



**MADERA COUNTY
BEHAVIORAL HEALTH SERVICES
MENTAL HEALTH SERVICES ACT (MHSA)
JANICE MELTON, LCSW, MENTAL HEALTH DIRECTOR**

**30 Day Public Review Period 11/10/08 – 12/10/08
Madera County Behavioral Health Services
Prevention Early Intervention (PEI) Plan
Fiscal Year (FY) 2008/09**

Dear Community Stakeholders:

Madera County Behavioral Health Services (BHS) is posting its Prevention Early Intervention (PEI) Plan online for a 30 day public review and comment period. The Madera County Mental Health Board will hold a public forum on December 10, 2008 to provide the public additional opportunity for input. If you would like to attend this public forum or speak to someone about the PEI plan, please contact by postal mail, email, in person, or telephone:

**Madera County Department of Behavioral Health Services
Attention: David Weikel
424 N. Gateway Drive
Madera, CA 93637
Telephone: (559) 675-7762
E-mail: david.weikel@madera-county.com**

**Prevention and Early Intervention Component
of the Three-Year Expenditure Plan**

November 2008

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 2007-08 and 2008-09**

County Name: Madera	Date: 12/08/08
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COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):

County Mental Health Director	Project Lead
Name: Janice Melton	Name: Debby Estes
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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 2007-08, 2008-09 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 _____ Director of Behavioral Health 12/3/08

Executed at Madera, California

PEI COMMUNITY PROGRAM PLANNING PROCESS

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

County: Madera

Date: 12/3/08

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 following staff assumed responsibilities for the Community Planning Process

Janice Melton, LCSW, Director, Madera County Department of Behavioral Health
 Debby Estes, LCSW, Assistant Director, Madera County Department of Behavioral Health

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

Debbie C. DiNoto, LMFT, Division Manager, Department of Behavioral Health

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

David Weikel, MHSA Coordinator

The Prevention Early Intervention (PEI) Community Planning Process (CPP) included broad general outreach, community forums throughout the county, targeted outreach to ethnic minorities and underserved populations, public stakeholder processes, key informant interviews, existing mental health staff and advisory groups. Madera County is a small, mostly rural county. There are no mental health community based organizations (CBO's) within Madera County. This created special challenges in involving stakeholders in the community planning process. As a result, Madera County Behavioral Health Services (MCBHS) conducted several specialized focus groups and key informant interviews in order to obtain the information and direction of the proposed services in this plan.

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1. Orientation to PEI

All of the following groups received orientation and training to PEI and dedicated time at their regular meetings to identify prevention and early intervention needs and best practices. The orientation included a brief history of the Mental Health Services Act (MHSA) law, the intent of the law, the Five Fundamental Elements and the types of services that could be funded under MHSA. They were also kept informed of the progress of PEI planning and continued to offer input on the process

- Madera County Chief Administrative Office—including the top management of Madera County
- Madera County Health, Behavioral Health Services and Social Service Executive Staff—including the Behavioral Health Services Director and the Director of Department of Social Services,
- Other Madera County Department Directors—including the Madera County Corrections Director, Director of Madera County Department of Public Health, their managers, supervisors, and line staff.
- Madera County Department of Behavioral Health Services Cultural Competency Committee—including the local Behavioral Health Services Director, managers, line staff, clients, mental health board members
- MHSA Steering Committee—including Behavioral Health Services, Social Services, Corrections, service agencies, staff, etc.
- Prevention and Early Intervention Committee – Included clients, family members, staff from county departments, staff from community based non-mental health organizations, school staff and others
- Client and Family Member Committee—including clients and family members who receive or have received behavioral health services from Madera County.
- General public was informed through postings on the MCBHS MHSA website, local fairs, local events, newspaper articles, surveys, key informant interviews, focus groups, etc.

In addition to the above groups, Madera County conducted several focus groups as well as key informant interviews. There was a “training” component in each of those groups to talk about the MHSA. During this time, the following was discussed;

- History of the Mental Health Services Act
- What the Community Services and Supports (CSS) planning and stakeholder process results recommended in regards to the priorities for services to be implemented, and the identified mental health services needs
- The types of services that could be funded with PEI funds; including examples of these services
- Evidence Based Practice (EBP) programs Madera County Behavioral Health Services currently has implemented, which meet PEI program criteria.

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2. Outreach—Information on PEI and the PEI CPP as well as announcements to attend local PEI Community Forums was provided through email, mailing lists, newspapers and postings. Announcements were also posted on the Madera County MHSAs website.

Madera County Behavioral Health Services learned from the CSS planning process, and the early stages of PEI planning, that large stakeholder meetings and community meetings were not as effective as focus groups and key informant interviews in engaging community stakeholders in the planning process. In addition, due to budget constraints, staffing for the PEI planning was very limited (administrative staff with existing duties were used for the PEI planning). For planning the programs to be developed through PEI, Madera County relied heavily on administrative staff to obtain information and educate the public and stakeholders.

3. Madera County Behavioral Health Services Community Forums—there were a total of five community forums. They were located in various parts of the county (metropolitan Madera, rural and mountain areas) in handicapped accessible locations and on major bus routes. Language interpreters including sign language were available. Forums were not held in behavioral health services buildings/clinics due to concern regarding stigma issues. Meetings were held in health care settings and community buildings. The agenda included opportunities for local residents to participate in setting priority populations to be served, program choices, defining the top issues for Madera County Behavioral Health to address, etc.

4. Stakeholders Group Meetings—PEI was discussed at different Stakeholder Group meetings. These meetings included the MHSAs Steering Committee and the PEI Committee Meetings. For a specific list of members of the MHSAs PEI Committee and the MHSAs Steering Committees, please see Question 2.

There were Client/Family Member meetings as well. They were held at the MHSAs Client/Family Member drop-in center, Hope House. During those regularly scheduled meetings, clients and family members learned about the MHSAs and provided input on the needs of Madera County and the MHSAs plans being developed to address those needs.

5. Focus Group Meetings—Early in the process of planning to implement the various MHSAs components, it became apparent that the Madera community stakeholders and partner agencies would not attend regularly scheduled meetings, due to other commitments. Madera County is a small county with limited resources. There are no mental health CBO's within this county. People wear multiple hats and may represent their agency on several boards and committees. It is often difficult to attend the multitude of meetings and still provide appropriate services. It was suggested; that many of the unserved and underserved populations may not feel comfortable attending formal committee meetings with others, e.g., farm workers, Native American community, the Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) community, etc. Therefore, Madera County Behavioral Health Services went to them to provide education regarding the MHSAs, seek out their opinions on the needs of the community,

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prioritize those needs and develop programs to would address them. A full list of focus groups/key informant interviews is listed in Question 2.

6. Key Informant Interviews — People in Madera County wear multiple hats. There are no mental health CBO’s within Madera County. Often, the same person represents an organization at multiple meetings. Therefore Madera County Behavioral Health Services conducted small focus groups and key informant interviews in an attempt to involve the community in the PEI planning process. Some of the most difficult stakeholders to reach were the faith community and the Native American populations. After two years of trying to connect, MCBHS staff was able to hold meetings with representatives from these groups.

7. Health Fairs and other Community Forums—MHSA staff attended several community forums including the local Farmer’s Market, Health Fairs, Native American health fairs and events, Latino cultural events, school events, etc. They spoke about the MHSA components, handed out questionnaires, and noted comments from the community on PEI issues and concerns.

8. Surveys—Web based surveys were posted on the Madera County BHSA MHSA website. Surveys were posted in English and Spanish. Those surveys were tallied and their results were included in the development of this plan.

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

Madera County established a PEI Committee to assist in the planning process. They included representatives from various community based organizations/agencies serving the community. These organizations serve or represent un-served and/or underserved populations, consumers, youth and family members, and county staff.

Reports of the work group’s progress were presented to the MHSA Stakeholder Steering Committee, which was originally developed to oversee the implementation of the CSS programs. The members of the committee are listed below.

1	Janice Melton	Director	Madera County Department of Behavioral Health Services
2	Janet Stutzman	Member	Local Mental Health Board
3	Linda Rosas		Family Member
4	Doug Papagni	Director	Madera County Department of Corrections

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5	Claudia Norris	Director	Special Education Local Plan Area
6	Hub Walsh	Director	Madera County Department of Social Services
7	Carol Barney	Director	Madera County Department of Public Health
8	Maria Salas	Department Manager	Housing Authority of the City of Madera
9	Randy Brannon	Pastor	Grace Community Church
10	Jean Robinson	Assistant Director	Fresno Madera Area Agency on Aging
11	Betty Cates	Manager	Madera Community Hospital
12	Debbie DiNoto	Division Manager	Madera County Department of Behavioral Health Services
13	Debby Estes	Assistant Director	Madera County Department of Behavioral Health Services
14	Elizabeth Catanesi	Manager	First 5 of Madera County
15	John Bell	Analyst	Madera County Office of the District Attorney
16	Judy Comer	Analyst	Madera County Department of Behavioral Health Services
17	Jeannie Turpenen	Contractor	Madera County Department of Behavioral Health Services
18	Jeanette Flores	Administrative Assistant	Madera County Department of Corrections
19	Kathy Hayden	Division Manager	Madera County Department of Behavioral Health Services
20	Salvador Cervantes	Analyst	Madera County Department of Behavioral Health Services
21	David Weikel	Program Coordinator	Madera County Department of Behavioral Health Services

In addition to the MHSA Stakeholder Steering Committee, there was a specific PEI Committee. This committee's members included:

1	Kenneth Bernstein	Medical Director	Darin Camarena Health Centers
2	Carol Barney	Director	Madera County Department of Public Health
3	Claudia Norris	Director	Special Education Local Plan Area
4	David Weikel	Program Coordinator	Madera County Department of Behavioral Health Services

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5	Julie M. Vlasis	Chief Operations Officer	Darin Camarena Health Centers
6	Tamala Fields	Program Coordinator	Center for Independent Living - Madera
7	Elizabeth Catanesi	Family Resource Center Manager	First 5 of Madera County
8	Hub Walsh	Director	Madera County Department of Social Services
9	Janet Stutzman	Member	Local Mental Health Board
10	Jean Robinson	Assistant Director	Fresno Madera Area Agency on Aging
11	Mary C. Ferrell	Vice-president Patient Care Services	Madera Community Hospital
12	Minnie Aguirre	Member (Family Member)	Local Mental Health Board
13	Linda Rosas		Family Member
14	Randy Brannon	Pastor	Grace Community Church
15	Donna Lutz		Madera County Department of Social Services – Child Welfare
16	Contessa Palermo	Analyst	Madera County Department of Social Services
17	Fern Mills		Madera County Department of Social Services – Child Welfare

The Consumer and Family Member Committee met at the Wellness and Recovery Center (Hope House), which was developed with CSS funds. The Consumer and Family Member Committee received training regarding all of the Mental Health Services Act components and were given multiple opportunities for comments and recommendations regarding the types of services that should be developed with these new funds.

In addition to the Stakeholder Steering Committee and PEI committee, specific focus groups were held. As part of the focus group, an educational forum took place to let the participants know about the MHSA and specifically the PEI component. Specific questions were asked in each of the focus groups about what services they would like to see for PEI activities and which age groups should have the highest priority for those services. Their responses were recorded and included in the development of programs within this Plan. The following is a list of the Focus Groups/Key Informant interviews held during February through November of 2008.

Focus Groups/Key Informant Interviews

The following key informant interviews and focus groups were conducted;

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	Date	Attendee #	Group
1	2/12/08	9	South Madera High School – School of Health Sciences - Curriculum Development Meeting (BHS Introduced Human Services Academy Model)
2	2/12/08	1	Madera Unified Special Education Coordinator
3	4/7/08	8	Early Childhood Initiative Group (Head Start, Madera County Office of Education, Madera County Special Education)
4	6/6/08	7	North Fork Tribal Temporary Aid to Needy Families (TANF)
5	5/19/08	1	California School Mental Health Centers Association
6	6/10/08	2	Nora and Associates (Latina Business Women’s Association)
7	7/1/08	15	Migrant Farm Workers (met at the camp)
8	8/6/08	1	Adult Outpatient Supervisor (LPS services, Courts, Intensive Services)
9	8/7/08	7	City of Madera Police Town Hall Meeting - (4) Police Department, (2) District Attorney’s Office , (1) Madera Unified School District
10	8/8/08	12	(6) Resource Management Agency, (6) Department of Behavioral Health Services
11	8/13/08	1	Older Adult Full Service Partnership - Senior Clinician
12	8/19/08	1	Center for Independent Living Program Coordinator
13	8/19/08	6	MHSA Children and Youth Full Service Partnership Team (therapists, case workers, supervisor)
14	8/22/08	6	Older Adult Consumer Focus Group
15	8/27/08	1	Madera County District Attorney’s Office
16	8/28/08	4	Chowchilla Police Department
17	8/29/08	6	Ready, Set, Go Program (At Risk TAY) and Workforce Development Office (WIB) (All ages)
18	9/3/08	1	Homeless Helping the Community Group
19	9/4/08	10	Chawanakee Unified School District Administration

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20	9/5/08	10	Department of Social Services
21	9/5/08	5	Housing Authority of the City of Madera
22	9/9/08	5	Yosemite High School District (Principle and Counseling Staff)
23	9/16/08	16	Madera County Juvenile Probation
24	9/16/08	2	Chowchilla Elementary School District - Special Education Directors
25	9/17/08	10	Fresno Madera Area Agency on Aging
26	9/19/08	2	Centro Binacional Para El Desarrolló Indígena Oaxaqueño
27	9/25/08	16	First 5 of Madera County and Madera County Adult Probation
28	10/1/08	2	Lesbian, Gay, Bisexual, Transgender, Questioning
29	10/2/08	6	Picayune Rancheria of the Chukchansi Indians Tribal Council
30	10/7/08	13	Community Action Partnership of Madera County
31	10/14/08	1	Head Pastor of Believers Church
32	10/15/08	14	Madera County Health Families Taskforce
33	10/16/08	4	Family Members of Transition Age Youth being served in the system (included Spanish speaking Family Members)
34	10/21/08	7	Madera County Behavioral Health Services Management
35	10/23/08	2	Madera Community Hospital
36	10/23/08	11	Adult Consumer Focus Group
37	10/30	3	Madera County Public Health Services (Administration and Direct Services)
38	11/1/08	4	State Center Community College District - North Centers (Administration and Counseling Services)

Total = 302

Madera County Behavioral Health also held Community Forums throughout the County. Meetings were held in the evenings and on weekends so people who worked during the daytime could participate. Language and deaf interpreters were available as necessary. Handicapped accessible buildings were used. Meetings were not held in MCBHS

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clinics to reduce stigma. They were held in physical health settings and community centers.

The Community Forums included an education component in addition to specific focus group questions. Information was given regarding the website and on-line questionnaires.

There was an ongoing Client/Family Member Group. During this group session, a portion of the MHSA was presented with visual guides and hand-outs. Specific questions were asked of the clients/family members during and after the presentations regarding their opinions, wants and wishes. These were recorded and included in this Plan.

- 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.

Madera's MHSA planning began in 2005 with the development of the three year plan for Community Services and Supports. Madera County made every effort to ensure comprehensive involvement of local stakeholders: consumers, family members, providers, and key agency/organization representatives. The focus was on trying to reach residents who have not received needed mental health services. Consumer and family member involvement was a crucial element of the MHSA process. However, many consumers and family members were unable or unwilling to participate in traditional committees, community meetings, and task forces. Therefore, a multi-pronged outreach effort was made to obtain input from this often under-represented and underserved population. This effort included specialized focus groups, involvement in ongoing committees, surveys, etc.

Again, due to the reluctance of clients and family members as well as unserved and underserved groups to participate in large meetings, there were small focus groups and key informant interviews held to obtain input and to continue education about the MHSA (See answer to question 2 for specific groups/individuals). In addition, individual key informant interviews were conducted along with community forums and computer surveys. Educational information and educational presentations were included. Educational material was included on the website for each of the surveys posted. Surveys were posted on the internet for the community and service partners as well as clients and family members.

The key informant interviews as well as small focus groups were conducted in areas of the county that clients, family members and the community at large would feel comfortable meeting. Most, if not all were done in places such as community centers, businesses, agency offices, schools, doctor's offices, etc., throughout Madera County. Individuals did not have to come to central Madera to participate; Madera County MHSA staff went to them. This included the mountain communities as well as other cities and unincorporated (rural) areas within Madera County.

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Interviews and focus groups were available in Spanish as well as English. Interpreters for deaf and hard of hearing were available as necessary. All forums, stakeholder meetings and committee meetings were held in handicapped accessible buildings. The meeting with farm workers was held at the farm worker's camp. Interviews and education about the Act were also held at homeless shelters, farmer's markets, back to school nights, health fairs, etc.

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

There was a special Client and Family group. This group was conducted at Hope House, Madera County Behavioral Health Service's client Wellness and Recovery Center. In addition to these regularly scheduled meetings, special focus groups were conducted. Please see response to Question 2 for a specific list of types of focus groups and key informant interviews.

Each of the components of the MHSA also had literature and flyers developed. Each had links to the Madera County MHSA website which included information about each of the MHSA components and surveys to address client and family members' desires for programming.

Computers were available at Hope House for clients to participate in the on-line surveys. Clients and family members were encouraged to complete the questionnaires and provide input into the Plan.

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, included but as 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

Please see Question 2 for a specific list of all of the individuals/groups and committees that met regarding PEI services through the MHSA.

Clients and family members were part of a specific Client/Family Member group regarding MHSA II and provide input into the Madera County Department of Behavioral Health Services' plan. When necessary, specific clients were sought out for input.

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They were clients who may have not been comfortable meeting in a large group setting, e.g., the Lesbian, Gay, Bisexual, Transgender and Questioning clients, farm workers, etc. Special groups were also conducted to obtain input from family members of children seen for services. Again, PEI staff went to the places where clients/community members would feel comfortable talking. Those groups/individuals did not have to come to MCBHS. Meetings were conducted at times that were convenient to the participants.

Providers of physical health and mental health services, educators, representatives of law enforcement as well as other organizations were also part of the PEI committee and again provided input through specialized focus groups and key informant interviews. If those individuals had difficulty attending meetings, Madera County went to them for their input into the plan.

In addition, there were surveys posted on the website, emails sent regarding input and the surveys, advertisements in the local paper about community forums, newspaper articles about the MHSA and the request for input, etc. Staff also attended at local health fairs, back to school nights, farmer's markets, various cultural events where unserved and underserved populations would gather. During this time they spoke about the MHSA II, handed out information, flyers for meetings, surveys, business cards, links to the website, arranged for follow-up meetings, etc.

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

Training was conducted during community forums. Information was also included on the website, including surveys, meetings, etc. This training included an overview of the Mental Health Services Act, the history of the MHSA's development, a description of each of the components of the Act, and the community needs identified in the initial program planning in 2005. All of the participants indicated that the needs identified in the initial planning were still applicable.

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.

Madera County BHS built on the successful strategies of the 2005 Community Program Planning Process. As in the initial planning, the majority of people that BHS sought to engage in planning activities were unwilling and/or unable to participate in large group or public meeting process. In addition, past participants stated they had already made their preferences known in the initial planning process and were reluctant to participate in a new planning process and/or community forums. Therefore, Madera County Department of Behavioral Health Services did extensive focus groups and key informant interviews. These were scheduled to accommodate the stakeholder's schedules, rather

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than expecting stakeholders to adjust their schedules to accommodate the Department's schedule. These were done at the informant's place of business, etc., so they didn't have to come to us. Staff was flexible and met on days and times that were convenient for the participants.

In an effort to provide outreach to the Native American population, MHSA staff continued to make regular contact with the various tribes in the community. Staff worked with local citizens who were already accepted by the Native American community. MCBHS worked with members of various boards, North Fork Rancheria of the Mono Indians Tribal TANF, Picayune Rancheria of the Chukchansi Indians Tribal Council, etc., to listen to their concerns and recommendations, while educating them on the MHSA.

- 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 (TAY).

Listed below from the PEI state guidelines are the PEI Priority Populations and Required and Recommended Sectors and Partner Organizations for Prevention and Early Intervention Planning.

PEI Priority Populations
Underserved Cultural Populations
PEI projects address those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, etc.) and would benefit from Prevention and Early Intervention programs and interventions.
Individuals Experiencing Onset of Serious Psychiatric Illness
Those identified by providers, including but not limited to primary health care, as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service.
Children/Youth in Stressed Families
Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of care giving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.
Trauma-Exposed
Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.
Children/Youth at Risk for School Failure
Due to unaddressed emotional and behavioral problems.

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Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

Those with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through Community Services and Supports (CSS).

Required Sectors for Planning	Recommended Partner Organizations for Planning
Underserved Communities	Individuals, families and community-based organizations (administrators and front line staff) representing Native American, African American, Hispanic/Latino, Asian/Pacific Islander, Refugee, Immigrant, Lesbian/Gay/Bisexual/Transgender/Questioning and other underserved/unserved communities
Education	County offices of education, school districts, parent/teacher associations, Special Education Local Plan Areas, school-based health centers, colleges/universities, community colleges, adult education, First 5 Commissions, early care and education organizations and settings
Individuals with Serious Mental Illness and/or their Families	Client and family member organizations
Providers of Mental Health Services	Mental health provider organizations
Health	Community clinics and health centers, school-based health centers, primary health care clinics, public health, specialist mental health services, specialist older adult care health services, Native American Health Centers, alcohol and drug treatment centers, developmental disabilities regional centers, emergency services, maternal child and adolescent health services
Social Services	Child and family welfare services, CalWORKs, child protective services, home and community care, disability services, adult protective services
Law Enforcement	County criminal justice, courts, juvenile and adult probation offices, judges and public defenders, sheriff/police

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Recommended Additional Sectors for Planning	Recommended Partner Organizations for Planning
Community Family Resource Centers	Multipurpose family resource centers, spiritual/faith centers, arts, sports, youth clubs/centers, parks and recreation, homeless shelters, senior centers, refugee and immigrant assistance centers
Employment	Public and private sector workplaces, employee unions, occupational rehabilitation settings, employment centers, Work Force Investment Boards
Media	Radio, television, internet sites, print, newspaper, ethnic media

As indicated by the participants in the planning committees, focus groups and key informant interviews, representatives in each category of all required and recommended sectors were engaged in the PEI planning process. Individuals from priority populations were engaged. When it was not possible to engage the individuals directly, members of organizations serving these populations were engaged in the planning activities.

