

County Name: El Dorado

Date: November 10, 2009

FORM #1
MENTAL HEALTH SERVICES ACT (MHSA)
PREVENTION AND EARLY INTERVENTION COMPONENT
OF THE THREE-YEAR
PROGRAM AND EXPENDITURE PLAN
Fiscal Year 2009-10 Request

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

County Mental Health Director	Project Lead
Name: Neda West	Name: Christine Kondo-Lister, LCSW
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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 2009-10 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief the administration budget and all related program budgets in all respects are true, correct and in accordance with the law. I have considered non-traditional mental health settings in designing the County PEI component and in selecting PEI implementation providers. I agree to conduct a local outcome evaluation for at least one PEI Project, as identified in the County PEI component (optional for "very small counties"), in accordance with state parameters and will fully participate in the State Administered Evaluation.

Signature _____
Health Services Department Director

Date

Executed at Placerville, California

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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 MHA Project Management Team was responsible for the Community Program Planning Process. Representation from the Division was widespread and included participation of extra help staff, volunteers, family and consumer (adult and TAY) community members. Phase I for CSS planning took place between February and October 2005 and provided us with a strong foundation of community connection and feedback. This phase was staffed by 33 individuals – some of whom were not involved in the Phase II nor on staff at the time of the Phase II process.

EI Dorado County Mental Health MHA Roles

Staff Member	Role/Functions	Average time per week
<i>Barry Wasserman, LCSW</i>	<i>Director/Project Leader</i>	<i>5 hours/12.5%</i>
<i>Chris Kondo-Lister, LCSW</i>	<i>QI Program Manager/Project Manager/Facilitator for Advisory and Writing Teams</i>	<i>32 hours/80%</i>
<i>Fay Sady, MSW</i>	<i>Project Facilitator/Outreach Coordinator</i>	<i>36 hours/100%</i>
<i>Rendy Criddle</i>	<i>Administrative Support</i>	<i>16 hours/50%</i>
<i>Carolina Meyer</i>	<i>Consultant, Cultural Competency and Data Management</i>	<i>32 hours/100%</i>
<i>Debra Brown, MSW</i>	<i>Outreach Social Worker</i>	<i>Extra help, 15 hours</i>
<i>Kaiahmi Quasne</i>	<i>Mental Health Aid/Outreach and Administrative Support</i>	<i>Extra help, 20 hours</i>
<i>Kim Brehm</i>	<i>Mental Health Worker/Outreach</i>	<i>Extra help, 8 hours</i>
<i>Anita Wallace</i>	<i>Parent Partner</i>	<i>Extra help, 2hours</i>
<i>Gregory Shaffer</i>	<i>Consultant</i>	<i>80 hours total</i>
<i>Mike Wright</i>	<i>Mental Health Aid/Administrative Support</i>	<i>Extra help, 10 hours</i>
<i>Deanna Hokansen</i>	<i>Mental Health Aid/Committee Member and Outreach</i>	<i>Extra help, 2 hours</i>
<i>Nancy Harp</i>	<i>Mental Health Aid/Committee Member and Outreach</i>	<i>Extra help, 2 hours</i>
<i>John Prock, MFT</i>	<i>WS Adult Services Program Manager/Workgroup</i>	<i>4 hours/10%</i>
<i>Sharon Colombini, MFT</i>	<i>WS Day Rehab Coordinator/Workgroup and Writing Team Member</i>	<i>4 hours/10%</i>
<i>Jane Williamson</i>	<i>WS Geriatric Specialist & Workgroup Member</i>	<i>4 hours/10%</i>

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EI Dorado County Mental Health MHA Roles (continued)

