (WET) plan was approved by the State in FY 2009-10, and is now being implemented. Through WET we have been able to hire several bilingual interns.
- Crisis Intervention Training is available to all law enforcement through training provided twice a year, educating law enforcement on how to recognize mental illness and how to intervene appropriately.

Major Focus for FY 2010-11**Using Technology to Improve Customer Service**

- The Health Agency, in conjunction with the Information Technology Department, began a project in FY 2007-08 to replace the current billing system. The vendor for the new system was selected in FY 2009-10 and implementation is scheduled to begin in FY 2010-11. The project goal is to meet the future Federal requirement to have an Electronic Health Record for each client served. We anticipate the new system will enable staff to have immediate access to the client records and enhance client care. It will facilitate more efficient processes throughout the Department and will improve cost recovery for services provided by boosting billing.

Internal Business and Program Improvements

- The availability of management information will be expanded through the use of Health Agency intranet web reports.
- Efforts to integrate MHSA services into the outpatient clinics will be expanded in FY 2010-11.

Finance

- MHSA funding is projected to decline in FY 2010-11. A plan has been developed with the participation of community stakeholders to mitigate the decline. The Department will continue to monitor these efforts to ensure that funding is maximized without creating dramatic services reductions.
- Ways to leverage existing funding will continue to be sought. Staff will continue to participate in State meetings and advocate for more funding and keep apprised of the State budget situation.
- The fund balance in the reserve will be maintained so that the County can continue to serve children, adults and seniors during years in which MHSA revenues are insufficient.

Learning and Growth

- The Behavioral Health Department will continue to seek opportunities to collaboratively train staff from Mental Health and Drug and Alcohol Services on issues such as co-occurring disorders.
- Provide training on documentation, law and ethics, writing collaborative treatment plans, Dialectic Behavioral Training, and Motivational Interviewing.

Key Challenges and Strategies for Fiscal Year 2010-11

- The decrease in funding will impact the services delivered. The Department will continue to work with the stakeholders to find ways to mitigate the reductions in funding. The Department will work on better capture of Medi-Cal Administrative Activities (MAA) to increase reimbursement revenue.
- The replacement of the information system in the Department is crucial to billing and to accurate reporting of data.
- The Program Supervisors will conduct chart audits to ensure compliance with the Department of Mental Health regulations.

- Efforts will continue to review and revise forms for case records to ensure efficiency and effectiveness by evaluating current forms and eliminating the use of unnecessary forms, where possible.
- A comprehensive cultural competency plan will be developed based on the guidelines established by the State Department of Mental Health.
- A process will be developed to hire consumers of mental health services.
- The ability to recruit and retain psychiatrists, nurses, bilingual/bi-cultural staff and other professional and technical staff is critical. There is a national shortage of psychiatrists and nurses. The shortage is intensified in San Luis Obispo County because of the presence of the California Men's Colony (CMC) and the Atascadero State Hospital (ASH), which make it even harder to recruit and retain qualified individuals.

COUNTY ADMINISTRATOR'S COMMENTS AND RECOMMENDATIONS

The Mental Health Services Act (MHSA) was enacted into law January 1, 2005. This enactment followed the passage of Proposition 63 in November 2004, which imposed a 1% tax on adjusted annual income over \$1,000,000. This new stream of funding is dedicated to transforming the public mental health system and seeks to reduce the long-term adverse impact from untreated serious mental illness.

To access the MHSA funds, counties are required to develop plans to carry out the goals and objectives of MHSA programs. These plans must be created in collaboration with clients, family members, providers, and other community stakeholders and circulated for public comment prior to being submitted to the California Department of Mental Health. There are five primary MHSA programs: Community Services and Support (CSS), Prevention and Early Intervention (PEI), Workforce Education and Training, Capital Facilities and Technology, and Innovation. This fund center is supported 100% by State and Federal funding and receives no General Fund support.