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

- a. The date of the public hearing:

The public hearing was held on December 3, 2008 at the Madera County Department of Behavioral Health Services Mental Health Board (MHB) meeting.

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

Madera County's PEI component or its Executive Summary was circulated to representatives of community stakeholder interests via email, posted on the Madera County MHSA website for thirty days in English and Spanish translation was available. Public notices were posted at all BHS and major county Department sites. In addition, notices were posted in English in local newspapers as well as a notice posted in the Spanish language newspapers.

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

There were none stated.

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d. The estimated number of participants:

- 302 Key Informant Interviews and Focus Groups
- 48 Planning Committees – SSC, PEI and Consumer and Family
- 55 Surveys

PEI PROJECT SUMMARY

Form No. 3

County: Madera PEI Project: The Connected Communities Program Date: FY 2009—10 and as funding permits

We have completed a Form 3 for each of the separate Projects contained within the Connected Communities Program. In order to not repeat the stakeholder process for each of the projects contained within the Connected Communities Program, the main description is below. Each Project within the Program references key pieces of the information below.

Complete one **Form No. 3** for each PEI project. Refer to Instructions that follow the form.

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	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>

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

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<p>A. Select as many as apply to this PEI project:</p> <ol style="list-style-type: none"> 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 	<input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
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B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Stakeholder Input

Madera County’s stakeholder input process started with the CSS planning during the first half of 2005. A letter and survey (English and Spanish) were sent to all consumers of public mental health and alcohol/drug services and to over 15,000 individuals who live or work in Madera County. The letter described the intent of the Mental Health Services Act and the establishment of a Leadership Team, Advisory Panel, and Targeted Task Groups (TTG’s) to develop the County’s Mental Health Services Act Community Services and Supports Three-Year Program and Expenditure Plan. Clients, family members and members of the community were invited to participate in groups/activities and to complete a questionnaire. The questionnaire focused on services needed and concerns with public mental health services.

Clients, family members and the community/stakeholders were asked to identify concerns regarding untreated mental illness. This was done in the four age groups targeted by the Mental Health Services Act. The letter gave a name, e-mail address, and telephone number of the individual who was coordinating the planning process in the event they preferred to talk to someone directly. Clients received training to become distributors of the surveys throughout the County. They performed this service at stores, swap meets, homeless shelters/meal sites, churches, counseling centers, apartment complexes, and by going door-to-door in their communities. Over 500 consumers and family members provided input to the planning process through surveys, forums, Leadership Team, Targeted Task Groups and individual contacts with the MHSA Plan Coordinator. Consumers and family members continued to serve on the Targeted Task Groups to develop procedures for implementing the new CSS programs.

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For the second round of MHSA planning, Madera County’s community input process took twenty-one months during 2006-08. The PEI planning process took approximately eleven months. Stakeholder participants included clients, family members, low-income communities, ethnic minorities, various age groups, migrant and new immigrant populations, traditionally marginalized populations, community leaders, associated agencies and MCBHS staff. When required, meetings were conducted in both English and Spanish. Interpreters for the deaf and hard of hearing were also available. Meetings were held in handicapped accessible locations. Focus groups and key informant interviews and community forums throughout the Madera County area were conducted (see Form 2, question 2 for the list of participants). Individuals representing diverse ethnic backgrounds such as Latino, Native American, African-American, Caucasian and monolingual Spanish were represented. The MHSA Division Manager and MHSA Coordinator also attended regular meeting held by various community groups. In addition, they took the input and planning process to stakeholders, clients and family members to ensure that as many individuals as possible had the opportunity to become familiar with the PEI planning process and were able to provide their input.

The statements of need from the 2005 MHSA community input process were reiterated and reconfirmed in the 2007-08 PEI community input process. Input from both efforts were considered and integrated into this plan.

During the initial 2005 planning process for Madera County’s CSS Plan, the PEI community issues identified for the mentally ill were:

<p>WECAN (Wellness Empowerment Consumer Action Network)</p>	<ul style="list-style-type: none"> • More groups and classes for consumers. • A drop-in socialization center in downtown Madera.
<p>Family Member Forums at Madera, Chowchilla, and Oakhurst Counseling Centers</p>	<ul style="list-style-type: none"> • More groups • Social activities • Education about mental illness • More proactive intervention when a consumer begins to have symptoms develop or return • Take mental health services to the streets • Use community resources to provide training • Train police officers regarding mental illness • Provided information to the public regarding mental illness

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	<ul style="list-style-type: none"> • Increase school-based services • Provide support for children of mentally ill persons
<p>Boot Camp and Parents of Children/Youth Served by BHS Programs</p>	<ul style="list-style-type: none"> • More services for youth after school • Classes and groups for parents to teach them how to help their children • More substance abuse counselors
<p>Countywide MHSA Community Letter and Survey</p>	<ul style="list-style-type: none"> • Provide more information to the public regarding mental health services available. • Increase the number of providers available to reduce waiting times and increase the time spent with clients (Psychiatrists, counselors, case managers) • Increase the numbers and types of services available including groups, classes, activities, and drop-in center • Increase services and supports to families • Make services more accessible and affordable to all who need them • Provide more services and supports (including housing) to the homeless • Increase substance abuse counseling for individuals with co-occurring disorders. • Increase services to children and youth in schools and juvenile justice programs. • Hire more bilingual/bicultural staff
<p>Community Forums and Focus Groups in Oakhurst, Madera, and Chowchilla</p>	<ul style="list-style-type: none"> • More services for Native Americans • Specialist for senior citizens. More outreach to older adults • Nurturing parent program in the community. • Family support groups including grandparents raising their grandchildren • Adult Day Care for adults with severe mental illness. Provide childcare • Drop-in Center • Peer counseling program – especially for older adults

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- Mental health training for primary health care providers
- Brochures regarding mental health service for law enforcement to hand out
- Integrated services in one location, e.g. social services, mental health, alcohol and drug counseling, health care
- Parenting classes, especially for those in Probation system
- Reduce the stigma associated with receiving mental health services
- Public education regarding mental health services available in the mountains
- Parenting classes for court-ordered clients
- Classes for older adults in non-clinical settings that deal with mature adult's needs such as depression, grief, alcoholism, understanding dementia, etc.
- Periodic column in local newspaper providing information on mental health and substance abuse issues
- Clinician time at school sites.
- More community education regarding mental illness.
- Anger management classes for children.

Spanish Speaking Forum in the City of Madera

- Provide family support group in Spanish.
- Re-open the WECAN Canteen.
- Provide more educational programs.
- Provide more outreach to the community.
- Provide home visits.

Seniors Forum at the Frank Bergon Senior Center in Madera

- Primary concern - people in the community do not know how to get mental health services when they need them

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	<p>Gay, Lesbian, Bi-sexual and Transgender (GLBT) Focus Group</p> <ul style="list-style-type: none"> • Develop a service center for GLBT people in Madera <p>Native American Focus Group at the Sierra Mono Museum</p> <ul style="list-style-type: none"> • Provide more support for family members • Provide more services for children with co-occurring substance abuse • Provide more information to Native Americans regarding services available
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The major issues selected by the 2005 CSS community stakeholder process, by age group, to be the focus of the MHSA services over the first three years are indicated by an asterisk (*) placed next to these issues. Many of these issues are common to more than one group.

- Homelessness*
- Isolation*
- Criminal Justice/Juvenile Justice involvement/Incarceration*
- Out of home placements/Institutionalization*
- Inability to obtain education/employment*
- Involuntary Treatment/Hospitalization
- Transportation

During the 2008 PEI planning process, the community continued to state that the above issues continued to be relevant. Specifically, during the PEI planning process, the community was enthusiastic in their response for the Mental Health First Aid program and the Promotores model of services as a program which would accomplish several needs they identified in the current community planning process. Those needs included;

- Obtaining basic education about mental illness
- How to respond to those experiencing mental health issues in a supportive manner
- Reduce stigma against mental illness
- Reduce isolation
- Provide early intervention

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- Prevention of mental illness or from the illness progressing
- An entry point to obtain employment in the system
- Utilizing existing persons in the community as a resource for those individuals reluctant to seek services in a traditional setting

It was mentioned over and over that the entire community could benefit from Promotores and Mental Health First Aid training including law enforcement, schools, transportation, etc.

Survey Results

English

- 83% of respondents identified as a member of an agency/organization that works with people with mental health issues or Spanish or a community member interested in improving mental health services.
- 74% of respondents were female
- 78% of respondents were between the ages of 25 and 59 years of age.
- 58% of respondents lived in the City of Madera
- The top three responses for the most important issues to address 1) Gang/school violence, 2) School failure, and 3) Number of undetected mental health problems
- 52% of respondents stated that there is an inadequate amount of prevention and early intervention services in Madera County
- The top three responses for the settings that would be the most effective for identifying person with mental illness were 1) Schools, 2) Doctor's offices or clinics and 3) Social Services (e.g. WIC, CalWORKs)
- The top two responses for the best approaches for addressing mental health prevention and early intervention in Madera County were 1) Provide early and periodic screening, diagnosis and treatment for mental illness (at primary health care, school/college, preschool, child care, and workplace settings and 2) Train educators, law enforcement, emergency responders, church leaders, transportation personnel, retail personnel, volunteers, doctors, nurses and nursing home staff on early recognition and response to mental illness
- The number one response to the priority population by age group was persons between the ages of 11 and 15 years of age

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- 58% of respondents stated that persons between the ages of 0 and 24 should be the emphasis of Madera County's PEI services
- The top two responses for the best ways to reach hard to reach populations were 1) Schools and a two way tie for 2) Social Services and 3) Community Events

Spanish

- 57% of respondents identified as a community member interested in improving mental health services
- 68% of respondents were male
- 68% of respondents stated they were between the ages of 16 and 24 years of age
- 71% of respondents stated that they lived in the City of Madera
- 43% of respondents stated that the following community issues were more important to them (a five way tie) 1) Unemployment, 2) Community/domestic violence, 3) Gang/school violence, 4) Lack of resources for Parents of Infants, 4) Education for the public, law enforcement personnel and other about how to deal with mental illness and mental health issues
- 52% of respondents felt that there were inadequate mental health prevention and early intervention services in Madera County
- 57% of respondents stated the most effective setting for early identification of mental illness and early intervention was doctor's office or clinics. The next most frequent response (41%) was a three way tie for Schools, Faith based organizations and Workplace
- The two best approaches for addressing mental health prevention and early intervention were 1) Provide education and support services for parents, grandparents and care givers at community centers, schools, churches and other community settings and 2) Work-based programs (e.g. Employee Assistance Programs, Workplace Health Promotion Programs)
- 43% respondents stated they were between the ages of 11 and 15 years of age or 60 or more years of age
- The top two responses for the best ways to reach hard to reach populations were 1) Medical Clinics and a four way tie for 2) Community Centers, Community Events, Child Care Providers (e.g. Day Care, Head Start), Through radio, television, newspaper, email or internet, and In homes.

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Focus Group Results

Priority Populations

The focus groups identified top two priority populations for PEI were the Trauma Exposed and Children/Youth in Stressed Families. The table below indicates the frequency of identification of a population as a priority. Many of the stakeholders felt that these population categories were not discrete; there was significant overlap in all of the categories and the people that were a part of all of the categories were often the same people and/or from the same families. Because of this, they were often reluctant to identify prioritization using the system of categorization provided in the PEI state guidelines.

1. **Trauma-Exposed - 14**
2. **Children/Youth in Stressed Families - 14**
3. Children/Youth at Risk of or Experiencing Juvenile Justice Involvement-12
4. Individuals Experiencing Onset of Serious Psychiatric Illness – 12
5. Underserved Cultural Populations – 4
6. Children Age 0 - 5

The recommendations most frequently given during the focus groups are in **bold** print. The numbers next to the category identify the frequency at which they were given, if they were mentioned more than once.

Type of Services	Where services should be provided	Who should provide the services
<ul style="list-style-type: none"> • Counseling– 14 Drop in counseling services <ul style="list-style-type: none"> ○ Family and youth counseling ○ Family counseling - 3 ○ More one to one counseling • Training for community members/stakeholders regarding identifying mental illness and how to address it- 8 <ul style="list-style-type: none"> ○ Public awareness ○ Mental Health First Aid • Peer counseling/peer support/developing support network- 15 <ul style="list-style-type: none"> ○ Children and Family Drop in Center 	<ul style="list-style-type: none"> • Schools – 21 • "Where people are"/where they congregate," On the street," communities - 6 <ul style="list-style-type: none"> ○ Community sites-1 • Clinics- 4 • Churches-5 • Primary care-6 • In homes-4 • Not at school • Counseling centers 	<ul style="list-style-type: none"> • Education staff/schools - 9 <ul style="list-style-type: none"> ○ Teachers • Community members/community - 9 <ul style="list-style-type: none"> ○ Community liaisons ○ Community leaders • Clinicians/therapists-7 • Care workers • Consumers • Parent partners • Mental health professionals • Community agencies - 4 • Faith based organizations-4

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<ul style="list-style-type: none"> • Parenting training - 7 <ul style="list-style-type: none"> ○ Foster parent education • Education regarding available mental health resources - 9 • Education for Primary Care, Family, Public Guardian, Housing Providers, and social services regarding developmentally appropriate behavior - 4 <ul style="list-style-type: none"> ○ Training regarding signs of emotional distress • Education of school staff to identify potential problems early • Education regarding independent living skills/social skill building/life skills – 5 • Physician/psychiatrists evaluation possibly leading to beneficial meds skill assessment to give individual hope of how to constitute normal activities or alternate activities • Case Management Services - 2 • Diagnosis (Understanding?) • Outreach and engagement • Education for families of people with mental illness - 2 <ul style="list-style-type: none"> ○ Education for families involved in the legal system, children labeled as challenging in schools • Services to address stigma – 5 <ul style="list-style-type: none"> ○ (Recovery) success stories given in person/public speaking • Anti-discrimination activities • Early identification through diversion services in court • Follow up services 	<ul style="list-style-type: none"> • Central locations - 2 • Parks-2 • Senior centers-2 • Community centers • Community Agencies-2 • Where youth feel most comfortable • Workforce sites • Homeless shelters/homeless-1 • Access to services in the community; not just clinics • One stop center • Co-location of services and braiding mental health services with social services. • Kaiser/medical • Mental Health Clinic-1 • Family Resource Centers • First 5 - 1 • Libraries • Juvenile detention centers • Everywhere—all areas of the County • California Youth Authority • Hospitals • Parks • Mountain Area • Drop-in-Center • Not at Mental Health 	<ul style="list-style-type: none"> ○ Religious leaders • Medical providers/Health - 7 • Public health • Legal system • First responders • Government • Families • Counselors-4 • Case managers • Mental Health Staff-4 • Interns with Supervision-2 • Student with supervision • Well trained paraprofessionals • Develop partnerships with community partners, agency collaborations, support systems - 1 • Social Services-3 • Hospital • Law enforcement-2 • People trained in assessing needs • Social workers • Caregivers Prevention Services • Others with training • Doctors/Physicians -2 • Volunteers • Multidisciplinary Teams • Probation officers - 2 • Paraprofessionals • Crisis workers • All public agencies-2 • Youth authority (only if it is not using scare tactics)
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<ul style="list-style-type: none"> • Group therapy • Rehabilitation - 2 • Services that facilitate access to mental health services and stigma as an issues as a barrier to seeking care - 4 • Resiliency Building for families, as it relates to mental health and school success • AOD education/substance abuse counseling - 4 • Information regarding public assistance • MDT approach for all ages/collaborative teams - 2 • Develop a behavioral health CBO in Madera • Grief Counseling • Trauma counseling (individual and groups) • Anger management - 2 • Psychiatric evaluation • Services for runaway and incorrigible children • Tutoring • After school programs PEI • Translation services/Services in Spanish - 2 • Assessment that includes explanation of mental health services • Interventions • Evidence Based Practices 	<ul style="list-style-type: none"> • Parent Groups • After School Activities • Madera Oakhurst, Chowchilla • AOD Clinics • Mental Health Clinics • Community Forums 	<ul style="list-style-type: none"> • Qualified Individuals • Community Educators • Trained Licensed Staff • Businesses • Primary Care
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Stakeholder Steering Committee

The PEI community needs and barriers to service access identified by this committee are:

- 1) Services in Oakhurst,
- 2) Community based services for youth,
- 3) Working with the faith community,

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- 4) Insufficient funding for prevention and early intervention outreach and engagement activities,
- 5) Difficulty connecting with the Native American community,
- 6) Suicide prevention services,
- 7) Transportation to from the mountain areas to services,
- 8) What services are currently being provided,
- 9) Parent education
- 10) Suicide prevention training
- 11) Training for consumers to tell their story
- 12) Supportive services to help SED high school students finish high school; with emphasis on at risk foster youth
- 13) Independent living skills
- 14) Cultural competency training; specifically regarding Latinos and LGBT+
- 15) Youth drop in centers
- 16) Homeless outreach services

Data Analysis

Madera County is located in the exact center of California, in the heart of the Central Valley and the Sierra Nevada mountain range. It is one of the fastest growing counties in California. With rich fertile farmlands, Madera County has a vibrant agribusiness economy which employs 30% of its 146,300 residents. Madera is projected to have a population of 224,600 by 2020.

Between 2005 and 2006, the Madera County population grew by 9%, from 134,200 to 146,300. The number of persons per square mile in Madera County is 57. Almost 45% of the documented population is Latino/Hispanic. In 2005, 20% of the population in Madera was foreign born, 30,000 of which were migrant and seasonal farm workers.

In 2000, 31% of residents were unemployed. 58% of students receive free/reduced price lunches and 1,610 people are homeless (2006). Nearly 17% of residents live in poverty (2005). The median household income is \$46,800. The County has, on average, 300 youth in foster care or group homes each month. About 16% of the population is disabled. The

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County is twelfth in the state for adults arrested for drug violations and thirty-ninth for alcohol violations. The 11-13% of the county population is over age 65; 8%-13% of these individuals are Latino and 72%-81% are White Non-Latinos. Of the 65 and older population, 29%-33% has an income below 200% of the federal poverty level. The California Health Interview Survey indicated that almost 80% of the teens that were at risk for depression and could have benefited from counseling services in 2003 and 2005, did not receive these services. Most community services are located in the County seat, but many residents are unable to access needed services due to limited public transportation. More than 11,000 residents need mental health services.

Generally, the most underserved groups in Madera are Latinos, Native Americans, Older Adults, TAY and LGBT+.

CY2006 Medi-Cal Approved Claims Data

Element	Madera	Small MHPs	Statewide
Penetration rate	4.85%	8.10%	6.28%
Penetration rate – Hispanic	2.67%	3.92%	3.24%

This information in the table above is current information from Medi-Cal approved claims data system. Madera County wants to provide better access to services for its Latino and Native American as well as other minority populations. While the overall statistics of people being served through “traditional” mental health services reflects the overall population of Madera County, Madera County BHS still needs to improve access and services to increase its Medi-Cal penetration rate. MCBHS believes that it can do this through the prevention, early intervention programs described below. Madera has first generation Latinos who would not traditionally seek mental health services. The Native American community would also not traditionally seek services through a mental health clinic location. Therefore, Madera County BHS proposed the following programs to address these issues and provide prevention and early intervention services in the communities and by community partners. In addition, a significant number of clients only attend a one to four service contacts before discontinuing treatment. Not completing the course of indicated treatment tends to have negative outcomes. The Promotores model has been shown to be an effective services engagement model in recruiting underserved populations into services and supporting them to remain engaged in service and completes the course of treatment.

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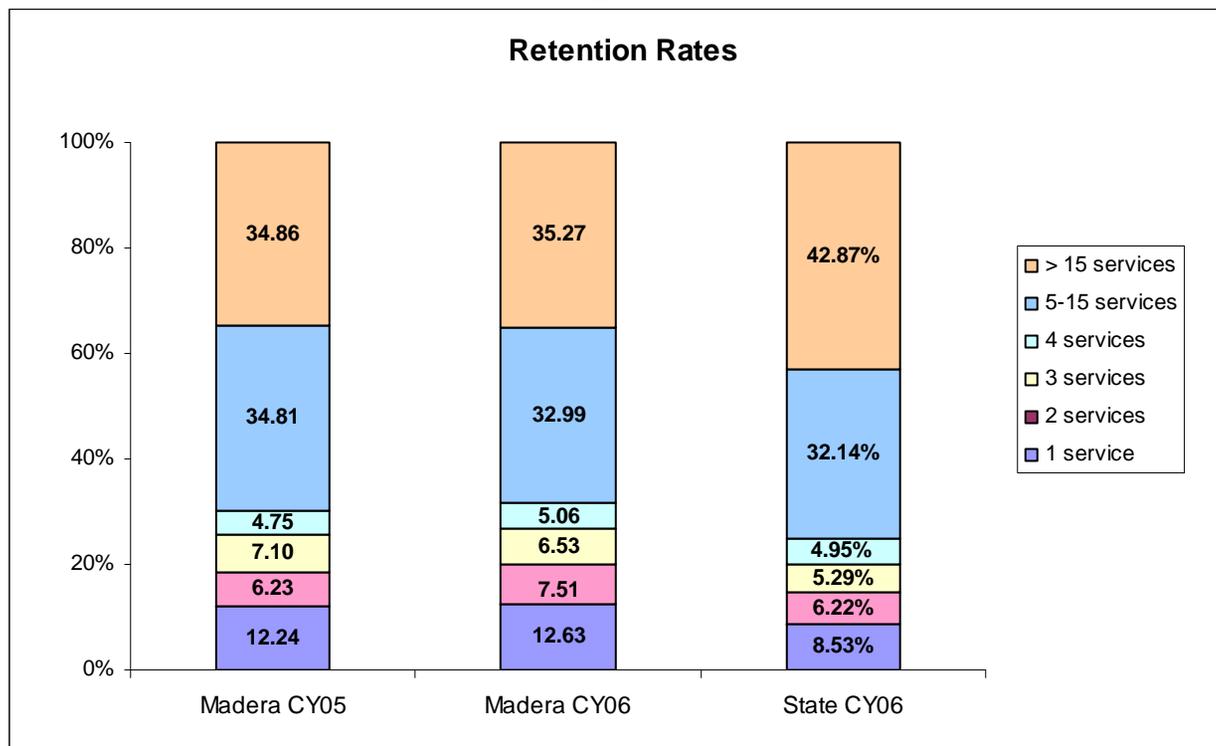
Retention Rates

Figure 1 displays the MHP's CY05 and CY06 Medi-Cal approved claims data showing retention rates – the percentage of beneficiaries who received the specified number of services during each annual period. Statewide data for CY06 is also presented for comparison. Figure 7 follows, depicting the raw numbers of beneficiaries who received the specified number of services, as well as the average amount of approved claims for each category for the MHP and the state.