Staff Member	Role/Functions	Average time per week
<i>Carl Bower</i>	<i>Mental Health Aid/Committee Member and Outreach</i>	<i>Extra help, 4 hours</i>
<i>Lise Wright</i>	<i>Mental Health Aid/Committee Member and Outreach</i>	<i>Extra help, 2 hours</i>
<i>Darryl Keck, LCSW</i>	<i>Children's Services Program Manager/Workgroup and Writing Team Member</i>	<i>4 hours/10%</i>
<i>Cheree Haffner, LCSW</i>	<i>WS Children's Services Coordinator/ Workgroup and Writing Team Member</i>	<i>4 hours/10%</i>
<i>Sally Williams, LCSW</i>	<i>SLT Children's Services Coordinator/ Workgroup and Writing Team Member</i>	<i>4 hours/10%</i>
<i>Sandra Branton, Ph.D.</i>	<i>SLT Adult Services Program Manager/ Workgroup and Writing Team Member</i>	<i>4 hours/10%</i>
<i>Arlene Hayward</i>	<i>SLT Day Rehab Coordinator and Geriatric Specialist/ Workgroup and Writing Team Member</i>	<i>4 hours/10%</i>
<i>Matthew Le Pore</i>	<i>Finance Director/Writing Team Financial Consultant, Budget Development</i>	<i>Varies</i>
<i>Bob Kamena</i>	<i>Day Rehab case manager/workgroup member</i>	<i>Varies</i>
<i>Rebecca Norris</i>	<i>Adult services clinician/workgroup member</i>	<i>Varies</i>
<i>Cathy Leonard</i>	<i>Community Volunteer</i>	<i>1 hour</i>
<i>Terry White</i>	<i>Day Rehab Clinician/workgroup member</i>	<i>Varies</i>
<i>Brian Long</i>	<i>Administrative Support</i>	<i>Varies</i>
<i>Yolanda McGillivray</i>	<i>Administrative Support/Latino Outreach</i>	<i>Varies</i>
<i>Cheryll Kent</i>	<i>Administrative Support</i>	<i>Extra help/varies</i>
<i>Kevin Wilson</i>	<i>Information Technology Specialist</i>	<i>Varies</i>
<i>Marlene Hensley</i>	<i>Psychiatric Health Facility Program Manager/Outreach</i>	<i>Varies</i>

Phase II, for PEI planning, took place between April 2007 and August 2009. This phase was staffed by 11 people. This team was comprised of individuals from the Administrative staff, Adult and Children's services, and Quality Improvement Team. Membership also included family members, bilingual/bicultural Spanish-speaking individuals, and representation from the LGBT community.

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Staff Member	Role/Functions	Average time per week
<i>John Bachman</i>	<i>Director</i>	<i>Varies</i>
<i>Chris Kondo-Lister</i>	<i>MHSA Project Manager</i>	<i>20 hours/week</i>
<i>Stephanie Carlson</i>	<i>Administrative Technician</i>	<i>30 hours/week</i>
<i>Trish Haines</i>	<i>Mental Health Worker</i>	<i>20 hours/week</i>
<i>Carolina Meyer</i>	<i>Sr Dept Analyst</i>	<i>16 hours/week</i>
<i>Luz Villarreal-Zeagler</i>	<i>Bilingual Clinician</i>	<i>Varies</i>
<i>Prestine Skinner</i>	<i>Patient Rights Advocate</i>	<i>Varies</i>
<i>Fay Sady</i>	<i>Mental Health Clinician</i>	<i>Varies</i>
<i>Debra G. McCartney</i>	<i>Program Manager</i>	<i>Varies</i>
<i>Maureen Focht</i>	<i>Parent Educator</i>	<i>Varies</i>
<i>Debbie Brown</i>	<i>Mental Health Clinician</i>	<i>Varies</i>

This planning period was prolonged due to the fiscal crisis experienced by EI Dorado County (EDC) EDC Mental Health and the integration of the former Mental Health Department and the former Public Health Department into a new Health Services Department. In conjunction with this merger, many programs within the Mental Health Division (MHD) of the Health Services Department were significantly redesigned, a new cost accounting system was put into place, and MHD staffing was significantly reduced through several phases of a Reduction In Force (RIF).