In FY 2010-11 revenues and expenditures for this fund center are budgeted to increase \$1,265,267 or 11% compared to FY 2009-10 adopted levels. The increase is due to new funding coming online from newer MHSA components, including \$814,300 for the Innovation component and \$296,400 for Prevention and Early Intervention (PEI). The Community Services and Support (CSS) component was the first to come on-line in FY 2006-07. Due to the recession and the resulting decline in the number of individuals earning over \$1 million in income each year, FY 2010-11 will mark the first year this funding has declined. Due to the time lag involved in receiving MHSA funding from the State it is expected that the effect of the recession will be seen over the next several years.

Services and supplies increase \$1,619,705 or 30%. Salaries and benefits decline \$671,870 or 12%. Due to the decline in CSS revenue and in order to sustain programs already in place, the Health Agency has requested the elimination of 5.00 FTE that had not yet been filled for a combined reduction of \$614,390. The positions reduced are listed below, and account for the majority of the reduction in salaries and benefits in FY 2010-11 compared to the FY 2009-10 adopted amount. Professional Services increase \$893,844 compared to the FY 2009-2010 adopted amount, mainly due to \$814,300 in expenditures related to the new Innovation component. The MHSA stakeholder input process for the Innovation component was not yet complete at the time the budget was submitted. Depending on the outcome process, the Health Agency may come to the Board of Supervisors once FY 2010-11 is underway to amend the budget, if needed.

Transfers to other County departments for services, overhead and other expenses are budgeted to increase \$711,306. This includes \$514,415 in funds transferred from the Capital Facilities and Technology component to FC 161 – Mental Health for staff costs to implement of the Behavioral Health Electronic Health Record (BHEHR) system, and \$196,891 for other interdepartmental and overhead charges. The \$296,400 in the Other Charges line item is budgeted from the Prevention and Early Intervention (PEI) component, and will be passed through to the California Counties' Mental Health Services Authority, a Joint Powers Authority (JPA). The JPA was created in February of 2009 and is charged with jointly developing and funding mental health services and education programs on a regional, statewide, or other basis using MHSA PEI funding.

An overall reduction of 4.75 FTE is recommended in the MHSA Position Allocation List (PAL) for FY 2010-11:

- 1.00 FTE Mental Health Therapist for North Coast Transitional Age Youth (TAY) Full Service Partnership (FSP) team due to declining Community Services and Support (CSS) revenue.
- -1.00 FTE Mental Health Therapist for the Jail FSP due to declining CSS revenue.
- -1.00 FTE Mental Health Therapist Geriatric Specialist due to declining CSS revenue.
- -1.00 FTE Medication Manager due to declining CSS revenue.
- -0.50 FTE Staff Psychiatrist due to declining CSS revenue.
- -0.50 FTE Mental Health Therapist for Latino Services due to declining CSS revenue.
- -0.50 FTE Mental Health Nurse eliminated to create a Administrative Assistant position in the Performance and Quality Improvement (PQI) unit in FY 2010-11.
- +0.75 FTE Administrative Assistant in the (PQI) unit.