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Figure 1



General Access Disparities and PEI Related Services Needs for Latinos and Native Americans

The information below was taken from a 2005 fact sheet that was revised by Yvette G. Flores, PhD, clinical psychologist, and Professor of Chicana/o Studies, UC Davis. The information presented in this fact sheet was assembled by Xóchitl Castañeda, California-Mexico Health Initiative Director, with the support of the CMHI staff. This information is available at the Binational Week website sponsored by UC Berkeley at: <http://hia.berkeley.edu/binational.shtml>

General Population

- Suicide is the eighth-leading cause of death in the United States, and 80% to 90% of people who die by suicide are suffering from a diagnosable mental illness.

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- Almost one-third of Americans have had one or more serious mental disorders during their lifetime. At any one moment, major mental disorders affect almost 15% of the nation's population.
- Studies have consistently shown that rates of substance abuse are positively linked with rates of mental disorders.

Latinos and Access to Care

- Among Latino Americans with a mental disorder, less than 1 in 11 contact mental-health specialists, and less than 1 in 5 contact general health-care providers. Among Latino immigrants with mental disorders, less than 1 in 20 use services from mental-health specialists, and less than 1 in 10 use services from general health-care providers.
- While the percentage of mental-health professionals who speak Spanish is not known, only about 1% of licensed psychologists who are also members of the American Psychological Association identify themselves as Latino. There are only 29 Latino mental health professionals for every 100,000 Latinos in the United States, compared to 173 non-Latino white providers per 100,000 non-Latino whites.
- Adult Mexican immigrants who have lived in the United States less than 13 years have lower rates of mental disorders than Mexican Americans born in the United States, and adult Puerto Ricans living on the island tend to have lower rates of depression than Puerto Ricans living on the mainland. This information suggests that factors associated with living in the United States are related to an increased risk of mental disorders.
- The incarcerated are at high risk for mental disorders compared to those who are not, and Latino men are nearly four times as likely as white men to be imprisoned at some point during their lifetimes.

Latinos and Insurance

- The lack of health insurance is a significant barrier to mental health care for many Latinos. Although Latinos constitute 12% of the U.S. population, they represent nearly 1 out of every 4 uninsured Americans. Nationally, 37% of Latinos are uninsured—more than double the percentage for whites.
- Studies have consistently shown that people in the lowest strata of income, education, and occupation have higher levels of psychological distress and are about 2 to 3 times more likely than those in the highest strata to have a mental disorder. Latinos are almost 3 times as likely to live in poverty as whites.
- In 1999, the per capita income of Latinos was less than half that of whites (\$11,621 compared with \$24,109).
- The low rate of health insurance enrollment among Latinos is driven mostly by Latinos' lack of employer-based coverage—43% compared to 73% for non-Latino whites. Medicaid and other public coverage reach 18% of Latinos.⁸

Culturally Bound Symptoms

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- Non-Latino providers may have trouble diagnosing certain symptoms among Latinos as a result of cultural differences.
- Latinos often report symptoms differently than non-Latinos, such as *susto* (fright), *nervios* (nerves), *mal de ojo* (evil eye), and *ataque de nervios* (an attack of nerves).
- Latinos tend to experience depression as bodily aches and pains (like stomachaches, backaches, or headaches) that persist despite medical treatment. Latinos often describe their depression as feeling nervous or tired for a prolonged period.

Latino Adolescents

- Latino youth experience or engage in proportionately more anxiety-related and delinquency problem behaviors, depression, and drug use than do non-Latino white youth.
- The current cost of treating children and adolescents for mental illness is estimated at nearly \$12 billion, significantly more than expected based on previous estimates. Despite these annual expenditures, nearly three-quarters of psychologically troubled youth do not get the care they need. Latino and African-American children are the most likely to go without needed care.

Latinas

- Depression is an illness that affects the body, mood, and thoughts. The rate of depression in American or other Latinas is about twice that of men. Among the various causes for depression are changes in brain chemistry, living through painful and difficult events, and even taking medications for other illnesses.
- One study found that Latinas who immigrate to the United States without their children were 1.52 times more likely to experience depression than Latinas who immigrated with their children or who had none.
- According to the 2003 Youth Risk Behavior Survey, Latina adolescents are more likely to feel sad or hopeless, seriously consider attempting suicide, and make a suicide plan than non-Latina white or African-American adolescents. Of the three groups, Latina adolescents in grades 9-12 have the highest attempted suicide rate in the United States, almost 1.5 times that of non-Latina white and African-American females of the same age.

Native Americans and Mental Health Services

The information below regarding the American Indian and Alaskan Native Communities was taken from a 2006 fact sheet prepared by the National Alliance on Mental Illness (NAMI). This is available at NAMI website at <http://www.nami.org>

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Cultural differences exist in seeking mental health services and in reporting distress.

- An historical distrust of the outside population exists among many American Indian communities. Individuals tend to have negative opinions of non-Indian health service providers, and traditional healing is used by a majority of Native Americans.
- Compared to the general population, AI/AN individuals tend to underutilize mental health services, have higher therapy dropout rates, are less likely to respond to treatment.
- A study of adult American Indians of a Northwest Coast Tribe demonstrated little differentiation between physical and emotional distress.
- The words “depressed” and “anxious” are absent from some American Indian and Alaska Native languages. Different expression of illness, such as *ghost sickness* and *heartbreak syndrome*, do not correspond to DSM diagnoses.

Living in a stressful environment has potentially negative mental health consequences.

- Approximately 26% of AI/AN live in poverty, as compared to 13% of the general population and 10% of white Americans.
- In the Northern Plains study, 61% of the children had experienced a traumatic event.
- The American Indian and Alaska Native population reports higher rates of frequent distress than the general population.

High prevalence of substance abuse and alcohol dependence is tied to a high risk for concurrent mental health problems.

- Alcohol abuse is a problem for a substantial portion of the American Indian adult population, but widely varies among different tribes.
- The Great Smoky Mountain study found that though prevalence of psychotic disorders is similar among American Indian and Caucasian American youth in the same geographic area, there are significantly higher rates of substance abuse in American Indian children.
- A study of Alaska Natives in a community mental health center found substance abuse was the reason for 85% of men and 65% of women to seek mental health care.
- In a study of Northern Plains youth, of those diagnosed with any depressive disorder 60% also had substance disorders.

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The prevalence of suicide is a strong indication of the necessity of mental health services in the AI/AN community.

- Alaska Native males have had one of the highest documented suicide rates in the world.
- Suicide rates are particularly high among Native American males ages 15-24, who account for 64% of all suicides by AI/AN individuals.
- A study of Eskimo children in Nome, Alaska found previous suicide attempts to be one of the most common problems for those seeking mental health care.

Mental health services are available for the AI/AN community, but are in need of improvement.

- The Indian Health Service funds 34 urban Indian health organizations, which operate at 41 sites located in cities throughout the United States offering a variety of care including mental health services and alcohol and drug abuse prevention. Approximately 605,000 American Indians and Alaska Natives are eligible to utilize this program. However, only 1 in 5 American Indians reported access to this care in 2000.
- Because Native tribes are not defined by state boundaries and many Native families have inadequately addressed dual-nationality issues, many tribal and intertribal family-run organizations face difficulty in obtaining critical funds through Federal grants.
- Grassroots organizations such as Intertribal Voices of Children and Families create a network to connect Native families across tribes to influence the improvement of mental health services.

Depression and Suicide in the San Joaquin Valley

The information below was taken from the Centrally Valley Health Policy Institute report titled HEALTHY PEOPLE 2010 A 2007 Profile of Health Status in the San Joaquin Valley.

“The 2005 California Health Information Survey CHIS found only 5.6% of San Joaquin Valley adults age 18 and older who reported feeling downhearted and sad all or most of the time (an indicator for major depression), saw a health professional. This was slightly lower than the state percentage of 8.3%. The percentage has drastically decreased since the 2001 CHIS. In 2001, 17.6% of San Joaquin Valley adults and 20.2% of California adults who reported depression were seeing a health professional. According to 2005 CHIS, San Joaquin County indicated the highest percentage (8.6%) among the eight Valley counties, yet still well below the HP 2010 objective. Results from a national telephone survey conducted in 1997-98 showed that 17.0% of adults with a probable depressive or anxiety disorder saw a health care

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provider (Young, Klap, Sherbourne, & Wells, 2001). The rates in the Valley, state and nation for this indicator were all well below the HP 2010 objective of 50%.

Suicide is the most dreaded complication of major depressive disorders. A review of psychological autopsies conducted by Angst, Angst, and Stassen (1999) estimated that approximately 10-15% of patients formerly hospitalized with depression committed suicide. When looking at all deaths by suicide, approximately 20-35% of deaths were among individuals who had been diagnosed with a major depressive disorder and received treatment at some point (Angst et al., 1999). In 2002, 132,353 individuals in the U.S. were hospitalized following a suicide attempt. An additional 116,639 individuals were treated in emergency departments following a suicide attempt and then released (CDC, National Center for Injury Prevention and Control, 2004). In 2004, 1.4% of the total number of deaths in California was the result of suicide (RAND California, 2004).

An increase in the suicide rate is evidence of the lack of access to mental health care. There has been an increase in the rates, per 100,000 persons, of deaths from suicide in six of the eight San Joaquin Valley counties between 2001 and 2004. However, rates have decreased since 2003. Suicide rates in California as a whole remained stable at 9.3 in 2001 and 9.4 in 2004 (Rand California, 2004). In 2004, only one of the San Joaquin Valley counties (Madera) met the HP 2010 objective of reducing the suicide rate to 5.0 suicides per 100,000 persons.”

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County: **Madera** PEI Project Name: **Community Outreach and Wellness Center** Date: **FY 2009--10**

	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			X	X
2. Psycho-Social Impact of Trauma		X	X	X
3. At-Risk Children, Youth and Young Adult Populations				
4. Stigma and Discrimination		X	X	
5. Suicide Risk				

	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		X	X	X
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				

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

Goals and Outcomes

The needs and priorities identified during the 2005, 2007 and 2008 community planning processes included:

- 1 Access to care
- 2 Lack of social supports
- 3 Stigma (related to receiving mental health services) and discrimination driven social isolation
- 4 Obtaining basic education and information about mental health conditions
- 5 Entry level employment in mental health services
- 6 Community members as providers
- 7 Providing services in non-mental health settings where people already go
- 8 Counseling and peer counseling
- 9 Public awareness
- 10 Training for mental health partner organizations
- 11 Access to care by seniors
- 12 Specialist for senior citizens
- 13 Increased outreach to older adults
- 14 Classes for older adults in non-clinical settings that deal with mature adult's needs such as depression, grief, alcoholism, understanding dementia, etc.

Trauma exposed individuals were identified as a high priority population in Madera's community planning processes. The trauma is related to the need and priorities identified in the planning process and chronic and extensive poverty in Madera County. Due to these living conditions these individuals and families experience high psychological distress due to exposure to traumatic events and prolonged traumatic conditions. These include grief, loss and isolation related to poverty. They are also unlikely to seek help from any traditional mental health services due to cultural, socioeconomic and linguistic barriers. Our highest underserved group is the Latino population, with a subpopulation of individuals from the Oaxaca region of Mexico. Another population that is not as large numerically but is isolated geographically is the local

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Native American tribes. Due to transportation and other resource inadequacies in the county, these populations often have significant geographic barriers that prevent access to mental health care.

There was a strong theme throughout planning to help people coping with trauma associated with poverty and poor living conditions to build their social skills and resiliency and decrease their vulnerability to serious mental health conditions. Stakeholders wanted the barriers both groups face in utilizing existing services addressed. A key recommend approach was to develop social supports that are age appropriate, specifically for Transition Age Youth and Older Adults.

Although our Wellness Center, Hope House, provides services to meet these needs and is open to these age groups, its current focus is to serve people with serious mental illness. Madera County has determined to expand the focus of the Wellness Center to serve the unique age-specific and cultural-specific prevention needs of these groups. As the Center is currently configured, the focus is not on prevention and early intervention for people without a mental health diagnosis. Its current primary focus on serving adults means that Transition Age Youth and Older Adults are not comfortable utilizing the center and therefore are not accessing it. In addition, there are significant transportation barriers for both groups.

The overall goal to address these needs and priorities is to expand the capacity and range of services provided by our Wellness Center (Hope House) to include outreach and provide supportive prevention services in the community and mountain areas. If there is additional funding in the future, services will be added to the community of Chowchilla.

The desired outcomes of the community outreach and wellness center will include:

- 1 Increased access to mental health care by Latinos, which is Madera's largest underserved population
- 2 Establish community based supportive services for at risk populations to prevent them from experiencing disability
- 3 Link individuals needing ongoing care to appropriate services in a timely manner
- 4 Establish community resources which promote wellness and self-sufficiency for target populations
- 5 Providing nurturing social supports and network development opportunities that are non-stigmatizing and culturally appropriate
- 6 Provide means through which adults and youth are able to effectively access the resource to meet their needs across all physical, safety, social, identity, and autonomous growth in life domains.

The Stakeholder Input Section provides;

- Detailed information regarding the information gather in the planning processes,
- Other data considered in the selection and prioritization of services, and

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- The proposed services selected to meet the identified needs.

3. PEI Project Description: (attach additional pages, if necessary)

Hope House. Early in the development of Hope House (2006), there were no restrictions on who could attend the program. A huge need was identified for services for people that were or had experienced traumatic events that put them at risk of developing a mental health condition. These individuals were obviously struggling, but did not meet the criteria for medical necessity and a disability designation. There were several of these people that attended the program for a few weeks and, after some social support and linkage to appropriate community resources, they were quickly able to “get back on their feet” without the need for any further services. However, because this program was started under the Community Services and Supports program and the participants for service under this program were required to be designated as Severely Mentally Ill, a screening process was put in place that ensured that only this population could attend the center. Since this change, the attendance at Hope House has dropped steadily and significantly. We now see that there is a large unmet need for services for the population that originally came to the center. We therefore would like to transfer this program over to Prevention and Early Intervention and transform it into a program that can meet this unmet need for prevention services.

The new goals for this prevention program are to prevent disability, identify mental health conditions early, link people to resources so they can meet their needs across all life domains in a timely manner, and increase access to care.

Because Hope House will be the only program in the county providing this service, we are requesting a funding increase to increase the capacity of this program. In addition considerations leading to the decision to expand Hope House

Services to include:

- 1 The proposed services are prevention, not treatment services
- 2 There is limited capacity to increase staffing through the department (due to hiring freeze and continuing budget restrictions)
- 3 There is an immediate need to increase the staff who are residents of Madera County to fit the Promotores service delivery model
- 4 The program will need to quickly increase its capacity to provide the proposed services
- 5 The services at Hope House are currently provided through the nonprofit organization Turning Point of Central California, Inc.
- 6 This contract can easily be expanded and continue after the program is transferred to PEI services/funding

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The general services that Hope House will provide include:

- 1 Peer Counseling
- 2 Support Groups
- 3 Community Education
- 4 Vocational Opportunities
- 5 Independent Living Skills Development
- 6 Community Resources Linkage and Brokerage
- 7 Community Integration

Geographic Expansion. In addition, to changing its target population and delivery mode, Hope House will expand to the mountain region of the county. As funding permits, there will be an expansion to the rural community of Chowchilla.

Outreach, Engagement and Support. A key component to Hope House's services will be community outreach. Promotores/Community Workers, –clients, families and members of the community–will be employed through Hope House to conduct outreach, engagement and supportive services at community sites. This will empower at risk populations to better meet their needs, with the goal of preventing disability. Service access points will move out into the community. This will increase access while reducing stigma and discrimination. Support groups developed at the Hope House site will be expanded to sites within the community. Linkage and brokerage services will be provided by the Promotores/Community Workers. The persons contacted will be directed into Hope House or an appropriate community resource for site based services. If a person needs treatment services, they will be directed into one of our treatment sites. Hope House will continue to conduct outreach and engagement activities in both Spanish and English and in an inclusive and culturally relevant manner.

Training and Consultation. Another component will be training/consultation for educators, law enforcement, community based organizations, faith based communities and the public. This training/consultation will expand the capacity of key community stakeholders to provide early identification prevention services. This will facilitate access to appropriate care, and help prevent mental health disabilities. The consultation component of this service will involve follow up from MCBHS staff regarding difficult mental health related issues to support interpretation or application of the information provided in the training.

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Educators, law enforcement and others see many people experiencing the earliest elements of mental health problems. Often they are not able to appropriately identify these conditions. They may unintentionally use intervention methods that exacerbate mental health issues rather than alleviate them. This is important. Often these people in key access points see people experiencing mental health distress long before they receive services within mental health, if they ever seek mental health services.

MCBHS would directly provide or contract with an agency to provide the Mental Health First Aid and the CASRA psychosocial rehabilitation training (described below). The training could be provided at one of the clinics or non-traditional mental health setting. The number of people attending, dates, time of day and area in the county where the training would take place, would determine the location of the training.

The training materials will be purchased through our Workforce Education and Training funding, but the ongoing staffing cost will come out of PEI. Again, as WET funds are a one time allocation, Madera is primarily using these funds for one time costs such as purchasing training curricula and initial "Train the Trainers" training.

Division Oversight. There will be direct service oversight through a Madera Division which will house the MHSA components. In addition to administrative oversight of the programs through the Department's administration, a special unit that will consist of a Mental Health Services Supervisor, a Licensed Mental Health Clinician, a Health Educator and various administrative support staff necessary for the day-to-day functioning of the programs. MCBHS is requesting a Supervising Mental Health Clinician and Licensed Mental Health Clinician to supervise the ongoing community education and cultural competency component of its programs. These staff will supervise training programs, including Mental Health First Aid (MHFA), California Association of Social Rehabilitation Agencies (CASRA), and the various parenting programs (Love and Logic, Incredible Years, Center for the Improvement of Child Caring, etc.) in Project Two (Community and Family Education Project). They will act as a resource for Hope House, the community and schools. Additional administrative support and Quality Improvement/Assurance staff is also being requested to fund a Division Manager and a MHSA Program Manager as well as other program support staff.

Transfer of Position from CSS Funds to PEI Funds

Currently, an approved Health Education Coordinator position is being paid out of MHSA CSS funds. This position was created using CSS funds, although this position provided prevention/early intervention and outreach services. This position is more appropriate for PEI and will be transferred from CSS to PEI funding upon approval of this plan. This Health Education Coordinator position currently provides education and training to the community. The topics include prevention information regarding identification of mental health conditions, risk factors for developing these conditions and ways to prevent mental health issues from becoming disabling. This education and training also includes information regarding a healthy diet, chronic medical conditions, stress management skills, social support, positive cognitive reframing, and pathways for personal growth as they relate to mental health and wellness. This empowers community

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members to access resources to meet their needs across all life domains. Staff would continue in this role and provide consultation to the Hope House Promotores/Community Worker staff as they deliver prevention services to the community.

During the initial MHSA planning process, the stakeholders and community indicated they wanted a mental health drop-in-center located within downtown Madera. As a result, Hope House was developed utilizing MHSA CSS funds. As described, it currently serves primarily clients with SMI, offering a variety of prevention activities. Since its inception, it has been extremely successful. As described, in response to input from community program planning, this service is going to be expanded to reach individuals who have experienced trauma, most who do not meet SMI criteria and are not currently clients of the mental health system. As a result of the development and expansion of services offered through Hope House, as well as the fact that its services are and will continue to be preventive in nature, MCBHS is requesting its transfer from CSS dollars to PEI. Transferring this program to PEI will also allow people to self-select for service participation. This promotes the internal motivation needed for long-term wellness and resiliency. The additional funding requested for this program will also allow Hope House to outreach into the community more frequently, as well as provide expanded vocational opportunities for people. The program will serve at least 145 additional individuals on an annual basis, starting with FY 09-10, with the additional prevention activities and expanded services.

(Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.)

Peer counseling, drop in services, identifying undetected mental health problems, education regarding independent living skills, and community members as providers were identified as service needs in the PEI planning processes. Due to the adverse living conditions in Madera County and high poverty prevalence, many people are not able to access resources to help them develop the personal and social resiliency resources needed to address life's challenges. By expanding the scope and capacity of this program, Hope House will better be able to meet the prevention needs of these populations. By providing services in community settings where people already go, the peer staff will be able to identify mental health conditions in their earliest stages, before they meet medical necessity criteria. The prevention activities would include reaching out to people at risk because of trauma associated with poverty and other stressors. They could receive the supportive self-help services that would facilitate wellness, build resiliency and prevent these conditions from becoming disabling. With its expanded capacity, Hope House will be able to expand its existing services to provide Universal and Selective Prevention services through health and wellness promotion, education and training regarding mental illness and appropriate supportive services.

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Hope House is not a mental health clinic, so is not regarded as a mental health site and people are more likely to access its services. In addition, the community outreach would be held in non-mental health settings where people already go. Both of these help reduce stigma and increase access. It also allows the general public to see and interact with persons experiencing mental health conditions, when they are functioning well. Hope House will continue and expand its regular community events where mental health issues are discussed, both onsite at the wellness center and off site in the community. An expanded Hope House will serve populations which are at higher risk for developing mental illness, such as the homeless. Because of the nature of the program, it is well positioned and designed to engage people before the onset of mental illness or before it becomes disabling. Through its volunteer and employment opportunities it supports sustained wellness and resiliency for peer staff.

(Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.)

The Madera site for services is a Wellness Center. It is not a traditional mental health treatment site. It is ideally situated to support access to the target population: people who have experienced trauma.

Turning Point of Central California, Inc. is a contracted agency of MCBHS. MCBHS will work with Turning Point staff to implement the proposed prevention program. Upon approval of this plan, MCBHS will work with Turning Point to locate space in the mountain area of Madera County to provide the expanded Wellness Center (Hope House) services. By providing the expanded services to this area, the community will have easier access to the prevention services rather than being transported or having to find transportation to the city of Madera. Public transportation within Madera County is limited. It is difficult for people to access services because of transportation issues. The Hope House will expand to the mountain area and if additional funding permits, Chowchilla will increase access to services for the Latino and Native American populations. Older adults and TAY will also have easier access to the Center. Again, during the community/stakeholder process, having Wellness Services within the mountain areas and Chowchilla was a priority that was mentioned.

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

By expanding its services to youth, older adults and a strong emphasis on targeting Latinos and Native Americans through the expansion of its services within the city of Madera and to the mountain area, Hope House will address some

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of the needs identified in both the 2005 and 2007-08 CPPP. In addition, increasing services outside the city of Madera has been a consistent theme throughout all MHSA planning activities since 2005. Further, Hope House will target unserved and underserved populations (Latino and Native American) through the proposed Promotores program.

(Highlights of new or expanded programs)

1. Expansion of program services to Transition Age Youth and Older Adult Services
 - Development of TAY peer counseling program
 - Development of a Senior Peer Counseling program
2. Services in the mountain area of Madera County
3. Outreach to rural areas of the county which currently do not have easy access to client directed services
 - Outreach to rural populations for development of Prevention activities such as Wellness, Recovery Action Plan (WRAP) services, education about mental illness, recovery and resiliency
4. Services specifically targeting Latinos and Native Americans
5. Services to individuals experiencing trauma at risk of developing serious psychiatric illness
 - Education and support to community members about mental illness wellness, recovery, and resiliency

(Actions to be performed to carryout the PEI project, including frequency or duration of key activities. Key milestones and anticipated timeline for each milestone)

1. Obtain approval from Oversight and Accountability Commission on PEI plan.
2. Obtain approval from State DMH on PEI plan CSS funding transfer
3. Upon approval of the PEI plan, transfer funding from CSS dollars to PEI and expand programs
 - Within three months after approval develop contract to expand services
 - Within six months after approval, Turning Point will hire staff into position(s) to expand program
4. Services will be expanded to include activities for older adults and senior peer counseling by the fall of 2009
5. Services will be expanded to include activities for transition age youth by the fall of 2010.
6. Work with Hope House and the communities in the mountain region to set up the expansion of the program
 - Program will be set up for implementation in the fall of 2009, with at least one site located in the mountain region

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- Dependent on the successfulness of the expansion in the mountain area, MCBHS will consider establishing a site in Chowchilla should funding permit.
- 7. Work with community members and organizations to implement program
 - Program will serve 145 additional clients June 30, 2010 for prevention services
 - Program will serve 145 clients by June 30, 2010 for early intervention services
- 8. Monitor and track progress of program and its goals/objectives

Promotores/Community Worker Program

This program would be added to the Hope House program as a separate but integrated service provided by the center. Promotores/Community Workers would act as a liaison between the mental health system and community residents. Promotores are known as guides to the public behavioral health care system. The model helps promote cultural competence and service access for those members of minority cultures. These populations may be reluctant to seek services in a traditional outpatient setting. They can utilize existing resources such as elders, natural healers. These are individuals the community would already turn to for information and support.

Promotores can work in a variety of setting, such as clinics, hospitals, community-based organizations, faith-based organizations academic settings, etc. Their outreach activities take them into community centers, homes, the streets, etc. As paid staff or volunteers through the Hope House expansion, they can perform the following tasks;

- 1 Provide cultural mediation between communities, health and human service systems
- 2 Provide informal counseling and support
- 3 Teach culturally and linguistically appropriate behavioral health education
- 4 Help clients and families navigate through services
- 5 Supporting individuals and families through the service enrollment process
- 6 Promote self-directed change and community development
- 7 Provide cultural mediation between communities, behavioral health and other service systems
- 8 Perform referral and follow-up services
- 9 Advocate for individual and community behavioral health and other service needs
- 10 Be an active member of multidisciplinary teams and services
- 11 Assure people get the services they need
- 12 Build individual and community capacity

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Promotores/Community Workers are unique in certain ways:

- 1 They may be neighbors to their clients and can relate from first-hand knowledge,
- 2 Established relationships with community members can overcome distrust of the behavioral health care system and use their rapport bridge relationship gaps,
- 3 Since they live in the community, they have a stake in eliminating barriers to care
- 4 They have been shown to be an effective tool in greatly reducing services access disparities
- 5 They are in a position to link behavioral health services directly to community residents.

Strength for this group lies mostly in its versatility. They may provide a variety of services, such as advocacy, language translation, benefit information and guidance in completing applications. They may take the lead in organizing and motivating their neighbors or provide education to their clients on preventing illnesses and managing chronic diseases. They are a viable force in ensuring their neighbors' participation in social programs for which they qualify. One of the most important factors that make this service delivery approach effective is that fact that these individuals are already culturally competent with the people they seek to serve, as they are members of these communities.

(Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.)

The Promotores/Community Worker program and various training components support the recommendations from our county stakeholders. It allows the community to obtain basic education about mental illness, resources for resiliency building, and sustainable wellness. The community can respond to those experiencing mental health issues in a supportive manner. It reduces stigma against mental illness. It provides opportunities for prevention services to address mental health conditions in their earliest stages, before these conditions are acute and disabling.

The proposed Promotores/Community Worker program will provide training and certification in core competencies to develop the following skills: communication, interpersonal skills, service coordination, capacity-building, advocacy, teaching, organizational and knowledge base. As described, Madera County intends to purchase training for the Promotores/Community Workers through Workforce Education and Training (WET) funds. This would help with sustainability, as purchasing curricula and training trainers are more often one time cost investments. It would also allow for more PEI funding going to ongoing personnel and other costs. The Promotores/Community Worker model provides

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opportunities for community members to prepare for employment in the mental health system, especially those that are from our underserved populations.

These skills can be used in a variety of settings. While Promotores/Community Workers are best known in the Latino community, similar models have been used in African-American communities as well as both urban and rural settings. It is hoped that eventually, through the outreach of Hope House services to the Latino/Native American populations as well as TAY and the older adult expansion services, there will be Promotores/Community Workers in the Latino, African American and Native American communities as well as services to clients/family members living throughout Madera County.

(Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.)

Turning Point of Central California, Inc. is a contracted agency of MCBHS. MCBHS will work with Turning Point staff to implement this prevention program. The Madera site for services is the Hope House Wellness Center currently being operated by Turning Point. It is not in a traditional mental health treatment site. Upon approval of this plan, MCBHS will work with Turning Point to locate space in the mountain area of Madera County to provide the expanded Wellness Center services. By providing the expanded services to this area, Trauma Exposed individuals will have easier access to services. They would not have to be transported or have to find transportation to the city of Madera. Public transportation within Madera County is limited. It is difficult for people to access services because of transportation issues. The Hope House expansion to this area will increase services to our community, especially the Latino and Native American populations residing there. Older adults and TAY will also have easier access to the center and services through the Promotores/Community Worker program. Services come to them rather than they go to the service. Again, during the community/stakeholder process, having wellness and resiliency services within the mountain area was a priority that was mentioned.

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

The primary focus population of this project is Trauma Exposed individuals. There will be expansion of existing services to youth and older adults. There will be a strong emphasis on targeting Native Americans through the expansion of its services to the mountain areas. This program will address some of the needs identified in both the 2005 and 2007-08 CPPP. In addition, increasing services outside the city of Madera has been a consistent theme throughout all MHSA planning activities since 2005.

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Madera County has a low penetration rate for the Latino and Native American population. The Promotores/Community Worker model of services has been shown to be an effective way to outreach to and engage the Latino community in their natural settings. These are two of the minority populations the proposed plan will attempt to reach.

The Native American representatives involved in the PEI CPPP indicated the Promotores/Community Worker model would be effective in working with the Native American community. Madera County has two reservations located within its boundaries. It has been extremely difficult to engage this community in services. It is hoped that by training members of the tribes as Promotores, Madera County Behavioral Health Services will be able to provide prevention services and linkage and brokerage through the Promotores for access to behavioral health services as necessary.

The Promotores/Community Workers would provide community based services. They could be located on tribal land, at health/medical clinics, the wellness center, at schools, etc., throughout Madera County. Having the Promotores/Community Workers located in the community where they live and work will increase access to services for Madera County residents. This would help increase our penetration rate into underserved populations.

(Highlights of new or expanded programs)

1. Expansion of Hope House program to provide Promotores/Community Worker services
 - Increase information about mental health issues to the community and act as a resource for information, thus reducing stigma
 - Provide support for individuals and assist them in obtaining appropriate services as necessary
2. Services in the mountain area of Madera County
 - Outreach to rural areas of the county which currently do not have easy access to client directed services
 - Outreach to rural populations for development of Prevention/Early Intervention activities such as Wellness, Recovery Action Plan services, education about their mental illness, wellness, recovery and resiliency
3. Services specifically targeting Latinos and Native Americans
4. Services to individuals experiencing the early signs of mental health conditions
 - Education and support to community members about mental illness, wellness, resiliency and recovery
 - Neighborhood/community organization—Promotores/Community Workers see and interact with families on a regular basis through formal and informal contacts
 - In-Culture services—Staff and volunteers share the same cultural background and language of the participating families and will provide services and supports.

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- Lack of existing relationships with target populations is a barrier to access. Promotores/Community Workers will be familiar to the target populations so this barrier would be bypassed.
- Increase duration of service engagement that would reduce acute care needs by addressing mental health conditions early

(Actions to be performed to carryout the PEI project, including frequency or duration of key activities. Key milestones and anticipated timeline for each milestone)

1. Obtain approval from Oversight and Accountability Commission on PEI plan.
2. Obtain approval from State DMH on PEI plan CSS funding transfer
3. Within three months after approval, State contracts signed and funds received by Madera County, additional training for staff will be developed and a plan developed for implementation.
4. Within six months after approval, Turning Point will hire staff into position(s) to expand program
5. Hired staff will participate in Mental Health First Aid and CASRA training within six months after contract for training has been approved by Madera County.
6. Hired staff will provide Wellness and Recovery Action Plan training to at least 20 additional clients/family members by FY 2009--2010.

Community Training and Promotores/Community Workers

All of the training for this project will be funded with out Workforce Education and Training (WET) funds, with staffing being funded out of PEI.

Mental Health First Aid

Training for the Promotores/Community Workers will be purchased through the MHSA WET funds. Purchasing these one time costs with WET funds helps to promote sustainability and will allow more funding to be available for ongoing costs. Training will include Mental Health First Aid (MHFA) and CASRA psychosocial rehabilitation training. Mental Health First Aid is an award winning training program for members of the public in how to support someone in a mental health crisis situation or who is experiencing non-crisis mental health issues.

Mental Health First Aid training can assist in the on-going community support of people with at risk for mental illnesses. It is useful for people employed in areas which involve increased contact with people experiencing mental health issues as well as for their families. It was recommended by the stakeholders, that Mental Health First Aid training become a prerequisite for practice in certain occupations which involved contact with people having mental health problems, such as teachers, public transportation personnel and police.

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The most critical time for prevention is when people are first developing mental health issues. Often this occurs during adolescence and early adulthood. To cover this crucial period of life adequately, a Youth Mental Health First Aid Program was developed. It is aimed at adults who have frequent contact with young people. It emphasizes the mental disorders and the crisis situations that are most common in this age group and includes additional modules on eating disorders and deliberate self-harm.

The Mental Health First Aid program has core elements that translate across various cultural groups. However, there is always a need for some cultural modification and translations. Cultural adaptations of the course have been developed for a number of groups with non-English speaking backgrounds. Lastly, it was developed in Australia, which is primarily rural, to address the chronic and acute shortage of mental health professionals in that area. This is very relevant to Madera County, as a small rural county.

The National Council for Community Behavioral Healthcare is in the process of culturally adapting the program for the Latino culture. Currently, the program has been implemented for the Latino population in Texas. Madera County will be working with the National Council for Community Behavioral Healthcare to develop a culturally appropriate program for the Native American population within Madera County.

During the community input process, every time MHFA program was described, there was great enthusiasm for it. This was the top requested program for services to be implemented. Law Enforcement, service organizations, transportation departments, schools are among many of the agencies already requesting this training for their staff. This program fulfills the public and stakeholders request to learn more about mental illness and how to respond to someone who may have mental health issues. This will help to reduce stigma.

For sites that participate in the Instructor Certification Program, the National Council of Behavioral Healthcare will provide ongoing technical assistance in program planning and implementation, marketing, funding and other core components critical to the sustainability of Mental Health First Aid in communities. In addition, the National Council of Behavioral Healthcare will provide trained sites with new research and updated materials, module supplements targeted to a variety of audiences, and best practices from other Mental Health First Aid sites across the country and around the world. Perhaps most importantly, the National Council of Behavioral Healthcare is also developing an evaluation processes to allow sites to benchmark and track program outcomes.

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Psychosocial Rehabilitation (CASRA)

In addition to MHFA, Madera County plans on using the CASRA psychosocial rehabilitation training for its Promotores/Community Worker staff. CASRA is dedicated to promoting wellness and resiliency for individuals at risk of developing mental health conditions. CASRA's purposes are:

- 1 To promote and support the development of community-based systems of services which provide care choices and which are based upon the promise of growth and recovery.
- 2 To encourage the development and implementation of community-based mental health programs consistent with the philosophy and practice of social rehabilitation.
- 3 To provide leadership and consultation to enhance the development of effective community services which promote self-help, resiliency and rehabilitation, and
- 4 To offer educational and training opportunities which address and evaluate the effective use of the social rehabilitation approach to meet human needs.
- 5 Will provide skill development to provide supportive services to someone who has experienced trauma as well as other mental health issues

Through the training received from MHFA, CASRA and other culturally appropriate workshops, the Promotores and other members of the community will be able to provide supportive and self-help services within their various communities and reduce the stigma of mental illness. When these programs have been presented to the community, several stakeholders indicated strong interest in being trained. These stakeholders included law enforcement, schools, social service agencies, clients, family members, citizens, etc. Specific cultural groups also wanted this training. They felt it was an appropriate way to provide prevention services to their communities. These included the Native American population, the Latino population and the African American populations. These trainings will be an entry level for employment opportunities for Madera County clients and family members to enter the Behavioral Health workforce.

Support from MCBHS staff

As previously stated, there will be MCBHS staff available to answer questions, concerns, provide consultation, training and expedite referrals into the mental health system as appropriate for the Promotores/Community Workers. All Hope House staff will be welcome to engage in any MCBHS ongoing training including cultural competency issues. Any additional training needs will be assessed and implemented for the Promotores/Community Worker staff as necessary.

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4. Programs

Community Outreach and Wellness Center (Expansion and New)	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Months of Operation for FY 2009—10
	Prevention	Early Intervention	
<p>Expansion and re-definition of Wellness Center Services program (Hope House) Expansion to prevention services in mountain area (and if additional funding permits, Chowchilla)</p> <p>Promotores Model/Community Worker incorporating</p> <p>a. CASRA training, (curriculum paid through WET plan)</p> <p>b. Mental Health First Aid Training, (curriculum paid through WET plan)</p>	<p>Individuals: 100 Families: 10</p> <p>25 individuals</p> <p>20 individuals</p>		<p>To be started July 1, 2009—12 months of operation</p>
<p>TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED</p>	<p>Individuals: 145 Families: 10</p>	<p>Individuals: Families:</p>	

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

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

The project will link individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to MCBHS, a primary care provider or other appropriate mental health professional. This will be done through providing direct referrals and linkage and brokerage to these services. The Promotores/Community Worker will also follow-up to ensure that the individual receives treatment or further assessment. This person will interface with the community partners and service providers to ensure that people are linked to services and resources they need, which are not provided by MCBHS.

Through the variety of training (CASRA, Mental Health First Aid, etc.) for the Promotores/Community Worker, they will be able to identify those individuals who need referrals into the behavioral health system for further evaluation and possible services. They will work closely with the MCBHS program supervisors and clinical staff to link people to services. The PEI programs will be readily available to serve individuals who would traditionally refrain from accessing services, overcoming cultural and language barriers as well as reducing stigma about mental health. As a result of service availability in non-traditional settings there would be a positive community impact with more individuals, reducing disability related to untreated mental health conditions and leading healthy thriving lives.

MCBHS staff that will be working with the school districts, Madera County First Five, community organizations, faith-based organizations, etc., to provide parent training, training for school personnel and child social skills training will also be able to link individuals to needed services. They will be able to work with these organizations to make sure appropriate follow-up care and services are provided.

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

Madera County is a small county. There are no mental health CBO's in Madera County. Alternative resources for services are scarce. However, as the need dictates, the Promotores/Community Worker will be able to link individuals and family members to appropriate health care providers, Madera County Department of Social Services, domestic

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violence programs, and other community resources, e.g., food banks, thrift stores, emergency housing, and others, as a means of personal and social resiliency building.

Again, the MCBHS staff that will be working with the school districts, Madera County First Five, community organizations, faith-based organizations, Hope House, etc., to provide parent training, training for school personnel and child social skills training. Staff will be able to refer individuals to needed services such as appropriate health care providers, domestic violence programs, etc. They will be able to work with these organizations to make sure appropriate follow-up care and services are provided.

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

The PEI staff and the Promotores/Community Workers will be able to provide services in any location including churches, the Rescue Mission, primary health care clinics, etc. Space within these organizations will be leveraged for the services provided.

The trainings and workshops will be open to all community agencies, organizations and the public. Local media will advertise the trainings/workshops for free.

6. Collaboration and System Enhancements

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

Currently MCBHS has strong collaborative relationships with the Madera County Department of Social Services, Madera Community Hospital, First Five, etc. Through the PEI process, MCBHS has been developing relationships with the Picayune Rancheria of the Chukchansi Indians Tribal Council and the North Fork Tribal TANF. MCBHS is just starting to forge relationships with the local churches. As time progresses, we anticipate the above relationships intensifying. Those organizations and others representing various interests/citizens in the community will continue as we are able to provide education and linkage services to them.

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

There are no community-based mental health organizations located within Madera County other than MCBHS and its contract with Turning Point of Central California, Inc. for Hope House. Through PEI funds, MCBHS will be able to expand services to the mountain and if future funding permits, the Chowchilla area. In addition, clients and family members will be able to be hired as Promotores/Community Workers to provide outreach, education, intervention and prevention services to the cities of Madera, Chowchilla and to the mountain region of Madera County.

MCBHS will continue to work with its health care providers to implement the co-location of services with primary health. MCBHS will also continue to work with the schools, First Five, Madera County Department of Social Services, the faith-based community to strengthen and build upon those systems and provide referrals and support for appropriate services.

(Describe how resources will be leveraged.)

Partnering agencies will provide space, materials and supplies for the services to be provided.

(Describe how the programs in this PEI project will be sustained.)

It is anticipated that this project will initially be sustained through PEI monies and the leveraging of community resources of our partners. Plans for future expansion of services and sustainability will be developed. Cultural competency training needs as well as other technical assistance will be identified and provided accordingly.

7. Intended Outcomes

(Describe intended individual outcomes.)

The Community Outreach and Wellness Center Project

Expansion of Wellness Center Services Program (Hope House)

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- 1 Increase access to services and nurturing social supports
- 2 Increased independent living and resiliency skills
- 3 Reduced stigma
- 4 Increased knowledge about symptoms of mental illness
- 5 Reduction in suicide attempts/completions
- 6 Increased self-esteem
- 7 Increased achievement motivation

Promotores Model/Community Worker Program

- 10 Reduced stigma
- 11 Increased knowledge about symptoms of mental illness
- 12 Increased social supports
- 13 Reduction in suicide attempts/completions
- 14 Increased positive service access experience

(Describe intended system and program outcomes.)

The Community Outreach and Wellness Center Project

Expansion of Wellness Center Services Program (Hope House)

- 1 Increased integration of mental health services and supports into community setting
- 2 Increased access by underserved populations
- 3 Increased client linkage to appropriate services
- 4 Improved inter-agency referral process
- 5 Increased community awareness about mental health issues
- 6 Reduced social, self, and label avoidance stigma

Promotores Model/Community Worker Program

- 7 Increased client access and linkage to appropriate services
- 8 Increased number of trained community members,
- 9 Increased number of clients, family members and community members that provide prevention/early intervention services,

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- 10 Improved inter-agency referral process
- 11 Increased community awareness about mental health issues
- 12 increases accessed to mental health services by underserved populations
- 13 Increased access to early intervention services in rural, isolated communities
- 14 Improved cultural competence specific to the Latino and Native American communities in the provision of mental health services
- 15 Established career pathway for people to enter the mental health work force.

(Describe other proposed methods to measure success. What will be different as a result of the PEI project and how will you know?)

The following are examples of proposed methods to measure success of the various programs comprising this project:

The Community Outreach and Wellness Center Project

Through PEI funds, MCBHS will be hiring a Quality Improvement/Assurance Specialist. This position will help to develop and monitor outcomes and successes for the proposed programs.

Expansion of Wellness Center Services Program (Hope House)

Performance Indicator: Increased access to care by underserved populations

Measure: Degree of client involvement in the planning, design, delivery and evaluation of services

Domain: Process

Data Source: Program Records

Performance Indicator: Increased self-esteem through support services

Measure: Number of clients who experience an increased level of psychological well-being by receiving

Promotes/Community Worker support services by

- 1 A reduction in psychological distress,
- 2 Increased sense of self-respect and dignity,
- 3 Increased level of functioning and
- 4 Degree to which clients feel good about themselves.