b. Coordination and management of the Community Program Planning Process

Resources to lead and facilitate a collaborative, county-wide planning process were obtained in a variety of ways:

For Phase I:

- A core Project Management Team was created by designating 80% of the Quality Improvement Program Manager’s time to function as a project manager, hiring a project facilitator and outreach coordinator, and increasing two part-time administrative support positions. Later, consultants were hired to assist with the application writing, data and cultural competency components. ***Under the supervision of the Director, the Project Manager had overall responsibility for developing and executing the planning process.***
- The seven member Management Team provided ongoing consultation for the planning process and three of the Clinical Program Managers served as content experts in the workgroups and writing teams. The Managers and Director were also recruited to contribute to the county-wide outreach efforts.
- Extra help positions staffed by consumers and community members were used at various times to provide administrative support and to participate in the outreach efforts.
- Additional staff members participated in the workgroups and/or writing teams on an ongoing basis.

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- Some staff members participated in the workgroups, on an as needed basis.
- Other staff members participated in aspects of the planning process, as needed.

For Phase II:

- A core Outreach Team was created under the leadership of the Deputy Director/MHSA Project Manager (20 hours/week). ***Under the supervision of the Director, the Project Manager had overall responsibility for developing and executing the planning process.***
 - Four members of the Administrative Team, three members of the Quality Improvement Team, two members of the Adult Services Team, one member of the Children’s Services Team, and an Extra Help employee were brought together to staff this effort.
- c. Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process

The Setting

El Dorado County encompasses a large geographic area (1,711 square miles) with a relatively small population (an estimated 178,000 in 2006). The County seat, Placerville, is located in a region known as the Western Slope (WS), and is surrounded by small, rural communities and unincorporated areas. South Lake Tahoe (SLT) is the most densely populated area of the County and features a resort community, a sizable transient community, and is much more ethnically diverse than the Western Slope. These two regions are connected by a 60 mile mountainous stretch that can be a difficult and time-consuming drive, particularly during the winter months. Local communities and services have developed out of the distinct characteristics of each of these regions and have historically operated quite independently. Based on 2000 Census data, approximately 22.5% of the population lives in the South Lake Tahoe region and 77.5% lives outside of this region which is essentially the Western Slope region.

In 2008, El Dorado County was designated as a geographic mental health professional shortage area with a Health Resources and Services Administration or HPSA score of 14. The federal government uses HPSA scores to “rank” designated communities in times of scarce resources. The highest score a community can receive is 26; the lowest is 0.

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Where do people in EI Dorado County live?

	South Lake Tahoe Region Rate	Outside of SLT Region Rate	EI Dorado County Total
Total Pop	22.5%	77.5%	100%
Ages			
0-19	22.1%	77.9%	100%
15-24	29.7%	70.3%	100%
20-59	24.7%	75.3%	100%
60+	16.1%	83.9%	100%
White	16.9%	83.1%	100%
Latino	64.4%	35.6%	100%
Other	38%	62%	100%

Therefore, the county-wide collaborative planning efforts for the MHA programs involved striking a critical balance between respect for and acknowledgement of regional differences and a need to work as a county-wide community. Since traveling between the two regions is sometimes not feasible due to inclement weather, the Division conducts teleconferences for MHA county-wide planning meetings.

Various levels of participation

A key feature of ensuring comprehensive and representative participation was providing a range of avenues for input and decision-making. Opportunities to participate in the Community Program Planning (CPP) process were ensured by mechanisms for information dissemination (announcements in meetings and groups attended by stakeholders, posted fliers, mass mailings, and the MHA website providing meeting announcements, updates, and meeting minutes), education and training, outreach (comprehensive and targeted), open planning meetings, and a representative MHA Advisory Committee. Options for anonymous input included a local phone line with a voice mailbox, an e-mail address, and use of written and online surveys. Outreach efforts included community meetings, readiness trainings, focus groups and key informant interviews which were intended to offer convenient one-time opportunities to gain information about the MHA and to offer feedback. The detailed planning occurred in the planning and advisory committee meetings which were arenas for ongoing involvement. During Phase I, a mailing list of 390 individuals was created and over 500 survey questionnaires were completed. During Phase II, the mailing list expanded to 450 and over 185 survey questionnaires were completed.