GOALS AND PERFORMANCE MEASURES

Department Goal: To help individuals experiencing severe mental illness or serious emotional disturbance to be as functional and productive as possible in the least restrictive and least costly environments.						
Communitywide Result Link: A Healthy and Safe Community.						
1. Performance Measure: The number of Transitional Age Youth and/or Adult clients placed in jobs or volunteer positions.						
05-06 Actual Results	06-07 Actual Results	07-08 Actual Results	08-09 Actual Results	09-10 Adopted	09-10 Projected	10-11 Target
N/A	39	62	54	55	40	50
<p>What: Mental Health Services Act (MHSA) programs are designed to provide services to clients with severe mental illness. An outcome required by the State includes supportive employment and vocational training for transitional-aged youth and adults. The program, through a cooperative agreement with the San Luis Obispo Department of Rehabilitation and Transitions-Mental Health Association, facilitates the placement of clients in jobs and volunteers positions.</p> <p>Why: Placing clients in vocational services allows them to take ownership in their treatment, to be productive, and actively participate in their recovery.</p> <p>How are we doing? Four clients were placed in jobs or volunteer positions in the first 3 months of FY 2009-10. Our first quarter results are well below our quarterly target level of 14 job placements. The vocational training and supported employment program competes with local job seekers for what has become fewer and fewer available jobs in the community in recent months. A result of the weak economy is fewer job openings and an increase in competition for the existing job openings. It is anticipated the pace of job placements will improve over the remaining three quarters since client referrals into the program have recently increased. In spite of the challenge to find job opportunities for these clients, we do anticipate placing 40 clients in total for FY 2009-10. A client's case remains open for as long as the individual desires and is actively participating in the process of returning to work. The optimistic target of 50 job placements for FY 2010-11 is based on the projected FY 2009-10 of 40 plus additional 2 – 3 clients per quarter for a total of 50 clients, with the assumption the economy will start to recover in FY 2010-11. We are expecting the State to provide other counties' comparison performance outcome data but it is not currently available. The State's budget crisis has delayed these efforts.</p>						
(Data Source: Transitions - Mental Health Association, Quarterly Performance Report, Plan 5, Section 6)						
2. Performance Measure: The number of Latino individuals attending outreach presentations or receiving mental health services through the MHSA Latino outreach and engagement program. (This performance measure is being deleted.)						
05-06 Actual Results	06-07 Actual Results	07-08 Actual Results	08-09 Actual Results	09-10 Adopted	09-10 Projected	10-11 Target
N/A	1,300	1,255	1,412	1,550	1,550	Deleted
<p>What: The Latino Outreach and Service program was designed to reach out to and provide community-based, culturally appropriate treatment and support to all age groups within the Latino population, who are typically not served or are underserved. This program aims to reduce stigma and fear of mental health services, identify mental health issues and make appropriate, culturally competent social service and treatment referrals.</p>						

Why: The Latino population is the largest ethnic minority group in the County and has historically been underserved. The Latino outreach and engagement efforts were established to provide an appropriate system to facilitate and expand this population's access to mental health services.

How are we doing? In the first quarter of FY 2009-10, 362 individuals were reached through various Latino outreach presentations and an additional 78 received direct mental health services. The demand for services in the Latino community continues to be high. Since the Latino Outreach Program has been successful in performing outreach and engagement efforts, staff will devote more time in delivering the mental health services to this population. While the Division views Latino presentations and treatment services to be important, the measure itself can fluctuate significantly based on the program's mix of outreach versus treatment services. In addition, the measure does not evaluate the effectiveness of the program itself.

(Data Source: Mental Health Services Act System)

3. Performance Measure: Percentage of individuals receiving crisis intervention services who are successfully diverted from psychiatric hospitalization.

05-06 Actual Results	06-07 Actual Results	07-08 Actual Results	08-09 Actual Results	09-10 Adopted	09-10 Projected	10-11 Target
N/A	63%	64%	57%	60%	60%	60%

What: Mental Health tracks the percentage of individuals receiving crisis intervention services that otherwise would have been placed in the County psychiatric hospital, which is a more costly alternative. MHSA provides funding to increase the number of crisis responders and to provide next day follow-up to those receiving crisis services. This measure includes crisis services provided to all clients in crisis regardless of age.

Why: Diverting an individual from the County psychiatric hospital is not only cost effective (psychiatric inpatient cost = \$1,100 per day), it also allows the individual to remain in their community and avoid a more restricted environment. A 55%-60% diversion rate is typical for the mobile crisis team.

How are we doing? In the first quarter of FY 2009-10, 55% (218 episodes) of crisis interventions did not result in hospitalization. This percentage is similar to the prior fiscal year as well as the number of crisis calls. It is projected 60% of individuals receiving crisis intervention services will be successfully diverted in FY 2009-10 and FY 2010-11. The percentage of clients diverted from the psychiatric hospital has remained fairly stable based on the philosophy of allowing crisis worker's more time with the individual to diffuse the situation. The "aftercare" component allows crisis workers to follow up with the client after the initial crisis call. This provides a degree of comfort and assurance that services will be available if needed. Comparison performance outcome data is not available from the State at this time.