Domain: Outcomes

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Data Source: Questionnaires

Promotores Model/Community Worker Program

Performance Indicator: Increased resiliency through Promotores/Community Worker services

Measure: Number of clients who experience an increased level of psychological well-being by receiving Promotes/Community Worker support services by

- 5 A reduction in psychological distress,
- 6 Increased sense of self-respect and dignity,
- 7 Increased level of functioning and
- 8 Degree to which clients feel good about themselves.

Domain: Outcomes

Data Source: Questionnaires

Performance Indicator: Increased access to mental health and community services by underserved populations

Measure: Increased number of clients who access services, as compared to base line measures

Domain: Outcomes

Data Source: Organization records

8. Coordination with Other MHSA Components

Describe coordination with CSS, if applicable.

This plan proposes to transfer a program and staff to provide prevention and early intervention activities that are currently being funded through CSS funds. PEI programs will be coordinated to serve as the first point of entry to wellness, resiliency and recovery for mental health services and activities for trauma-exposed individuals. As necessary, PEI services will connect clients, youth and family members to CSS programs and other mental health services available from MCBHS.

The MHSA stakeholders/steering committee will continue to advise, monitor and provide input and feedback on all MHSA programs.

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

WET funds will be used to purchase curriculums and training for the staff providing services through PEI programs. Various PEI programs will contribute to employment for clients, family members, and individuals from underserved communities.

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

As Madera County implements the portion of MHSA utilizing Capital Facilities and Technology funds, staff and/or programs may be housed in buildings or utilize technology paid through that MHSA component.

9. Additional Comments (optional—limit to one page)

None.

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County: **Madera** PEI Project Name: **Community and Family Education** Date:

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Psycho-Social Impact of Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At-Risk Children, Youth and Young Adult Populations	X	X		
4. Stigma and Discrimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Children and Youth in Stressed Families	X	X		
4. Children and Youth at Risk for School Failure	<input type="checkbox"/>	<input type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input type="checkbox"/>	<input type="checkbox"/>		
6. Underserved Cultural Populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Community Priorities

The needs and priorities identified during the 2005, 2007 and 2008 community planning processes included:

- Access to care
- Lack of social supports
- Stigma and discrimination driven social isolation
- Obtaining basic education and information about mental health conditions
- Support for children of people experiencing mental illness
- Parenting skill development for marginalized populations
- Increase services and supports for families
- Services at school sites
- Increased school based services
- Providing services in non-mental health settings where people already go
- Training for mental health partner organizations
- Nurturing parent program in the community
- Parenting classes
- Family support group in Spanish
- Priority population age group identification as ages 11 to 15
- Increased resources for parents of infants
- Recommended way to reach people through child care providers and sites such as Head Start

Children and youth in stressed families were identified as top priority populations in Madera's community planning processes. The stakeholders believed that good mental health resides within the interactions of the child and their social environment including family, school and other child service systems in the community. Family stability can be stressed by multiple factors. This may have a negative impact on adults, their children and youth. Stakeholders requested services that would help build and strengthen the protective factors that guard against problem development. Parenting courses were seen as one way to help families strengthen their protective factors in a meaningful and significant way.

Due to chronic and extensive poverty within Madera County, many individuals and families experience high psychological distress due to lack of adequate resources to meet their daily living needs. Many have prolonged traumatic conditions including grief, loss and isolation related to poverty. They are unlikely to seek help from any traditional mental health services due to cultural, socioeconomic and linguistic barriers. Our highest underserved group is the Latino population. This includes a subpopulation of individuals from the Oaxaca region of Mexico. Another population that is not as large numerically, but is very isolated geographically

is the local Native American tribe. Due to transportation and other resource inadequacies in the county, these populations often have significant geographic barriers that prevent them from access mental health care.

There is limited .capacity in Madera to provide parent training programs. First Five of Madera County and the local Community Action Partnership provide general parenting education and support; however, according to stakeholders, existing parenting education capacity is insufficient to meet the need. Community planning participants prioritized parenting courses that are culturally appropriate to underserved populations. They also want parenting skills training programs for parents of school age children, infants and preschoolers.

One of the overall goals of the Community and Family Education Project is to expand the capacity and range of parenting courses to include other age ranges and ethnic specific services. Madera plans to offer Effective Black Parenting Program and Los Niño's Bien Educados for specific cultural populations. Also, Madera County Department of Behavioral Health Services currently has several peer support staff trained in the United Advocates for Children and Families Educate Equip and Support course. They could provide this 12-week course to community members as a component of training for Promotores.

Increasing the skill sets of parents, especially in underserved communities, to more effectively parent their children can increase wellness, and personal and social resiliency in both the child and parent. Parents play key roles in identifying and responding to early indicators of emotional problems that can manifest themselves in behaviors such as school truancy, poor grades, substance abuse, and social isolation. And families facing early indicators of children's emotional and mental issues can benefit from the support of a culturally appropriate parenting program to help with challenges, grief, and frustrations and to celebrate learning, joy and successes.

In addition to the parenting programs, there were numerous requests to assist school personnel to improve the emotional and social climate of classrooms. When children with risk factors enter school, the risk factors become more complex. Teachers, particularly those with ineffective classroom management skills, can be more critical and less supportive of children with challenging and evolving behavior problems. Limited parental involvement in school can compound the problem. Teachers who misunderstand the reasons for lack of parental involvement may respond critically to the parents and caregivers, further eroding the home-school bond. Over time, children who experience difficulty in school may find friends who have a similar experience and eventually may form deviant peer groups that continue to reinforce antisocial behaviors.

This issue is especially important to Madera. It is a small county with a large gang problem and many children at risk due to poverty and other factors. The evidence-based teacher curriculum that will be implemented through the PEI plan can teach many of the skills that correlate with resilient behaviors.

The Stakeholder Input section provides detailed information regarding the information gathered in the planning processes, other data considered in the selection, prioritization of services and the proposed services selected to meet the identified needs.

3. PEI Project Description: (attach additional pages, if necessary)

The project proposes an expansion of existing parenting and children's social skill development programs to address the prevention needs identified in the community planning process for both children in stressed families and their parents/care givers. The programs have the capacity to

help to prevent the development of anxiety and depression associated with chronic poverty, increase parenting skills/knowledge, and increase social supports.

The project will also provide skill-building programs for parents and teachers aimed at establishing nontraditional portals of entry for prevention and supportive services, e.g., schools. Planned parenting programs include Los Niño Bien Educados and Effective Black Parenting. The expansion of the existing classroom management programs includes the Incredible Years (toddlers/preschool) and Love and Logic (elementary through high school). These programs will increase the capacity of parents and teachers to support the life goals that parents have for their children and the characteristics the children need to develop in order to achieve those life goals. The programs also help to convey positive messages about African American and Latino cultures and history and avoid ethnic self-disparagement.

Evidence-based programs presented in this plan (parenting programs and classroom management programs) can teach many of the skills that correlate with resilient behaviors. The skills taught by these evidence-based or promising practice programs include;

- How to recognize and manage emotions,
- Develop caring and concern for others,
- Make responsible decisions,
- Strategies for building strong, emotionally healthy children
- Establish positive relationships and
- Handle adversity effectively.

(Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.)

Key Community Needs and Priority Populations

These services (parenting skill education as well as teacher/classroom management behavior training) were selected because of the following:

- It addresses the most-often mentioned needs identified in the stakeholder process
- They were the programs our community identified as being the most important to serve the following population;
 - Services to children and youth in stressed families

Research-based prevention and wellness promotion that strengthen parenting and enhance child resilience can have a significant impact on the mental health of children and youth. The underlying premise is that it is better to promote mental health and prevent mental health issues before they begin. Research and practice have identified risk and protective factors that affect the vulnerability of children to mental health problems. A child's risk of mental health problems can be diminished by addressing risk and protective factors in the child's environment. Some of the risk factors, such as poverty and community violence, cannot be eliminated by a mental health prevention program alone. However, many protective factors such as relationship skills, conflict management, and positive problem-solving can be taught to children, family members, teachers, and other caregivers.

According to research, while a single risk factor may provide some influence, it is the accumulation and complex interaction of risk factors that increase the probability of mental illness. Many numerous risk factors can be encountered when children are toddlers. These can lead to early onset of conduct problems. Left untreated, conduct problems can turn into antisocial conditions such as substance abuse, delinquency, and violence.

According to research, parents and other caregivers can be overwhelmed by a child's temperament particularly a child that is more impulsive, hyperactive or quick to show anger. Their response to the child's behavior may be an approach that inadvertently increases the likelihood of further conduct problems. Harsh and punitive discipline provides a negative model of behavior and fails to promote pro-social child behavior. This can impede the development of social and cognitive skills. Alternatively, "giving in" to a child reinforces the demanding behavior. Contextual factors, such as poverty and other life stressors, can also contribute to a child's risk of developing conduct problems.

When children with risk factors enter school, this becomes more complex. Teachers, particularly those with ineffective classroom management skills, can be more critical and less supportive of children with challenging and evolving behavior problems.

These issues are extremely important in Madera County. It is a small county with a large Latino population. This population has a large first and second Latino generations and a new third generation emerging. Their needs are different. Many do not seek traditional services as it is not part of their culture. By having the programs go to them, in locations they feel comfortable and respected will assist in the success of the overall goals of the program.

Parenting Programs

To address the prevention needs for these families, MCBHS plans to expand its existing parent training. MCBHS will work with the Madera County Department of Social Services and Madera County First Five to expand the parent training classes available for the public (not just MCBHS clients).

The **Los Niño's Bien Educados** program is respectful of the traditions and customs of Latino families. It is sensitive to the variety of adjustments that are made to acculturate to life in a multicultural society. This program teaches parenting skills within a Latino cultural frame of reference. The program uses Latino proverbs or "dichos." Parents learn effective skills and strategies which promote positive child behaviors. They are reflective of a child who is "bien educados" (well educated in a social and academic sense). The program can be taught in either English or Spanish. One of the evidence-based results of this program is the reduction of youth entering gangs and reducing delinquency behaviors, a priority outcome for community planning participants.

The **Effective Black Parenting** program teaches parenting strategies unique to parents of African American children. It is the same Confident Parenting Program but from African American frame of reference. The program uses African American proverbs to teach parenting skills. One of the results of this program is the reduction of youth entering gangs and reducing delinquency behaviors.

Both programs have been shown to aid in preventing behaviors associated with negative mental health outcomes. Classes for both programs can be taught in community sites, including schools, churches, mosques, agencies, and community centers, which positions these services

for accessible prevention. Both programs will be able to link children and families to a network of supportive services, e.g., food, clothing, shelter, recreation, employment for parents and appropriate mental health and social services

School/Community Supports Services

MCBHS will implement the Love and Logic Classroom Curriculum for teachers of students (K—12 grades). The Love and Logic model for the classroom is an evidenced-based program which develops social skills in students to meet legitimate needs in a health and productive manner. This program focuses on developing healthy working relationships between children and educators. It also helps to develop the social skill sets needed for children to meet legitimate socio-emotional needs in a healthy manner; thereby supporting wellness and resiliency development. The Love and Logic program for teachers helps to;

- Build positive relationships with children and parents
- Strategies for building strong, emotionally healthy children
- How to “bully proof” children, diffuse power struggles & handle difficult people
- Proactive classroom management ideas that lower stress for students and teachers

MCBHS will also expand existing applications of the Incredible Years to Include the Dinosaur Curriculum. This curriculum is designed to promote children’s emotional literacy, problem-solving and anger management skills during conflict situations that occur during unstructured play interactions. This evidenced-based program teaches how to use effective strategies for reducing aggressive and oppositional behavior and strengthening young children’s social competence. It helps to promote parental involvement, social skills and problem solving behaviors. These are factors leading to maintaining wellness and resiliency.

In addition, PEI funds will support a mental health staff person will be a resource to teachers for implementing and maintaining this program. During the planning process educators often said they were not equipped to address these conditions and wished they could support children that were struggling, before they developed mental illness. This training was specifically requested for those who work in the pre-school and Head Start programs. However, we received requests for training from all of the schools on how to address challenging behaviors, regardless of the age of the students.

Schools also requested training for their personnel on mental illness, signs and symptoms and how to link students to mental health services. When the Mental Health First Aid training was explained to them, schools indicated they wanted their personnel to go through this training, as it appeared to meet the needs they identified, in addition to the classroom management programs listed.

(Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.)

Implementation partners will include Madera County Department of Social Services, Madera County First Five, schools and eventually the faith-based community. The settings that deliver the PEI program and interventions will be schools, community organizations, First Five, etc. MCBHS will seek to provide these prevention services in places where the public is used to going, e.g., schools, churches, etc. MCBHS will also seek to provide these services during

hours and days that are convenient for the community to participate. It is hoped that by attending these services in non-traditional mental health settings, stigma can be reduced and services be more accessible to the community.

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

Target community regions include all of Madera County, including rural, mountain and metropolitan areas. There will be special emphasis to the Latino, Native American, African American and other unserved, underserved populations.

(Highlights of new or expanded programs)

- Increase information about mental health issues to the community as act as a resource for information, thus reducing stigma
- Provide support for children, families and educator and assist them in obtaining (linking to) services as necessary
- Outreach to rural areas of the county which currently do not have easy access to services
- Services specifically targeting Latinos, Native Americans and African Americans

(Actions to be performed to carryout the PEI project, including frequency or duration of key activities. Key milestones and anticipated timeline for each milestone)

- Within three months after approval, State contracts have been signed and funds received with Madera County, additional training for staff will be set up to be implemented.
- Within three months after approval, State contracts signed and funds received, Madera County will work with school districts within Madera County to set up training program for teachers and other personnel for Incredible Years and Love and Logic to be implemented during FY 2009—10.
- Within six months after approval, State contracts have been signed and funds received, 50 school personnel and/or community members will have received the training.
- Within twelve months after approval, State contracts signed and funds received, 100 school personnel and/or community members will have received the training.

4. Programs

Program Title Community and Family Education Program (Expansion and New)	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Parent Training, Teacher Training and Child Social Skills Training; <ul style="list-style-type: none"> • Incredible Years (curriculum paid through WET plan) • Love and Logic (curriculum paid through WET plan) • Effective Black Parenting (curriculum paid through WET plan) • Los Niños Bien Educados (curriculum paid through WET plan) 	Individuals:100 Families:	Individuals: Families:	To be started July 1, 2009 12 months of operation
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: Families: 100	Individuals: Families:	

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

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

MCBHS staff that will be working with the school districts, Madera County First Five, community organizations, faith-based organizations, etc., to provide parent training, training for school personnel and child social skills training will also be able to link individuals to needed services. They will be able to work with these organizations to make sure appropriate follow-up care and services are provided.

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

MCBHS staff that will be working with the school districts, Madera County First Five, community organizations, faith-based organizations, Hope House, etc., to provide parent training, training for school personnel and child social skills training will also be able to refer individuals to needed services such as appropriate health care providers, domestic violence programs, etc. They will be able to work with these organizations to make sure appropriate follow-up care and services are provided. In partnership with the Promotores from the Community Outreach and Wellness Center Project, when members of underserved populations are engaged, they will be linked to appropriate community resources, including mental health care.

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

The trainings and workshops will be open to all community agencies, organizations and the public. Local media will advertise the trainings/workshops for free.

Both Madera County Department of Social Services and MCBHS have been cross trained on the Incredible Years and Love and Logic. That cross training will continue. MCBHS will continue to work with Madera County First Five for all of the training/workshops and for program services, and will utilize the First Five site at no cost, to provide services.

The department is in the process of establishing working relationships with local agencies and faith community to engage Latinos and African Americans in the parenting programs as a means of providing a needed service, as well as a method of linking representatives from these communities to other resources, that they need. These services will be provided at non-mental health services sites these communities already frequent. It is hoped that by working with these groups, we will be able to continue to understand their needs. For the Native American population, we will continue to work with the tribes to find which program/services would best meet their needs in a culturally appropriate way. Both local tribes have TANF offices which provide some general parenting courses. It is possible that, working with these offices, MCBHS can transculture the Center for the Improvement of Child Caring's Confident Parenting program, which was the program that was transcultured into Los Niño's Bien Educados and Effective Black Parenting. This transculturing methodology appear to be effective in adapting programming and services to meet unique cultural needs.

6. Collaboration and System Enhancements

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

Currently MCBHS has strong collaborative relationships with the Madera County Department of Social Services, Madera Community Hospital, First Five, etc. Through the PEI process, MCBHS has been developing relationships with the Picayune Rancheria of the Chukchansi Indians Tribal Council and the North Fork Tribal TANF. As the project is implemented, we anticipate those relationships strengthening. MCBHS is just starting to forge relationships with the local churches. As time progresses, we anticipate those relationships intensifying. Those organizations and others

representing various interests/citizens in the community will continue as we are able to provide education and linkage services to them.

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

There are no community-based mental health organizations located within Madera County other than MCBHS and its contract with Turning Point of Central California, Inc. (based in Tulare County) for its Wellness Center, Hope House. Through PEI funds, MCBHS will be able to expand services to the Eastern mountain and Chowchilla areas for more client-directed programming at non-mental health community sites.

(Describe how resources will be leveraged.)

Partnering agencies will provide space, materials and supplies for the proposed MHSA services to be provided.

(Describe how the programs in this PEI project will be sustained.)

It is anticipated the project will initially be sustained through PEI monies and the leveraging of community resources of our partners. Plans for future expansion of services and sustainability will be developed. Cultural competency training needs as well as other technical assistance will be identified and provided accordingly.

7. Intended Outcomes

(Describe intended individual outcomes.)

Parent Training, Teacher Training and Child Social Skills Training

- Reduced stigma
- Increased knowledge about parenting a child exhibiting behavioral issues or mental health needs
- Increased individual and family functioning
- Improved parent-child relationships
- Increased parenting skills
- Increased educator skills in addressing and arresting behaviors that could need to behavioral health issues
- Increased access to care and services
- Increased self-esteem

These evidence-based programs have produced the following outcomes, all of which are relevant to children's mental health;

- Increased parents bonding and involvement with teachers and classrooms
- Reduced conduct problems in children's interactions with parents and teachers
- Increased children's positive interactions with peers, school readiness, and engagement in school activities
- Increased children's appropriate cognitive problem-solving strategies

- Increased children's use of pro-social conflict management strategies with peers
- Increased children's social competence and appropriate play skills

Selected Programs and Desired Outcomes

The desired outcomes of these proposed PEI services, which will meet these identified needs and priorities include:

Systems Level

- Increase the capacity of the existing parenting courses to served more people
- Increase the capacity of the existing classroom programs to teach the skills that correlate with resilient behaviors
- Increase mental health protective factors related to an healthy parent /child relationship that are culturally appropriate to improve quality of life indicators
- Establish community based supportive services that address risk factors related to the parent/child relationship, which, if left unaddressed, can lead to mental illness
- Increased number of individuals linked to ongoing appropriate care in a timely manner
- Increase linkage of individuals to community resources that promote wellness and self-sufficiency
- Increase opportunities for individuals and families to link to nurturing social support networks that are non-stigmatizing and culturally appropriate

Individual/Family Level

- Increasing access to mental health care by Latinos (Madera's largest underserved population)
- Increased satisfaction with the parent-child relationship
- Increased self-confidence related to competency/skill development
- Increased social supports/decreased social isolation that promote wellness and resiliency
- Persons served will have improved functioning at home with their children and family members from prior to taking the course(s) to after taking the course(s). e.g., improved sense of well-being, greater confidence in their parental roles, etc.
 - Research has shown reductions in aggression, conduct disorders, ADHD and oppositional defiant disorder as a benefit of family skills training
 - Research has shown the prevention of child abuse, later drug use and delinquency (risk factors)
 - Provide prevention strategies that are based on individual and family needs, strengths and resiliencies through the encouragement of wellness, personal empowerment and growth
 - Increase in self-esteem
 - Increase in positive behaviors

Outcomes for the School/Community Support Services

- Improve the relationship between the at-risk child and teachers (school personnel)

- At-risk students who lack positive relationships with their teachers and other adults at school will be more likely to engage in academic activities and are less likely to drop-out before they graduate
- Research has shown that resiliency factors or “developmental assets” help children avoid academic failure, emotional problems, criminal behavior, substance abuse and other negative outcomes
- School staff and faculty will be able to recognize developing signs and symptoms associated with mental disorders, substance abuse or suicidal risk.
- School staff and faculty will be able to make appropriate referrals for services (both mental health and social services) should they become necessary

(Describe intended system and program outcomes.)

Parent Training, Teacher Training and Child Social Skills Training

- Increased client referrals to appropriate services
- Improved inter-agency referral process
- Increased community awareness about mental health issues
- Reduced stigma
- Increased parenting education/training
- Increased integration of mental health services into non-mental health settings

(Describe other proposed methods to measure success. What will be different as a result of the PEI project and how will you know?)

Through PEI funds, MCBHS will be hiring a Quality Improvement/Assurance Specialist. This position will help to develop and monitor outcomes and successes for the proposed programs.

Parent Training, Teacher Training and Child Social Skills Training

Performance Indicator: Increased knowledge about parenting a child exhibiting behavioral issues to increase protective or buffering, factors that promote resilience.

Measure: Report of increased parent confidence due to positive behavior changes in their children that they relate to changes in their knowledge and behaviors they associated with the parenting course.

Domain: Outcomes

Data Source: Questionnaires

Performance Indicator: Increased access to mental health and community services by children and families from underserved populations

Measure: Increased number of clients who access services, as compared to base line measures

Domain: Outcomes

Data Source: Organization records

8. Coordination with Other MHSA Components

Describe coordination with CSS, if applicable.

PEI programs will be coordinated to serve as the first point of entry to wellness, resiliency and recovery for mental health services and activities. As necessary, PEI services will connect clients, youth and family members to CSS programs and other mental health services available from MCBHS.

The MHSA stakeholders/steering committee will continue to advise, monitor and provide input and feedback on all MHSA programs.

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

WET funds will be used to purchase curriculums and training for the staff providing services through PEI programs.