EI Dorado County’s efforts to ensure a comprehensive and representative MHA planning process included the following accomplishments during Phase I:

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- 82 focus groups and readiness trainings reaching 925 respondents
- 23 key informant interviews
- 5 written surveys with a total of 545 responses
- An MHSA mailing list of 390 individuals used to send out announcements, surveys, meeting notifications, and updates.
- Local media (newspapers, cable television and radio) were used to announce community meetings and to inform the public of the MHSA planning activities and contact information.

In addition, the targeted outreach strategy that characterized Phase II ensured that we contacted the following groups via focus groups and/or use of key informant interviews:

County Mental Health Staff
Mental Health Commission Members
MHSA Program members (current consumers)
Women’s Center staff
NAMI members
CASA (Court Appointed Special Advocates) volunteers (TAY program)
Shingle Springs Rancheria (Native American services provider, tribe members and elders)
Youth Commission members
MORE (Mother Lode Rehabilitation Enterprises, Inc.) Disabled adults program – staff members
PFLAG (LGBT program) - volunteers
Caregivers Support Groups (various)
United Outreach (homeless services agency) - volunteers
Local Collaboratives
Headstart – Latino parents
Youth Groups (various)
Adult Drug Court Interdisciplinary Team
Teen Drug Court Representative
Juvenile Hall staff member
Alcohol and Drug Program (ADP) providers
School Nurses
School Psychologists
County Office of Education representative
Faith-based community organization members
Foster Parent Association - Representative
First 5 Commission Representative
County Office of Education – staff members
Public Guardian’s Office – staff members
Early Childhood Council - Representative
Department of Human Services – staff members
School District Superintendents – staff members

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County Public Health staff
 Medical Library staff
 County Veterans Services Office
 Head Start - employees
 Family Resource Centers – staff members
 City Police
 County Sheriff Department
 County Superior Court
 District Attorney’s Office
 Public Defender’s Office
 State Department of Rehabilitation
 Medical Centers, Clinics, Hospitals
 Council for Disabilities
 Holistic Medicine Practitioners

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

During Phase II, targeted outreach (focus groups, key informant interviews, and use of written and on-line surveys) to the following groups was used to ensure input from un-served and underserved populations and their family members. Focus groups typically targeted more than one individual with similar characteristics (youth, teachers, parents) to ask for their input regarding needs and proposed ideas for PEI services. Key Informant Interviews were 1:1 interviews often targeting a content expert or someone who was difficult to reach in the context of a group, to ask for feedback regarding PEI needs and services. These strategies, like the surveys, were used to obtain feedback from parties who might otherwise not attend a planning meeting, community meeting, or public hearing, etc. The following groups and individuals participated in Phase II in focus groups or key informant interviews:

Developmentally disabled population	1
First 5 commission representative	1
Early childhood council representative	1
Church youth group	46
Youth commission members	9
High School Youth panels	57
TAY supported education class	9
Teen court representative	1
TAY court volunteers	15
Juvenile Hall representative	1
PFLAG members	2
Women’s Center	19

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Headstart, parents, Latino	8
Incredible Years parents	4
Foster parent association	1
NAMI	14
Caregivers Support Group members	10
Church-based ESL class students	25
Latino Family Resource Center	1
Native American individuals	22
Native American Resource Collaborative	11
Staff in Alcohol and Drug Treatment facility	32
MHSA Homeless TAY and adults consumers	7
Volunteer Homeless Service Providers	2
County veterans service office representative	1
Public Guardian representative	1
El Dorado Community Foundation	1
Project Uplift (Older Adults MHA Services)	1

(Bold lettering indicates participation in Planning and/or Advisory capacities, as well.)