(Data Source: Insyst Data System-Mobile Crisis Query)

4. Performance Measure: Net MHSA operating cost per full service partnership enrollee.

05-06 Actual Results	06-07 Actual Results	07-08 Actual Results	08-09 Actual Results	09-10 Adopted	09-10 Projected	10-11 Target
N/A	\$10,579	\$13,446	\$15,711	\$19,325	\$16,000	\$16,000

What: MHSA requires that over 50% of the Community Services and Support funding go to full service partnership (FSP) programs. FSP programs are designed to provide "whatever it takes" services to clients, but if not monitored can be very expensive. The cost per FSP enrollee is determined by taking the net amount of MHSA dollars used for client services, which takes into consideration any reimbursements from Medi-Cal and EPSDT, and then divided by the number of enrollees served.

Why: This measure can be used to review relative spending per FSP enrollee compared to other counties. In addition, this measure provides a treatment cost comparison between FSP enrolled individuals and non-FSP enrolled individuals. The cost per non-FSP enrollee is approximately \$6,000 per year. FSP clients require the most intensive services, which results in a higher cost per individual.

How are we doing?

When the FY 2009-10 Budget performance measure was determined, it did not include the expansion of the FSP Programs. The expansion included two programs, Behavioral Health Treatment Court and South County Youth FSP team. Due to the FSP program expansion, the number of FSP enrollees increased 26% (31 enrollees) compared to the prior fiscal year. Since both programs have larger caseloads than the traditional FSP programs, the average cost per client in theory should be reducing. The FY 2009-10 projected operating cost per enrollee will be \$16,000, which is derived from using planned FSP expenditures of \$2,849,078 and dividing by 180 (includes 20% turnover rate) projected clients. This projection is also representative of the FY 2010-11 target. Comparison performance outcome data is not available from the State.

(Data Source: Mental Health Services Act System and Enterprise Financial System)

5. Performance Measure: Average reduction in the number of hospital days for transitional age youth (TAY) after enrolling in a MHSA full service partnership (FSP). (This measure is being deleted.)

05-06 Actual Results	06-07 Actual Results	07-08 Actual Results	08-09 Actual Results	09-10 Adopted	09-10 Projected	10-11 Target
N/A	N/A	52%	50%	55%	50%	Deleted

What: This measures the average percent reduction in County psychiatric hospital days by comparing the number of hospital days in the 12 months prior to enrollment in the program with the number of hospital days after enrollment. The TAY FSP program is designed to provide "whatever it takes" services to youth ages 16-21. These services include 24/7 availability, intensive case management, housing and employment linkage and supports, independent living skill development and specialized services for those with a co-occurring substance abuse disorder. Expending MHSA funds to "wrap" intensive services around full service partnership individuals is expected to reduce the number of hospital days for these individuals.

Why: Reduced County psychiatric hospital days indicates that enrollees are functioning at a higher level than prior to enrollment and represents a significant savings for the system as a whole, as inpatient days are extremely expensive at approximately \$1,100 per day.

How are we doing? Of the 28 TAY FSP enrollees in FY 2008-09, the average reduction in the number of hospital days was 50%. This percentage varies depending on the severity of the individuals in the program and can be skewed by one individual. During the past fiscal year one enrollee had three hospitalizations after enrollment. If we remove this one individual from the results a 60% average hospitalization reduction would have been achieved. The basis used in the evaluation cannot be verified since it is voluntarily reported by client upon enrollment and statistics for hospital stays outside the county are not tracked rendering this statistic unreliable.

(Data Source: Mental Health Services Act System)

6. Performance Measure: Rate of client satisfaction with County MHSA services delivered at the McMillan site. (This is a new measure in FY 2010-11.)