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

As Madera County implements the portion of MHSA utilizing Capital Facilities and Technology funds, staff and/or programs may be housed in buildings or utilize technology paid through that MHSA component.

9. Additional Comments (optional—limit to one page)

None.

Form 3

County: **Madera** PEI Project Name: **School Based Services** Date: As Funding Permits

School Based Services Date: as funding permits 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At-Risk Children, Youth and Young Adult Populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Stigma and Discrimination	X	X	<input type="checkbox"/>	<input type="checkbox"/>
5. Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Children and Youth in Stressed Families	<input type="checkbox"/>	<input type="checkbox"/>		
4. Children and Youth at Risk for School Failure	X	X		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input type="checkbox"/>	<input type="checkbox"/>		

6. Underserved Cultural Populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Goals and Outcomes

The needs and priorities identified during the 2005, 2007 and 2008 community planning processes included:

- access to care
- school violence
- gang activity
- lack of social supports
- label avoidance stigma and discrimination driven social isolation
- obtaining basic education and information about mental health conditions
- entry level employment in mental health services
- community members as providers
- school based social supports
- providing services in non-mental health settings where people already go
- counseling and peer counseling
- public awareness
- training for mental health partner organizations

Children and youth at risk of school failure, adolescents exhibiting violent and disruptive behavior and Transition Age Youth were identified as high priority populations in Madera’s community planning processes. Accessible age appropriate community based services and supports were other significant need themes identified in the planning processes.

The identified populations are significantly impacted by the chronic and extensive poverty in Madera County. Due to these living conditions, these individuals and families experience high psychological distress due to exposure to traumatic events and prolonged traumatic conditions including grief, loss and isolation related to poverty. They are also unlikely to seek help from any traditional mental health services due to cultural, socioeconomic and linguistic barriers. Due to transportation and other resource inadequacies in the county, these populations often have significant geographic barriers that prevent them from access to mental health care.

There was a strong theme throughout planning regarding the inadequate independent living and social skill development opportunities that would help build personal and social resiliency to address poor living conditions. This increases the acuity of the

impact of poverty as it relates to increasing the prevalence of mental health conditions. The development of vocational skills that would lead to employment as adults was another significant identified need for Transition Age Youth.

The overall goal to address these needs and priorities is to expand the capacity and range of preventative mental health services provided by our system, but which are delivered in non-mental health community settings.

The Stakeholder Input section provides detailed information regarding the information gathered in the planning processes, other data considered in the selection and prioritization services, and the proposed services selected to meet the identified needs.

3. PEI Project Description: (attach additional pages, if necessary)

Human Services Academy/Primary Intervention Program

(Briefly describe the PEI project. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

This program has two components: 1) the Human Services Academy (HAS) and 2) the Primary Intervention Program.

The Human Services Academy would be funded out of our Workforce Education and Training (WET) funding. The Primary Intervention Program will be funded out of our Prevention and Early Intervention (PEI) funding. Both programs within this project will only be funded if there are additional monies available through PEI. The high school students going through the Human Services Academy will act as mentors for the younger children attending the Primary Intervention Program. The program benefits both the youth delivering the services as well as the younger children receiving the services. Both will be developing independent living skills that will build personal and social resiliency and timely achievement of developmental milestones. Blending these two strategies also addresses some logistical implementation issues that arose during planning for both program components: 1) location of services 2) staffing for services 3) transportation 4) supervision of staff 5) confidentiality and 6) real world training experience. Ideally, these services would be provided and received at program sites that are either located on a high school campus or nearby elementary school.

Through WET funds, MCBHS is working with South Madera High School to develop a program that acquaints students in secondary education to a career in the mental health workforce. Staff from the Chowchilla School District has also expressed interest in developing this type of program. The HSA program will help youth achieve developmental mental milestones through real world work experience that requires responsibility and self-awareness. This work experience will be providing services for the Primary Intervention Program. The course work involved with this program will help youth identify the personal strengths they can capitalize on, develop social supports, and increase academic engagement. More details about this dimension of the program will be included in our request for WET funds.

The **Primary Intervention Program (PIP)**, funded with PEI funds, is a school-based program designed for the early intervention and prevention of mild to moderate school adjustment difficulties in primary (K-3) grade students. This program will help the children achieve developmental milestones in the areas of language acquisition and communication, social interaction development, self-awareness and emotional regulation.

As described, the Human Services Academy students will provide the “personnel” for this program as part of their field placements. These students will be supervised by school professionals. Referrals for appropriate services will be provided for the elementary school students whose needs are beyond scope of the PIP.

Kindergarten through third grade students who will be receiving the PIP services will be selected using the Walker Screening Instrument (WSI, a screening tool designed to identify young children experiencing school adjustment difficulties. Participation will be based on the WSI score (i.e. rating of teacher-preferred social behavior, peer-preferred social behavior and social adjustment required for success in classroom settings) and other pertinent information (i.e. out-of-home placement, changes in family/home situation, behavioral/discipline referrals). Screeners would include MCBHS and school personnel.

Elementary school children selected to participate in the PIP program will receive one-to-one, non-directive play experience from a specially trained Human Services Academy student, once a week, for 30 to 40 minutes in a specially designated and equipped activity room. Identified children will follow a twelve to fifteen sessions timeline for program participation. Through non-directive play experience and support of their choice of activities in a nurturing environment, children will gain confidence in expressing their feelings and work out their own problems related to school adjustment, adult and peer relations, social behavior, etc.

The **Human Services Academy** student would be a supportive listener helping the child deal with issues that may interfere with learning at school. The non-directive play sessions for children are designed to establish a positive, meaningful relationship to reduce school adjustment difficulties. The academy students would be trained to be culturally and ethnically sensitive. The academy students will receive specific ongoing supervision and training from a mental health professional and the school.

During the FY 08-09, and FY 09—10, MCBHS will work with South Madera High School and Chowchilla High School to develop a Health and Human Services Academy and Primary Intervention Program, as initial implementation sites.

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

Madera County has a large Latino population and is a small, primarily rural county. This program targets the elementary school age youth experiencing problems with school adjustment. Students receiving services will reflect county demographics.

Highlights of new or expanded programs.

Program has high-risk youth providing prevention/early intervention services to younger youth also at risk. These programs, Human Services Academy and the Primary Intervention Program have both been shown to be effective with their respective populations. The job skill development and personal growth developed through this process will promote the wellness and resiliency of the youth as well as the children they serve, and the at-risk youth will serve as effective mentors and role models for younger youth. This will be the first time such a program utilizing at risk youth as providers to at risk youth in elementary schools will be implemented within Madera County.

Actions to be performed to carry out the PEI project, including frequency or duration of key activities. Key milestones and anticipated timeline for each milestone.

MCBHS continues to work with South Madera High School and the Chowchilla School District in developing these programs. It is anticipated these programs would be implemented during FY 09-10 and FY 10-11 as additional funds become available. MCBHS is seeking overall approval of the program for continued program development and future implementation.

Responding in Peaceful and Positive Ways Program

Briefly describe the PEI project. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

The Responding in Peaceful and Positive Ways Program (RIPP) for ages 6—12 and 13—17 is a best practice school-based violence prevention program. It contains a peer mediation program. This program promotes the wellness and resiliency of youth, as well as increased self-esteem, independent living skills, problem-solving, essential social skills, autonomy and life satisfaction. The program emphasizes social-cognitive problem-solving techniques for dealing with conflict, and increases students' capacity to identify and choose nonviolent strategies for dealing with conflicts. This program will facilitate the teen's development in the areas of advanced reasoning, abstract thinking, self-awareness/meta-cognition, developing a positive self-image, empathy, motivation for personal growth and achievement.

A school-based prevention specialist teaches RIPP sessions are taught in the classroom. Sessions are typically incorporated into existing social studies, health or science class. The full-time violence prevention specialist also supervises and coordinates the peer medication program.

The RIPP program supports the following;

- Social skill development
- Increase sense of social competency

- Increase self-esteem
- Increase satisfaction with social interactions with peers and adults
- Increase positive social identity
- Increase appropriate methods of meeting needs across life domains
- Increase conflict-resolution and positive risk-taking skills
- Diminish stereotypes, beliefs, attributions, and cognitive scripts that support violence.
- Develop cognitive scripts for pro-social behavior.
- Enlarge skills repertoire for non-violent conflict resolution and positive risk-taking.
- Provide opportunities for mentally rehearsing non-violent means for conflict resolution and achievement.
- Promote self-management through repeated use of problem-solving models.
- Enable participants to identify the optimal violence prevention strategy in a given situation and given personal skills

Madera County Department of Behavioral Health Services will have staff trained in the RIPP program and act as the resource for a school district to provide RIPP services. This school district would be located in a rural or mountain area of Madera County. As the program's successes are reported and as additional dollars become available for services, this program could be expanded to other schools and school districts within Madera County. Chowchilla school personnel and North Fork School personnel have expressed interest in having this program located within their schools.

(Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.)

Addressing violent behavior and anger management were listed as key mental health services needs in both the 2005 and 2007-08 CPPPs. In the 2005 CPPP indicated a need for increased services for children and youth. The 2008 stakeholder input identified gang/school violence and community/domestic violence as a priority mental health services needs. Madera County has a large gang population. Two of the priority populations as indicated by the focus groups were Youth in Stressed Families and Children and Youth at Risk of School Failure. Schools were consistently identified as priority sites for PEI service delivery.

Madera County BHS surveys for the PEI component were translated into Spanish. All of the respondents to the PEI Latino survey listed on the Madera County PEI website were transition age youth. In listing the community issues they thought were most important for mental illness prevention and early intervention services was gang/school violence. Gang/school violence also rated as one of the top choices for the surveys completed in English.

Key informant interviews with school district personnel as well as specific focus groups also echoed the survey's results. Madera's population was interested in programs that would reduce school violence. They wanted to create positive problem solving opportunities for students. They stated interest in programs that taught mediation skills to students.

Additional desired outcomes include;

- Reduction of negative outcomes due to unaddressed risk factors
- Increase satisfaction with peer and adult social interactions
- Increase social support
- Increase developmentally appropriate problem solving

All of these outcomes help to promote mentally healthy behaviors.

Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

Implementation partners would be the school districts. Services would be provided on school campuses. The Chowchilla and North Fork School districts which have expressed an interest in the development of this program has a large Latino and Native American population attending their schools.

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

The Native American community was listed as one of the main underserved groups in both the 2005 and 2007-08 CPPPs. As indicated in the data section of this proposal, the Latino population and Native American population experience a high rate of poverty and trauma. This trauma is due to experiences such as genocide and immigration issues that have multi-generational and intergenerational impacts on interpersonal behavior. This can lead to increased violent behavior. In addition, both populations consistently underutilize mental health services which could address these issues. Both tend to not access public mental health services even though they are eligible for services. However, children and youth from both populations regularly attend schools. While the services would be based at school sites, they would have some elements of services that would reach beyond the school campus to engage at-risk youth in other community settings, as needed in a culturally appropriate manner.

Madera County BHS would partner with a school district in the rural or mountain area of the county. The Chowchilla school district has expressed interest as has the Chawanakee Unified School District in North Fork. The Chowchilla Unified School District serves a large Latino population. The Chawanakee School District has a reservation located within its district.

(Highlights of new or expanded programs)

1. Provides a strong basis or support for the development of youth peer support
2. Teaches wellness skills that are essential independent living skills
3. Develops an alternative to school and gang violence

(Actions to be performed to carryout the PEI project, including frequency or duration of key activities. Key milestones and anticipated timeline for each milestone)

- MCBHS continues to work with South Madera High School and the Chowchilla School District in developing this program. It is anticipated this program would be implemented during FY 09-10 and FY 10-11 as additional funds become available. MCBHS is seeking overall approval of the program for continued program development and future implementation.

(Actions to be performed to carryout the PEI project, including frequency or duration of key activities. Key milestones and anticipated timeline for each milestone)

- MCBHS continues to work with health services providers located within Madera County in developing this program. It is anticipated this program would be implemented during FY 09-10 and FY 10-11 as additional funds become available. MCBHS is seeking overall approval of the program for continued program development and future implementation.

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 2010
	Prevention	Early Intervention	
Responding in Peaceful and Positive Ways (RIPP)	Individuals: 50 Families:	Individuals: Families:	To be developed during FY 09-10, possibly implemented FY 10-11 if we obtain sufficient funds
Human Services Academy/Primary Intervention Program (PIP)	Individuals: 40 Families:	Individuals: Families:	To be developed during FY 09-10, possibly implemented FY 10-11 if we obtain sufficient funds
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 90 Families:	Individuals: Families:	

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

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

The School Based Services project will link individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to MCBHS, the primary care provider or other appropriate mental health professional through providing direct referrals to agencies. The mental health staff associated with this PEI project will facilitate referrals as appropriate.

The mental health staff will work with the Promotores/Community Worker from the Community Outreach and Wellness Center project to ensure that the individual receives treatment or further assignment. This person will interface with the community partners and service providers. The PEI programs will be readily available to serve individuals who would traditionally refrain from accessing services, by overcoming cultural and language barriers as well as reducing stigma about mental health. They will do this by providing their educational and supportive services in community settings, thereby moving the service access points out of the clinic settings and integrating them into community settings. As a result of service availability in non-traditional settings there would be a positive community impact with more individuals leading healthy and thriving lives.

MCBHS staff that will be working with the school districts, community organizations, faith-based organizations, etc., to provide parent training, training for school personnel and child social skills training will also be able to link individuals to needed services. They will be able to work with these organizations to make sure appropriate follow-up care and services are provided.

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

Madera County is a small county. There are no mental health community based organizations within its county limits. Alternative resources for services are scarce. However, as the need dictates and resources are available, the Promotores/Community Worker from the Community Outreach and Wellness Center project will be link individuals and family members to appropriate health care providers, Madera County Department of Social Services, domestic violence programs, and other community resources (e.g., food banks, thrift stores, emergency housing).

Again, the MCBHS PEI staff will also be able to refer individuals to needed services such as appropriate health care providers and domestic violence programs. They will be able to work with these organizations to make sure appropriate follow-up care and services are provided.

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

The School Based Services project will work with schools to identify and serve appropriate youth for the RIPP program, to address their aggressive behaviors and other mental health risk factors through the program. The services will be provided on school campuses so some co-location of behavioral health staff on these campuses is likely.

The Human Services Academy, when implemented, will utilize MCBHS staff to help teach the program, however the Primary Intervention Program will be staffed from students who are attending the Academy. Space and classroom materials will be provided for the MCBHS staff/instructor of the program by the schools. The students will be provided the coursework on campus and provide the PIP services at Head Start or similar program on the school campuses. It is likely that MCBHS staff would be provided some office space and access to some of the school resources while they are on campus.

6. Collaboration and System Enhancements

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

As previously mentioned, the services provided by this project will be located at schools, and serve other community sites, as needed.

The partnerships with the schools will involve the development of education, training and supportive services for students on campus, as well as vocational preparation. This will involve coordinating the delivery of these services between school staff and MCBHS staff. Memorandums of Understanding or similar agreements will be developed which will help clearly, yet flexibly, define the roles of the schools and MCBHS in providing these services. Models for mental health integration into schools, such as those developed by the University of California, Los Angeles School Mental Health Project Center for Mental Health in Schools, will be used to guide service development. In addition, consultation with schools and behavioral health departments that have successfully developed the proposed services will help guide the development process, as well as anticipate any unforeseen issue that arise in the development of these types of services.

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

There are no community-based mental health organizations located within Madera County other than MCBHS and its contract with Turning Point of Central California, Inc. (which is based in Tulare County) for its Wellness client-directed center, Hope House.

MCBHS will continue to work with its community partners, primarily schools for this project, to strengthen and build upon the local supports facilitating timely access to care, especially for underserved populations that would be unlikely to seek mental health care. The schools do see many underserved populations that need mental health care; however, linking these individuals and families to mental health care is often unsuccessful due to factors such as stigma, transportation, and amount of time away from work and family. The services proposed in this project and the Community Outreach and Wellness Center project will address these issues.

(Describe how resources will be leveraged.)

Schools will provide space, materials and supplies for the services to be provided. They may also provide In-kind staff time to support the project.

(Describe how the programs in this PEI project will be sustained.)

It is anticipated the School Based Services project will initially be sustained through PEI monies and the leveraging of community resources of our partners. Plans for sustainability and/or future expansion of services will be developed, as resources are available. Cultural competency training needs as well as other technical assistance will be identified and provided accordingly.

7. Intended Outcomes

The outcome variables described below are intended to be quantifiable and measurable, while also being relevant indicators of wellness and resiliency.

(Describe intended individual outcomes.)

School Based Services Project

Responding in Peaceful and Positive Ways (RIPP)

- Improved teacher/child interactions
- Increased progress towards attaining developmental milestones
- Increased positive peer interactions
- Increased peaceful conflict resolution
- Increased self-esteem
- Increased life satisfaction

- Increased self-awareness
- Increased social competencies and problem-solving skills
- Increased self-efficacy
- Increased positive expectations/optimism for the future

Primary Intervention Program (PIP)

- Improvement in social skills and peer interactions
- Increased positive interactions
- Increased sense of empathy
- Increased emotional regulation
- Increased planning and decision making
- Increased self esteem/sense of being valued by others
- Increased skill mastery

All of these outcomes for this project help to increase the mental health of the community.

(Describe intended system and program outcomes.)

The desired system level outcomes of this project overall include:

- Establish learning and developmental supports
- Increasing access to mental health care by underserved populations, including Latinos and older adults,
- Linking individuals to community resources needed, which promote wellness and self-sufficiency
- Providing nurturing peer and adult supports that are non-stigmatizing and culturally appropriate
- Establish clear rules and consequences that are consistently followed
- Establish adult role models/mentors

- Establish system of rewards to reinforce positive behaviors with high expectations that children and youth are capable or and will do well
- Reduction in student violence
- Provide daily living skill development opportunities that can lead to self-sufficiency and personal resiliency

Responding in Peaceful and Positive Ways (RIPP)

- Increased learning supports
- Increased positive social supports
- Increased systems integration
- Increased access to care
- Establish mentors/role models for youth
- Establish clear behavior expectations and positive behavior reinforcements

Primary Intervention Program (PIP)

- Integration of MHSA PEI and WET components
- Integration of mental health into other systems (e.g. schools)
- Increased systems integration

(Describe other proposed methods to measure success. What will be different as a result of the PEI project and how will you know?)

Through PEI funds, MCBHS will be hiring a Quality Improvement/Assurance Specialist. This position will help to develop and monitor outcomes and successes for the proposed programs.

The following are examples of the proposed methods to measure success for the various programs that comprise this PEI project.

Responding in Peaceful and Positive Ways (RIPP)

Performance Indicator: Increased demonstration of personal responsibility

Measure: Increased reporting of interactions with positive outcomes and less school violence

Domain: Outcomes

Data Source: School records

Primary Intervention Program (PIP)

Performance Indicator: Degree to which students experience a decreased level of psychological distress

Measure: Increased reporting of teacher/student interactions with positive outcomes

Domain: Outcomes

Data Source: Questionnaires

8. Coordination with Other MHSA Components

Describe coordination with CSS, if applicable.

PEI programs will serve as the first point of entry to wellness, resiliency and recovery mental health services and activities. All Madera PEI services will connect clients, youth and family members with more serious mental health disorders to CSS programs and other mental health services available from MCBHS.

The MHSA stakeholders/steering committee will continue to advise, monitor and provide input and feedback on all MHSA programs.

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

WET funds will be used to purchase curriculums and training for the staff providing services through PEI programs. WET funds will pay for the Human Services Academy and PEI funds will pay for the Primary intervention Program. This will help with sustainability and will allow more PEI dollars to go to staff positions, as these one time cost will be covered with the one time WET funds.

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

As Madera County implements the portion of MHSA utilizing Capital Facilities and Technology funds, staff and/or programs may be housed in buildings or utilize technology paid through that MHSA component.

9. Additional Comments (optional—limit to one page)

None.

Form 3

County: **Madera** PEI Project Name: **Focus on Early Intervention** Date: **as funding permits.**

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	X	X	X	X
2. Psycho-Social Impact of Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At-Risk Children, Youth and Young Adult Populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Stigma and Discrimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
D. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Children and Youth in Stressed Families	<input type="checkbox"/>	<input type="checkbox"/>		
4. Children and Youth at Risk for School Failure	<input type="checkbox"/>	<input type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<input type="checkbox"/>	<input type="checkbox"/>		
6. Underserved Cultural Populations	X	X	X	X

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

Goals and Outcomes

The needs and priorities identified during the 2005, 2007 and 2008 community planning processes included:

- Access to care
- Access to care by seniors
- Specialist for senior citizens
- More outreach to older adults
- Classes for older adults in non-clinical settings that deal with mature adult's needs such as depression, grief, alcoholism, understanding dementia, etc.
- Lack of social supports
- Label avoidance stigma and discrimination driven social isolation
- Obtaining basic education and information about mental health conditions
- Community members as providers
- Providing services in non-mental health settings where people already go
- Counseling and peer counseling
- Public awareness
- Training for mental health partner organizations

Underserved cultural populations, in particular older adults and Transition Age Youth, were identified as high priority populations in Madera's community planning processes. Accessible age appropriate community based services and supports were other significant need themes identified in the planning processes. The identified populations for this project are significantly impacted by the chronic and extensive poverty in Madera County. Due to these living conditions, these individuals and families experience high psychological distress due to exposure to traumatic events and prolonged traumatic conditions including grief, loss and isolation related to poverty. They are also unlikely to seek help from any traditional mental health services due to cultural, socioeconomic and linguistic barriers. Due to transportation and other resource inadequacies in the county, these populations often have significant geographic barriers that prevent them from access mental health care.

There was a strong theme throughout planning regarding the inadequate independent living a social skill development opportunities that would help people build person and social resiliency to address the poor living conditions in Madera County. This was tied into how this increases the acuity of the impact of poverty, as it relates to increasing the prevalence of mental health conditions. The development of vocational skills that would lead to employment as adults was another significant identified need for Transition Age Youth.

The overall goal to address these needs and priorities is to expand the capacity and range of mental health services, including prevention and early intervention, provided by our system, but which are delivered in non-mental health community settings. The

Stakeholder Input section for detailed information regarding the information gathered in the planning processes, other data considered in the selection and prioritization services, and the proposed services selected to meet the identified needs.

3. PEI Project Description: (attach additional pages, if necessary)

Co-location of BHS staff with Physical Health Services

(Briefly describe the PEI project. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.)

When the population of Madera County was asked either in key informant interviews, focus groups or on questionnaires, repeatedly, they stated they wanted services to be co-located with primary care. Being co-located made it easier to obtain services. It also helped to reduce stigma.

Also, national reports recommend an integrated and coordinated model of care;

- President's New Freedom Commission, 2003
- IOM: Improving the Quality of Health Care for Mental and Substance-Use Conditions, 2006
- The Surgeon General's report on Mental Health, 1999
- SAMHSA: Transforming Mental Health Care in America, 2006

Collaborative MH/Physical healthcare helps increase access to Mental Health care. It has been well documented that people experiencing mental health conditions frequent primary care settings at a greater rate than mental health settings. In addition, while these conditions are often identified initially in primary care settings, individuals and families experiencing mental health symptoms and conditions are not always able to access appropriate mental health care in these settings. Mental health care co-located in primary care settings supports the holistic need to address co-occurring health and mental health disorders. It has been well documented that the majority of people experiencing mental health conditions also have co-occurring general medical conditions. If left untreated these conditions can complicate or exacerbate their mental health conditions and visa versa.

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

This project will target individuals from underserved communities, especially Latinos. Numerous research studies and MHSa CPPP activities agree that Latinos are much more likely to access mental health care when it is co-located with primary care services. In

addition, due to the high rate of co-morbidity between mental health and physical health conditions, locating mental health services in the primary care setting well positions these services to identify these conditions in the earliest stages.

(Highlights of new or expanded programs)

Madera County's local FQHC provided brief mental health care until 2007, when it lost its funding to continue the services. There has been ongoing discussion regarding integrating mental health into either the FQHC, Madera Community Hospital outpatient clinics or the Madera County Public Health Department. Funding has always been a barrier.

Madera County would use clinical staff and Promotores/Community Workers from the Community Outreach and Wellness Center project in a team approach to provide ongoing education and coordination services. In particular, there would be an outreach to the senior population who needs coordination of care for depression. This would reduce stigma as Mental Health services are provided as part of routine medical care. It provides improved client access to care. It recognizes the client's identified "Medical Home." Physical health care is often where the client will seek help first for symptoms. Staff would also be able to educate primary health personnel on mental health issues and resources in the community.

The primary approach for services would be brief intervention and referral. Modalities would include:

- Mental health screening
- Assessment
- Case management/care coordination, including to reduce barriers to services and wellness
- Brief interventions and supportive services in an individual or group situation
- Brief individual and group therapy
- Medication evaluation and monitoring
- Collateral consultation to primary care providers; support primary care MD's who provide psychotropic meds
- Referrals for those clients with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED)

Services would be provided in a similar model to the IMPACT program only it would serve other age groups besides the senior population and other diagnoses including depression. The Four Quadrant Model will also be used to address, funding programmatic, and care prioritization issues which arise when address physical and mental health disorders simultaneously in two systems.

The mental health clinical staff would assist with depression screening and services. The Promotores/Community Workers from the Community Outreach and Wellness Center project would act as Care Coordinators and provide brief intervention services and care management. They will help engage and strengthen individuals' natural community and family support networks, as appropriate, as well as make referrals to community services and supports. Mental Health staff would provide support to the primary care staff providing medication and other health related services. Madera County is still in discussion with its health and primary care providers. It anticipates implementing this program in FY 2009—10 through FY 2010—11.

(Actions to be performed to carryout the PEI project, including frequency or duration of key activities. Key milestones and anticipated timeline for each milestone)

- MCBHS continues to work with health services providers located within Madera County in developing this program. It is anticipated this program would be implemented during FY 09-10 and FY 10-11 as additional funds become available. MCBHS is seeking overall approval of the program for continued program development and future implementation.

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	
Co-location of staff with Physical Health Care Services	Individuals: Families:	Individuals:30 Families:10	To be developed during FY 09-10, possibly implemented during FY 10-11 if we obtain sufficient funds
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: Families:	Individuals: 30 Families: 10	

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

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

The Early Intervention project will link individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to MCBHS, the primary care provider or other appropriate mental health professional through providing direct referrals. The Promotores/Community Worker from the Community Outreach and Wellness Center project will also follow-up to ensure that the individual receives treatment or further assignment and to provide other supports. This person will interface with the community partners and service providers.

Once trained, the Promotores/Community Worker from the Community Outreach and Wellness Center project will be able to identify those individuals who need referrals into the behavioral health system for further evaluation and possible ongoing services. They will work closely with the MCBHS program supervisors and clinical staff to link people to appropriate services. The PEI programs will be readily available to serve individuals who would traditionally refrain from accessing services, by overcoming cultural and language barriers as well as reducing stigma about mental health. They will do this by providing their educational and supportive services in community settings, thereby moving the service access points out of the clinic settings and integrating them into community settings. They will be making contact by other means, such as telephone, to facilitate access to care. As a result of service availability in non-traditional settings there would be a positive community impact with more individuals leading healthy and thriving lives.

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

Madera County is a small county. There are no mental health community based organizations within its county limits. Alternative resources for services are scarce. However, as the need dictates and resources are available, the Promotores/Community Worker from the Community Outreach and Wellness Center project will be link individuals and family members to appropriate health care providers, Madera County Department of Social Services, domestic violence programs, and other community resources (e.g., food banks, thrift stores, emergency housing).

Again, the MCBHS PEI staff will also be able to refer individuals to needed services such as appropriate health care providers and domestic violence programs. They will be able to work with these organizations to make sure appropriate follow-up care and services are provided.

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

The co-location program would provide its services at health services sites such as the local Federally Qualified Health Clinic (FQHC) or Public Health.

Access to services and care will be increased, due to the access points being moved into a community site such as primary care. Stigma to mental health care access will also be reduced to this co-location approach that will ideally reduce the need for ongoing care, increase nurturing social supports, and increase the resiliency and wellness of the service participants.

6. Collaboration and System Enhancements

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

As previously mentioned, the services provided by this project will be located at the local Federally Qualified Health Clinic (FQHC).

The arrangement and partnerships with health services will involve brief behavioral health interventions such as therapy, linkage, brokerage, education, training and supportive services for clients and families at health sites, which will involve coordinating the delivery of these services between health staff and MCBHS staff. Memorandums of Understanding or similar agreements will be developed which will help clearly, yet flexibly, define staff roles in providing these services. The Four Quadrant Model developed by the National Council for Community Behavioral Health Services will likely be used as a framework to develop and implement these integrated health and mental health services. This is a model that addresses practice models as well as programmatic issues related to the delivery of integrated care. Integrated services models help increase timely access to care while providing opportunities to provide holistic care that addresses health and mental health conditions simultaneously. It has been well documented that, historically, when these conditions are not treated simultaneously, in a coordinated manner, the benefits of the individual services are not realized by clients and families.

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

There are no community-based mental health organizations located within Madera County other than MCBHS and its contract with Turning Point of Central California, Inc. (which is based in Tulare County) for its Wellness client-directed center, Hope House.

MCBHS will continue to work with its health care providers to implement the co-location of services with primary health to strengthen and build upon systems and provide referrals and support for appropriate services, as described. This strengthens and builds upon the local health system by providing timely access to care, especially for underserved populations that would be unlikely to seek mental health care. Currently, the various health care providers do see many underserved populations that need mental health care; however, linking these individuals and families to mental health care is often unsuccessful due to factors such as stigma, transportation, and amount of time away from work and family. The services proposed in this project and the Community Outreach and Wellness Center project will hopefully address these issues.

(Describe how resources will be leveraged.)

Partnering agencies will provide space, materials and supplies for the services to be provided. They may also provide In-kind staff time to support the project.

(Describe how the programs in this PEI project will be sustained.)

It is anticipated the Early Intervention project will initially be sustained through PEI monies and the leveraging of community resources of our partners. Plans for sustainability and/or future expansion of services will be developed, as resources are available. Cultural competency training needs as well as other technical assistance will be identified and provided accordingly.

7. Intended Outcomes

The Early Intervention Project

Co-location of staff with Physical Health Care Services

The outcome variables described below are intended to be quantifiable and measurable, while also being relevant indicators of wellness and resiliency.

(Describe intended individual outcomes.)

- Reduced stigma
- Increased knowledge about symptoms of mental illness
- Increased support from friends and family members

- Increased access to mental health care
- Increased follow through with treatment and medication
- Timely reduction of mental health symptoms such as depression and anxiety
- Reduced stress for family members of people with a mental health disorder or symptoms
- Earlier resolution of a mental health issues

(Describe intended system and program outcomes.)

Co-location of staff with Physical Health Care Services

- Accurate identification of people with mental health disorders
- Increased overall access to mental health care for underserved populations
- Increased community based supportive services that address mental illness early enough in its manifestation to prevent disability
- Increase in effective ways to link individuals that need ongoing care to appropriate care in a timely manner
- Increase in effective ways to link individuals to community resources needed that promote wellness
- Nurture social support network development opportunities that are non-stigmatizing and culturally appropriate
- Increased quality of care, due to integrated service delivery
- Expand community education, training opportunities and support for non-mental health professionals
- Expand system integration, including interagency and interdisciplinary collaboration
- Expand the use of multidisciplinary interventions

(Describe other proposed methods to measure success. What will be different as a result of the PEI project and how will you know?)

Through PEI funds, MCBHS will be hiring a Quality Improvement/Assurance Specialist. This position will help to develop and monitor outcomes and successes for the proposed programs.

Co-location of staff with Physical Health Care Services

Example Performance Indicator: Health status

Measure: 1) Degree to which the health status of clients is maintained and improved;
2) Degree to which clients report positive changes in the problems for which they sought help

Domain: Outcome

Data Source: Medical Records or Questionnaires

8. Coordination with Other MHSA Components

Describe coordination with CSS, if applicable.

PEI programs will be coordinated to serve as the first point of entry to wellness, resiliency and recovery mental health services and activities. As necessary, PEI services will connect clients, youth and family members to CSS programs and other mental health services available from MCBHS.

The MHSA stakeholders/steering committee will continue to advise, monitor and provide input and feedback on all MHSA programs.

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

WET funds will be used to purchase curriculums and training for the staff providing services through PEI programs. This will help with sustainability and will allow more PEI dollars to go to staff positions, as these one time cost will be covered with the one time WET funds.

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

As Madera County implements the portion of MHSA utilizing Capital Facilities and Technology funds, staff and/or programs may be housed in buildings or utilize technology paid through that MHSA component.

9. Additional Comments (optional—limit to one page)

None.

Community Outreach & Wellness Center

**Form
No. 4**

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

County Name: Madera Madera County Date: 3/13/09
 PEI Project Name: Connected Community Individual Experiencing Onset of Serious Psychiatric Illness
 Provider Name (if known): Negotiation with Turning Point
 Intended Provider Category: Family Resource Center
 Proposed Total Number of Individuals to be served: FY 08-09 0 FY 09-10 145
 Total Number of Individuals currently being served: FY 08-09 0 FY 09-10 _____
 Total Number of Individuals to be served through PEI Expansion: FY 08-09 0 FY 09-10 145
 Months of Operation: FY 08-09 0 FY 09-10 12

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			
0		\$0	\$0
0		\$0	\$0
0		\$0	\$0
0		\$0	\$0
0		\$0	\$0
0		\$0	\$0
0		\$0	\$0
0		\$0	\$0
b. Benefits and Taxes @ 0 %			
		0	0
c. Total Personnel Expenditures			
	\$0	\$0	\$0
2. Operating Expenditures			
a. Facility Cost			
	\$0	\$0	\$0
b. Other Operating Expenses			
	\$0	0	0
c. Total Operating Expenses			
	\$0	\$0	\$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Hope House Expansion	\$0	\$645,968	\$645,968
	\$0	\$0	\$0
	\$0	\$0	\$0
a. Total Subcontracts			
	\$0	\$645,968	\$645,968
4. Total Proposed PEI Project Budget			
	\$0	\$645,968	\$645,968
B. Revenues (list/itemize by fund source)			

		\$0	\$0	\$0
		\$0	\$0	\$0
		\$0	\$0	\$0
	1. Total Revenue	\$0	\$0	\$0
	5. Total Funding Requested for PEI Project	\$0	\$645,968	\$645,968
	6. Total In-Kind Contributions	\$0	\$0	\$0

COMMUNITY OUTREACH & WELLNESS CENTER (1)

FORM 4 - BUDGET NARRATIVE

A. Expenditures

Subcontracts/Professional Services: The estimated expenditure for this contract is \$645,968. Hope House is a drop-in center for client empowerment/socialization that has expanded to a Wellness/Recovery Center; The Wellness Recovery Action Plan Training has been utilized along with participants hired as staff, and peer support groups, and a town hall meeting for participants input for planned activities.

B. Revenue

1. New Revenues

There is no additional revenue anticipated for this program

Community & Family Education

**Form
No. 4**

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

County Name: Madera Madera County Date: 3/13/09
 PEI Project Name: Connected Community Children and Youth Stressed Families
 Provider Name (if known): Madera County Behavioral Health Services
 Intended Provider Category: Mental Health Treatment /Service Provider
 Proposed Total Number of Individuals to be served: FY 08-09 0 FY 09-10 100
 Total Number of Individuals currently being served: FY 08-09 0 FY 09-10
 Total Number of Individuals to be served through PEI Expansion: FY 08-09 0 FY 09-10 100
 Months of Operation: FY 08-09 0 FY 09-10 12

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				
0.50	Supervising Mental Health Clinician		\$39,222	\$39,222
1.00	Mental Health Clinician		71,510	71,510
0.33	MHSA Coordinator		25,886	25,886
0.50	Health Education Coordinator		26,040	26,040
1.25	Mental Health Case Worker		58,371	58,371
.0.50	Administrative Analyst		30,939	30,939
1.75	Program Assistant		61,807	61,807
1.00	Accounting Technician		39,389	39,389
b. Benefits and Taxes @ 25.88 %			123,332	123,332
c. Total Personnel Expenditures		\$0	\$476,496	\$476,496
2. Operating Expenditures				
a. Facility Cost		\$0	\$62,681	\$62,681
b. Other Operating Expenses		\$0	17,000	17,000
c. Total Operating Expenses		\$0	\$79,681	\$79,681
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
		\$0	\$0	\$08
		\$0	\$0	\$0
		\$0	\$0	\$0
a. Total Subcontracts		\$0	\$0	\$0
4. Total Proposed PEI Project Budget		\$0	\$556,177	\$556,177

B. Revenues (list/itemize by fund source)			
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$556,177	\$556,177
6. Total In-Kind Contributions	\$0	\$0	\$0

COMMUNITY & FAMILY EDUCATION (2)

FORM 4 - BUDGET NARRATIVE

B. Expenditures

2. **Personnel Expenditures:** The actual estimated expenditures are \$476,496.
 - a. **Proposed Staffing:** A 0.50 FTE Clinical Supervisor, 1.00 FTE Mental Health Clinicians, 0.33 FTE MHSA Coordinator, 0.50 Health Education Coordinator, 1.25 FTE Case Workers, 0.50 Administrative Analyst, 1.75 FTE Program Assistant, and 1.00 FTE Accounting Technician. Salaries are based on current Madera County salaries approved by the Board of Supervisors. **Total FTE: 6.83.**
 - b. **Proposed Staffing Justification:** The Clinical Supervisor and Mental Health Clinician will supervise the ongoing community education and cultural competence components of this program. The MHSA Coordinator and Health Education Coordinator will provide prevention/early intervention and outreach services. The Case Workers will provide linkage with the mental health system and community residents. The Program Assistant will provide direct support to the program staff. The Administrative Analyst and the Accounting Technician will provide statistical data collection for the program and develop and maintain the necessary data for reporting the outcome and other data requirements.
 - c. **Employee Benefits:** Benefits for the 6.83 FTE are based on the current Madera County benefits package that includes the following: FICA 0.0608, Medicare 0.0142, PERS 0.1622, and health insurance coverage of \$585.29 per month based on full time equivalency.
 - d. **Facility Cost:** The actual estimated expenditures are \$62,681. This includes translation and interpreter services. Travel and transportation staff will use a County van or will be reimbursed at 55 cents per mile if they use their own vehicle. This rate will be modified to the current rate as authorized by the Madera County Board of Supervisors. The Madera County Board of Supervisors adopts the current Internal Revenue Service business travel rate General Office includes the estimated costs for office supplies, phone system, cell phones, educational materials, program flyers and bulletins. Operating expenditures also include the building lease and utilities. The cost of obtaining the training material for Mental Health Aid, CASRA, and Love N Logic.
 - e. **Operating Expenditures:** The estimated expenditures for the purchase of one car in the amount of \$17,000.

B. Revenue

1. New Revenues

There is no additional revenue anticipated for this program.

School Based Services

**Form
No. 4**

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

County Name: Madera Madera County Date: 3/13/09
 PEI Project Name: Connected Community
 Provider Name (if known): Madera County Behavioral Health Services
 Intended Provider Category: Mental Health Treatment /Service Provider
 Proposed Total Number of Individuals to be served: FY 08-09 0 FY 10-11 90
 Total Number of Individuals currently being served: FY 08-09 0 FY 10-11 _____
 Total Number of Individuals to be served through PEI Expansion: FY 08-09 0 FY 10-11 90
 Months of Operation: FY 08-09 0 FY 10-11 0

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 10-11	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
_____		\$0	\$0
_____		\$0	\$0
_____		\$0	\$0
_____		\$0	\$0
_____		\$0	\$0
_____		\$0	\$0
_____		\$0	\$0
_____		\$0	\$0
b. Benefits and Taxes @ 0 %		\$0	\$0
c. Total Personnel Expenditures	\$0	\$0	\$0
2. Operating Expenditures			
a. Facility Cost	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$0	\$0
c. Total Operating Expenses	\$0	\$0	\$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
_____ Hope House Expansion	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
a. Total Subcontracts	\$0	0	\$0
4. Total Proposed PEI Project Budget	\$0	\$0	\$0
B. Revenues (list/itemize by fund source)			

		\$0	\$0	\$0
		\$0	\$0	\$0
		\$0	\$0	\$0
	1. Total Revenue	\$0	\$0	\$0
	5. Total Funding Requested for PEI Project	\$0	\$0	\$0
	6. Total In-Kind Contributions	\$0	\$0	\$0

SCHOOL BASE SERVICES (3)

FORM 4 - BUDGET NARRATIVE

C. Expenditures

Budget Expenditures: The actual estimated expenditures are \$0. As funds permit, there will be cost for the funding in two programs of Responding in Peaceful and Positive Ways Program (RIPP) and Human Services Academy (HSA) program providing Primary Intervention Program for Children and Youth in Stressed Families.

B. Revenue

1. New Revenues

There is no additional revenue anticipated for this program.

Focus on Early Intervention

**Form
No. 4**

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

County Name: Madera Madera County Date: 3/13/09
 PEI Project Name: Connected Community Trauma Exposed Individuals
 Provider Name (if known): Madera County Behavioral Health Services
 Intended Provider Category: Mental Health Treatment /Service Provider
 Proposed Total Number of Individuals to be served: FY 08-09 0 FY 10-11 0
 Total Number of Individuals currently being served: FY 08-09 0 FY 10-11 0
 Total Number of Individuals to be served through PEI Expansion: FY 08-09 0 FY 10-11 0
 Months of Operation: FY 08-09 0 FY 10-11 0

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 10-11	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
		\$0	\$0
		\$0	\$0
		\$0	\$0
		\$0	\$0
		\$0	\$0
		\$0	\$0
		\$0	\$0
		\$0	\$0
b. Benefits and Taxes @ %		\$0	\$0
c. Total Personnel Expenditures	\$0	\$0	\$0
2. Operating Expenditures			
a. Facility Cost	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$0	\$0
c. Total Operating Expenses	\$0	\$0	\$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$0
4. Total Proposed PEI Project Budget	\$0	\$0	\$0
B. Revenues (list/itemize by fund source)			

		\$0	\$0	\$0
		\$0	\$0	\$0
		\$0	\$0	\$0
	1. Total Revenue	\$0	\$0	\$0
	5. Total Funding Requested for PEI Project	\$0	\$0	\$0
	6. Total In-Kind Contributions	\$0	\$0	\$0

FOCUS ON EARLY INTERVENTION (4)

FORM 4 - BUDGET NARRATIVE

D. Expenditures

Budget Expenditures: The actual estimated expenditures are \$0. As funds permit, this program will fund staff in primary health care facilities providing Trauma Exposed Individuals.

B. Revenue

1. New Revenues

There is no additional revenue anticipated for this program

PEI Administration Budget Worksheet

Form No.5

County: Madera

Date: 3//13/09

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2008-09	Budgeted Expenditure FY 2009-10	Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator					0
b. PEI Support Staff					0
c. Other Personnel (list all classifications)					0
Administration		0.62		\$8,267	\$8,267
Fiscal		1.16		6,736	6,736
Quality Control		1.22		9,551	9,551
					0
d. Employee Benefits				8,528	8,528
e. Total Personnel Expenditures			\$0	\$33,082	\$33,082
2. Operating Expenditures					
a. Facility Costs			\$0	\$427	\$427
b. Other Operating Expenditures			\$0	4,617	4,617
c. Total Operating Expenditures			\$0	\$5,044	\$5,044
3. County Allocated Administration					
a. Total County Administration Cost			\$0	\$7,629	\$7,629
4. Total PEI Funding Request for County Administration Budget			\$0	\$45,755	\$45,755
B. Revenue					

PEI Administration Budget Worksheet

1. Total Revenue				\$0	
C. Total Funding Requirements			\$0	\$45,755	\$45,755
D. Total In-Kind Contributions			\$0	\$0	\$0

Mental Health Service Act Prevention and Early Intervention
Component Administrative Budget Worksheet
FORM 5 BUDGET NARRATIVE

A. Expenditures:

Personnel Expenditures

a. Other Personnel: Salaries are based on the current Madera County Salary Schedule approved by the Board of Supervisors. There are no significant changes in staffing categories.