05-06 Actual Results	06-07 Actual Results	07-08 Actual Results	08-09 Actual Results	09-10 Adopted	09-10 Projected	10-11 Target
New Measure	New Measure	New Measure	New Measure	New Measure	New Measure	85%

What: A State provided survey is given to all clients receiving mental health services during one-week periods in November and May of each fiscal year. Populations surveyed are Adult, Older Adult, Youth, and Youth Families. Surveyed customer service indicators are Access to Service, Cultural Sensitivity, and Participation in Treatment Planning, Outcomes, and General Satisfaction. The MHSA McMillan site includes the full service partnership, client and family wellness and recovery, Latino outreach and engagement, enhanced crisis response and aftercare, and behavioral health treatment court programs. The rate is an average for all indicators and populations, with the maximum possible score of 100%. The following rate ranges are indicative of the following responses: 70-79% "satisfactory"; 80-89% "above satisfactory"; 90-100% excellent".

Why: Client satisfaction is one indicator of the quality of services provided by MHSA.

How are we doing? Due to budget constraints, the State cancelled the November 2009 survey. Other comparable county results are not published by the State and unavailable for comparison purposes. The May 2010 survey is not expected to be cancelled and will be the basis for the FY 2010-11 measure.

(Data Source: DMH – Performance Outcomes and Quality Improvement: Consumer Perception Surveys)

Department Goal: To reduce behavioral health-related problems, including mental illness, substance abuse and depression, by providing high quality evidence based prevention strategies in county schools.

Communitywide Result Link: A Healthy Community.

7. Performance Measure: Percentage of youth participants in MHSA Prevention and Early Intervention (PEI) school-based programs who demonstrate a reduction in indicators of mental illness.

05-06 Actual Results	06-07 Actual Results	07-08 Actual Results	08-09 Actual Results	09-10 Adopted	09-10 Projected	10-11 Target
N/A	N/A	N/A	New Measure in FY 09-10	85%	85%	85%

What: School-based wellness and prevention programs will engage youth in activities which reduce risk factors and/or increase protective factors which reduce or eliminate the onset of problems associated with mental illness. Participants demonstrate (as measured by staff observation, surveys, and focus group outcomes) improvements in school attendance, problem-solving skills, family environment, academic performance, school and pro-social bonding, choice of peer group, awareness of mental health and wellness, and reduced or eliminated substance use, and disciplinary referrals.

Why: Based upon community stakeholder input in developing the Prevention and Early Intervention Plan in 2008, and in response to State MHSA directives which place priority on youth populations at risk for mental illness, Behavioral Health is directing resources towards a multi-age school wellness project. Youth at transitional stages, including those in preparing for middle school and high school, are at greater risk for stress, depression, substance abuse, involvement with the juvenile justice system, and academic failure (National Institute of Health, 2003).

How are we doing? California's Department of Mental Health has clearly outlined strategies which serve to effectively address the growing need for mental illness prevention and wellness promotion in the community. San Luis Obispo County will utilize these strategies in the PEI School-Based Wellness programs, which meet the State requirements of being "culturally and linguistically competent; demonstrate system partnerships, community collaboration, and integration; are focused on wellness, resiliency and recovery; and include evidence indicating high likelihood of effectiveness and methodology to demonstrate outcomes."

Student Assistance Programming (SAP), a strategy recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) and based on risk and resiliency research, will be employed in this effort. SAP identifies and links students to behavioral health care education, programs and services in the school and community to address students' barriers to learning due to a social, emotional or mental health concern or problem. Student success will be measured by decreases in standardized risk factors, or increases in standardized protective factors resulting in reduced risk of academic failure, mental illness, and/or substance abuse. Risk Factors include: emotional instability, substance use, exhibiting low levels of parent/youth communication, truant behavior, and inability to handle stress. Protective Factors include: improved school attendance, high levels of developmental assets, academic progress, school/community bonding, and perceived harm of substance use. The PEI School-Based Wellness programs will launch in the FY 2009-10 and the initial performance results will not be received from the schools until January 2010.