Administration

The Behavioral Health Services (BHS) administrative staff (Director and Assistant Director) time related to Mental Health Services Act functions.

Fiscal

BHS fiscal staff (1.0 FTE Account Clerk, 2.3 FTE Account Technicians, 0.3 Accountant Auditor, and 1.0 FTE Staff Services Manager, plus 1.0 FTE Office Assistant) is responsible for human resources reporting, client account receivables, payment of outside vendors, contract development, and contract monitoring. The budget reflects the estimated staff time related to Mental Health Services Act functions. The actual estimated expenditures are \$6,736

Quality Control and Management

BHS quality control and management staff (1.0 FTE Staff Services Manager, 2.0 FTE Administrative Analysts, 1.0 FTE Clinical Supervisor, and 3.00 FTE Program Assists) are responsible for input of client services and reposting of the necessary data to the appropriate state department. The budget reflects the estimated time related to Mental Health Services Act functions. The actual estimated expenditures are \$9,551.

b. Employee Benefits

The personnel benefits are supported by the FTE's as disclosed in Exhibit 5 of the Mental Health Services Act Prevention and Early Intervention Component and Supports Administration Budget Worksheet. These expenditures are based on the current County Human Resources position allocation. Benefits rates of FICA at 0.0608, Medicare at 0.0142, PERS at 0.1622 and Health, Dental and Vision at an estimate of \$585.49 per month for each staff. The actual estimated expenditures are \$8,528.

1. Facility Cost:

The actual estimated expenditures are \$427. This includes the building lease and utilities.

2. Operating Expenditures:

The actual estimated expenditures are \$4,617. This includes Professional Services of the MIS contract based on the MHSA staff need of the client system and translation and interpreter services. Travel and outreach staff will use a County van or will be reimbursed at 55 cents per mile if they use their own vehicle. General Office includes the estimated costs for office supplies, phone and cell phones, educational materials, program flyers and bulletins.

4. County Allocated Administration

a. Countywide Administration (A-87): The countywide cost allocation for County Administration expenditures is estimated to be \$7,629. There is a signification increase due to the growth in Madera County Behavioral Health Services (BHS) Department. The growth has resulted in an increase in the BHS share of the A-87 plan costs.

**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:	Madera
Date:	3/13/2009

#	List each PEI Project	Fiscal Year			Funds Requested by Age Group			
		FY 08/09	FY 09/10	Total	*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
1	Community Outreach & Wellness Center	\$0	\$645,968	\$645,968	\$129,194	\$161,492	\$258,387	\$96,895
2	Community & Family Education		556,177	\$556,177	556,177			
3	School Base Services		0	\$0				
4	Focus on Early Intervention		0	\$0				
				\$0				
				\$0				
				\$0				
				\$0				
				\$0				
	Administration		45,755	\$45,755				
	Total PEI Funds Requested:	\$0	\$1,247,900	\$1,247,900	\$685,371	\$161,492	\$258,387	\$96,895

*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).

LOCAL EVALUATION OF A PEI PROJECT

(Form No. 7)

County: **Madera**

Date: **December 16, 2008**

- Check this box if this is a “very small county” (see glossary for definition) and the county is electing the option to waive the requirement to conduct a local evaluation of a PEI project. Very small counties electing this option do not need to complete the remainder of this form.

PEI Project Name:

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

The Connected Communities Program— Community and Family Education Project (Expansion and New)

These services include the expansion of existing and incorporation of new parent education programs and classroom management skills programs. These programs were the ones selected by the stakeholders as the most requested services. They include the expansion of parenting programs to include Effective Black Parenting Program and Los Niño’s Bien Educados. The expansion of the existing classroom management programs will include the Incredible Years (toddlers/preschool) and Love and Logic (elementary through high school).

Research-based prevention and wellness promotion that strengthen parenting and enhance child resilience can have a significant impact on the mental health of children and youth. The underlying premise is that it is better to promote mental health and prevent mental health issues before they begin. Fundamental to this approach is the issue of risk and protection. Research and practice have identified risk and protective factors that affect the vulnerability of children to mental health problems. Some of the risk factors, such as poverty and community violence, cannot be eliminated by a mental health program alone. However, many protective factors such as relationship skills, conflict management, and positive problem-solving can be taught to children, family members, teachers, and other caregivers. Mental health is everyone’s concern. Responsibility for promotion and prevention programs is shared across multiple systems, including schools, mental health care, juvenile justice, child welfare and substance abuse services, etc.

These issues are extremely important in Madera County. It is a small county with a large Latino population. This population has a large first and second Latino generations and a new third generation emerging. Their needs are different. Many do not seek traditional services as it is not part of their culture to do so. By having the programs go to them, in locations they feel comfortable and respected will assist the overall goals of the program.

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

The Connected Communities Project— Community and Family Education Program (Expansion and New);

These services (parenting skill education as well as teacher/classroom management behavior training) were selected because of the following:

- ***It addresses the most-often mentioned needs identified in the stakeholder process:***
 - ***Services to children and youth in stressed families***
 - ***At risk children and youth***
 - ***At risk young adult populations***

These programs were selected for local evaluation because they were the most requested programs selected by our stakeholders. They were the programs our community identified as being the most important.

In addition, these programs are evidenced-based or promising practice programs so as part of the fidelity to the program, outcome measures, consistent with those our community has prioritized, have been developed. Madera County will follow the fidelity of the program in utilizing the standardized program outcome measures and measurement tools.

Overall Goals of the Community and Family Education Program

Goals for the program include;

1. Convenience of the program locations
 - Important to know if we are succeeding in bringing the program to the community rather than the community coming to us, thereby increasing access
2. Convenience of program hours of operation
 - Important to know if the times the program is offered are convenient for the participants to attend
 - Emphasizes the Department bringing the program to the community rather than the community coming to the Department.
3. Children and youth have nontraditional (school and community) portals of entry to prevention services and supportive services
 - Part of MHSA transformation
 - When necessary, link children and families to a network of supportive services, e.g., food, clothing, shelter, recreation, employment for parents and appropriate mental health and social services
4. Persons served will have improved functioning at home with their children and family members from prior to taking the course(s) to after taking the course(s). e.g., improved sense of well-being, greater confidence in their parental roles, improved communication, etc.
 - Research has shown reductions in aggression, conduct disorders, ADHD and oppositional defiant disorder as a benefit of family skills training
 - Research has shown the prevention of child abuse, later drug use and delinquency (risk factors)

- Provide prevention strategies that are based on individual and family needs, strengths and resiliencies through the encouragement of wellness, personal empowerment and growth
 - Increase in self-esteem
 - Increase in positive behaviors
5. Improve the relationship between the at-risk child and teachers (school personnel)
- At-risk students who lack positive relationships with their teachers and other adults at school will be more likely to engage in academic activities and are less likely to drop-out before they graduate
 - Research has shown that resiliency factors or “developmental assets” help children avoid academic failure, emotional problems, criminal behavior, substance abuse and other negative outcomes
 - School staff and faculty will be able to recognize developing signs and symptoms associated with emotional disturbance or mental disorders, substance abuse or suicidal risk.
 - School staff and faculty will be able to make appropriate referrals for services should they become necessary

PERSONS TO RECEIVE INTERVENTION

(Numbers reflect people served for FY 09—10 when program is implemented)

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ON-SET	CHILD/ YOUTH STRESSED FAMILIES	CHILD/ YOUTH SCHOOL FAILURE	CHILD/ YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/ DISCRIMINATION
<u>ETHNICITY/ CULTURE</u>							
African American			25				
Asian Pacific Islander							
Latino			50				
Native American							
Caucasian			25				
Other (Indicate if possible)							
<u>AGE GROUPS</u>							
Children & Youth (0-17)							
Transition Age Youth (16-25)							
Adult (18-59)			100				
Older Adult (>60)							
TOTAL			100				
Total PEI project estimated <i>unduplicated</i> count of individuals to be served <u>100</u>							

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

The program will be required to gather data and report participant demographic data (age, ethnicity, geographic location, language, etc.)

Program will be required to report contacts on a monthly basis.

Program will be required to supply a logic model and evaluation plan narrative that will address:

- Collection of client demographic data
- Maintaining records of client participation, training provided to staff, etc.
- Assist evaluator in developing and administering any program assessment tools
- MCBHS data as appropriate.

The following are the outcomes, data collection and objectives for the various courses that make up this program

No.	Performance Indicator Name	Measure	Concern	Domain	Data Source
1.	Convenience of program locations	Number of positive responses to a survey question regarding location / total number of responses, e.g., The location of services was convenient (i.e., parking, public transportation, distance, etc.)	Access to program, transportation to program	Access	Participant survey
2.	Convenience of program hours of operation	Number of positive responses to a survey question regarding convenience / total number of responses, e.g., services were available to me at times that were good for me	Access to program, availability of program (waiting times)	Access	Participant survey
3.	Children and youth have nontraditional (school and community) portals of entry to prevention and supportive services (part of MHSA transformation)	Number of positive responses to a survey question regarding knowledge and use of community resources available for supportive services / total number of responses, e.g., I know where to go to get help with questions about parenting, I know where to go to get help if I think my child is developing a mental health issue, etc.	Access to services in the community, knowledge of services in the community	Access	Participant survey
4.	Persons served will have improved functioning at home with their children and family members from prior to taking the course(s) to after taking the courses, e.g., improved sense of well-being, greater confidence in their	Number of positive responses to standardized questionnaires from pre-test / number of positive responses from post-test (tests provided by the evidenced-based programs)	Persons will have improved functioning/relationships with their children	Outcome	Pre and post-tests given by the evidenced-based programs as part of providing fidelity to the service

	parental roles, etc.				
5.	Improve the relationship between the at-risk child and teachers (school personnel)	Number of positive responses to standardized questionnaires from teachers, classroom personnel, etc., from pre-test / number of positive responses from post-test (tests provided by the evidenced-based programs)	Classroom personnel will be able to increase warm, positive responses towards students	Outcome	Pre and post-tests given by the evidenced-based programs as part of providing fidelity to the service

**Summary of Pre-Post Test Program Effects/Outcomes
Parenting Skills Education Programs**

	<i>Parental Acceptance- Rejections</i>	<i>Parenting Practice Objectives</i>	<i>Family Relations Objectives</i>	<i>Child Behavior Problems/Competencies Outcomes</i>
Number of families/parents	Reduction in subtle forms of rejection (undifferentiated)	Trend to increase use of praise	Improvement in parent-target child relations	Reduction in withdrawn behaviors
		Trend to increase a variety of warm and accepting practices		Reduction in delinquent behaviors
				Reduction in sexual acting-out problems
Number of families/parents	Reduction in hostile/aggressive rejection practices	Trend to decrease use of hitting	Improvement in parent relations with other family members	Reduction in delinquent behaviors
		Trend to decrease a variety of hostile and aggressive practices		Increase in competencies
		Increase in the use of praise		

**Summary of Pre-Post Test Program Effects/Outcomes
Classroom Management Programs**

<i>Interventions</i>	<i>Skills Targeted</i>	<i>Person Trained</i>	<i>Settings Targeted</i>	<i>Outcomes</i>
Teacher Classroom Management	Classroom management skills <ul style="list-style-type: none"> • Promoting parent involvement • Proactive teaching strategies • Effective praise & incentive systems • Managing misbehavior • Promoting social skills & problem solving 	Teachers	Home/school	Decreases in teachers' harsh and critical discipline Improved communication between students and school personnel Increase positive relationships between school personnel and students, e.g., empathy, warm and accepting behaviors Increase in praise, warm and accepting practices Reduce rejections of child by school personnel Reduction in delinquent, withdrawn and hyper-active behaviors

5. How will data be collected and analyzed?

The Connected Communities Project—Community and Family Education Program (Expansion and New)

The data will be collected and analyzed as described in the chart above and by the specific programs listed below. The data will be used to inform stakeholders, provide a feedback mechanism for the program, identify areas for quality improvement, collaborate with community organizations to improve service delivery systems and establish goals and standards.

Data Collection

Parent Skills Education Programs

Data will be collected and analyzed by program and internal evaluator staff using;

- Client demographics
- Referral forms
- Program reports
- Pre-class surveys of behaviors, etc.
- Post class surveys of behaviors and changes in behaviors after training including follow-up surveys after six months
- Satisfaction surveys
- Record keeping of client attendance
- Completion of homework assignments

There will be certain forms completed by the instructors to reflect program fidelity in teaching the courses. There will be session-by-session curriculum implementation forms filled out by the instructors to reflect fidelity of program implementation and problems encountered. Any necessary changes that need to be made regarding the delivery of the training, improvement of the program, etc. will be considered and if appropriate, implemented.

Questionnaires taken by the parents will explore the following:

- Whether a child's skills are developing along the lines of other children the same age.
- Whether any of a child's behaviors should be considered as problems.
- If a child has been exposed to conditions that put her/him at risk for future difficulties which could lead to risks for mental health conditions.

Further the questionnaires will allow;

- Immediate feedback on skills, behaviors and risk exposure that informs if something should be done immediately.

The questionnaires also have Result Pages showing the child's current status, indicating the child is either:

- Developing according to norms or;
- May have special needs that may require immediate professional attention.

Result Pages can be used as a record of the child's growth, and can be shared with doctors, teachers and family members. Furthermore, each participant will be able to receive referrals to a variety of professionals, community agencies and websites, such as:

- Pediatric Consultations and Health Services
- Referrals to Psychologists for Developmental Assessments
- Information and Referral Agencies
- First Five
- The Regional Centers for Disabilities
- School District Programs
- Mental Health Agencies
- Child Care Referral Agencies
- Head Start Centers
- Social Service Agencies
- Websites and Organizations for Parents in General
- Websites and Organizations About Children with Special Needs

Each class and seminar will be evaluated by having the parents complete the standardized questionnaires provided through the evidenced-based program. Questionnaires will be given before the start of the class or seminar and at the end of the class or seminar. These rated questionnaires will test the parents on the effective parenting concepts, skills and strategies that were taught in the program (pre-post test design). This method allows for determining whether the parents made significant gains from the beginning to the end of the classes and seminars.

At the end of each class, the parents will also be asked to speak about changes they had observed in themselves and their children as a result of using the skills and strategies from the program. These parents will have ample time to observe such changes, as classes may be conducted from two to 12 weeks.

A similar set of questions about parent and child behavioral change will be asked of parents who attend the one-day seminars. Here, however, the parents will have to indicate the changes they expect to see as a result of their participation in the seminar,

since they had not had any time to actually apply what they had learned. So, for the seminar parents, the behavior change questions address their expected or anticipated changes.

A third method for evaluating the impact of the classes and seminars may be used. This method utilizes a series of rated questions about what they learned from the classes/seminar. There is also an evaluation of the instructor of each class and seminar.

Data Analysis

Evaluation results on program effectiveness will be conducted. The following will be examined;

- Reductions in different varieties of parental rejection (risk factor reduction)
- Trends and results in terms of increases in the use of positive parenting practices (protective factor enhancement)
- Decreases in use of negative practices (risk factor reduction)
- Trends and improvements in the quality of family relationships (protective factor enhancement)
- Reductions in delinquent, withdrawn and hyperactive behaviors (risk factor reduction)
- Trends and differences in social competencies (protective factor enhancement)

There will be pre and post tests administered in addition to one-year follow-up surveys for those wishing to participate. These surveys will measure maintenance in most of the positive program effects, slippage back to pre-program levels on certain variables and enhanced performance on other variables. If there is slippage, there will be booster sessions to help parents to stay on the path of success for their children.

Data Collection Classroom Management Training

Assessment Forms & Tools

The assessment tools consist of a combination of teacher's reports of their classroom's emotional climate. These assessment tools can be completed prior to starting the programs and again upon completion of the programs. In addition, there are program evaluations to be completed at the end of the programs.

To assist in these evaluation activities, the evidenced-based programs provide a variety of tools and forms. As the program develops, MCBHS will be in contact with Incredible Years and Love and Logic to determine which of the instruments listed below would be best for the various modules/programs as they are implemented.

Customer Satisfaction Forms

These are the standardized forms that are to be issued as part of maintaining the evidenced-based program fidelity. They will measure the satisfaction of the personnel and show needs for future training on behavior issues that may impact risk for mental health issues.

- Best Practices Inventory for Teacher Classroom Management
- Teacher Evaluation of Classroom Program
- Teacher Classroom Management Satisfaction Questionnaire
- Teacher Workshop Evaluation Form

Teacher Special Services Forms

These are the standardized forms that are to be issued as part of maintaining the evidenced-based program fidelity. They will measure the satisfaction of the personnel and show needs for future training on behavior issues that may impact risk for mental health issues.

- Survey - Teacher Report of Special Services

Teacher Strategies Questionnaire

These are the standardized forms that are to be issued as part of maintaining the evidenced-based program fidelity. They will measure the satisfaction of the personnel and show needs for future training on behavior issues that may impact risk for mental health issues.

- Teacher Strategies Questionnaire
 - This questionnaire asks teachers to rate the frequency with which they use a number of teaching strategies and their ratings of the usefulness of each strategy.
- Teacher Strategies Information
 - Summary scales and internal consistency scores.

Analysis of program effectiveness will be conducted. The following will be examined for each of the Classroom Management Programs and the need for further training on prevention of mental health issues.

These various outcomes will be measured depending upon the standardized assessment tools implemented for each of the programs. MCBHS will work with Incredible Years and Love and Logic to analyze the data from the appropriate standardized assessment tools.

Data will be analyzed by MCBHS MHSA staff. The data will be examined for future training needs by school personnel on risk and protective factors regarding mental health issues. Data will be reported to MCBHS staff/administration and to the Steering Committee, Mental Health Board and other entities as appropriate, e.g., State DMH, MC Board of Supervisors, External Quality Review Organization (EQRO), etc.

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

The programs, Effective Black Parenting and Los Niño's Bien Educados are evidenced-based, culturally appropriate programs for working with those populations. Effective Black Parenting is the country's first culturally-adapted parenting skill-building program for parents of African American children. Successful field testing recognized the need for a parenting skill-building program that addresses issues that are specific to African Americans.

Los Niño's Bien Educados teachings have been reframed around the unique Latino American value of raising children to be "bien educados" (well-educated in a social sense as well as an academic sense, including knowing one's place in the family and being respectful of adults and elders). Content regarding the meaning of "bien educados" is included in the program. Instructional units on traditional family roles and the types of acculturation adjustments that Latino American families make to life in the United States are included. The program uses Spanish proverbs (dichos) to help ground the teaching of the program skills in a culturally and linguistically familiar mode. This culturally-adapted program is also translated into Spanish. Therefore it is a translated and transculturated program. Whenever appropriate and possible, the Los Niño's Bien Educados training to Latino families will be done in Spanish.

A good example of how the research that confirmed the centrality of the value of "bien educados" is as follows. The parenting program which originated the Los Niño's Bien Educados program, teaches parents how to pinpoint those troublesome child behaviors they want to see less and to pinpoint those they want to see more. Behavior consequence skills to change the future frequency of these "inappropriate" and "appropriate" child behaviors are taught.

This basic strategy was reframed by having the Los Niño's Bien Educados Program start with asking the parents their definitions of what "bien educados" means (being respectful, etc.). They then describe their general definitions into the specific behaviors they view as reflecting when a child is behaving in a "bien educados" fashion (when he speaks in a polite tone of voice to his parents or elders, etc.). The orienting of the parents is that the program will be teaching skills to help them bring out more of the "respectful" behaviors of their children that they define as characteristic of a child who is "bien educados". A similar procedure is used to help the parents define child behaviors that they see as being reflective of a child who is behaving in a "mal educados" fashion, and here they are oriented that the program will teach methods to diminish these "disrespectful" behaviors, etc.

Parenting programs that respect and honor one's culture are not only maximally effective in getting parents to use the skills that they teach, they also lead to a sense of group ownership and are seen as vehicles for advancing the group as a whole. These are goals that are unlikely with non-culturally specific interventions. The long range goal will be to have parents guide their children's

development away from delinquency, dropping out and substance abuse. It is important to have them experience a sense of pride in their heritage. Short-term goals are to reduce family risk behaviors and increase child protective factors.

Madera County has a large Latino gang problem as well. There are methamphetamine labs within the county borders which according to the Madera District Attorney's Office are operated through the Mexican Mafia. The strategies chosen have evidenced-based outcomes that help to reduce the behaviors that would cause youth to seek gang membership and commit violent activities.

The Classroom Management programs have been culturally adapted to meet the needs of the Latino population. Again, by educating school and classroom personnel about the various cultures within Madera County, it will help to reduce risk behaviors and increase child protective behaviors.

Parents and other caregivers are a child's first and foremost teachers. Promotion and prevention programs that address issues of parents and other caregivers increase the potential of positive outcomes. Family members and caregivers should be equal partners, along with school and community leaders in selecting, implementing, evaluating, and sustaining programs. Parents and other caregivers are more likely to be involved if services are provided in easily accessible settings and if they are culturally and linguistically appropriate. This is Madera County Behavioral Health Services plan through providing these services that are culturally appropriate and in places where the population "normally" gathers.

School settings present a key opportunity to reach out with evidence-based programs to parents and other caregivers. The social and emotional skills taught by the programs listed usually have a positive impact on improving academic achievement.

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

All of the staff providing these programs will be extensively trained. They will follow the scripted Instructor's Manual as they run the program to increase fidelity of program implementation.

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

MCBHS will report findings to the MHSA Steering Committee, Mental Health Board, External Quality Review Organization (EQRO) Quality Improvement Committee, Turning Point and any interested clients/community partners. Reports will be made available on the MCBHS MHSA Website. Data will be discussed in the various meetings listed above and in Quality Improvement meetings.

Feedback regarding the data will be incorporated into the program to continuously improve the services provided. The feedback will be acknowledged that it was appreciated and received. This will help to establish benchmarks for the program. It will also help to integrate with other internal and external performance measures.