Local under-represented and un-served groups include homeless individuals, consumers and their family members, older adults, individuals with disabilities, and youth, the LGBT population, and individuals of ethnic minority groups, with co-occurring disorders, and veterans. Representatives of each of these stakeholder groups was reached in this effort.

Some additional examples in which MHA CPP outreach occurred as a result of participation in other existing activities include the following: an outreach team member visited three local assisted living centers for seniors during a large traditional community event thereby connecting a significant audience; homeless individuals not yet engaged in treatment (outreach clients) and those receiving MHA services were engaged in a drop in and treatment setting; consumers receiving services – including those in Board and Care placements – were reached in connection with their participation in Community Integration activities; and MHA information exchange occurred regularly in a local consumer support group.

- 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.

Context:

Ensuring that the staff capacity, knowledge and skills are in place to address the County diversity issues is an ongoing challenge that is being addressed as part of the MHA program development process. During the MHA PEI CPP process, two MHA Project Management Team members received training

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regarding use of the California Brief Multicultural Competency Scale - a diversity-training tool designed specifically for mental health practitioners with the goal of moving from cultural sensitivity to cultural competence. The goal has been to provide local Division-wide training for staff and community members over time. Implementation of this strategy, along with other strategies to address diversity of culture and language, have been significantly impacted by the Reduction in Force that took place this past year. We have lost staff capacity related to this training, diversity, and interpretation and translation skills. Yet, the initial stage of this training process is reflected in this year's Quality Improvement Committee plan as part of the Cultural Competency sub-committee plan.

Race/Ethnicity:

The County demographics based on the 2000 Census were used during the MHSA CSS planning phase – a re-assessment pending the Census findings in 2010 will need to be conducted. To date, however, the EDC population profile is, as follows:

Race/Ethnicity:

African American	0.7%
Asian American	2.7%
Latino	11.0%
Native American	1.4%
Caucasian	82.0%
Other	2.2%

Targeted outreach occurred where there were known groups or places where the Latino and Native American populations could be reached (English as a Second Language/ESL classes, Latino Family Resource Center, and the Rancheria). Together with the Caucasian population, this comprises 94.4% of the County population. The challenge is significant in relationship to outreach to the African American and Asian populations – together they comprise 3.4% of the county population – and we have not yet identified any particular group or setting to target for outreach purposes. It is unclear what comprises the category of “Other” but there is a growing population of Russian immigrants in the western county area closer to Sacramento. We have identified one potential contact person by which to begin to reach this population and a few of these stakeholders were represented in an outreach group.

Youth with disabilities, African American and Asian middle school students were among youth reached in the context of a special all day event which targeted youth who self-identified with a unique group or identity – typically along the lines of race/ethnicity. A MHSA team member participated in this event as a group facilitator. This event solicited their input in relationship to the exploratory question: “What is needed to help students like yourselves successfully move from middle to high school?” Issues of concerns with bullying were predominant,

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as was the feedback related to a need for the student voice in planning and decision-making.

Efforts to maintain feedback and dialogue with underserved populations have improved to a degree with experience and diversified MHSA service providers (Latino and Native American). The MHD is committed to continuing our efforts to improve further.

Language

Targeted outreach to the Latino population included use of bilingual/bicultural staff, focus groups at churches, ESL classes and a Latino Community Family Resource Center (FRC). In one interesting scenario, an ESL class hosted by the Latino Community FRC included a Vietnamese individual. During Phase I, extensive work was invested in getting materials translated into Spanish – including the Executive Summary of the original CSS plan. Furthermore, we had individuals at many of our key presentations available to provide interpretation for Spanish-speaking individuals. Our findings were that these resources were not utilized and that targeted outreach to small groups was a far more effective technique to engage this population in our community.

Geographic Regions

As indicated earlier, to address the separation of the Western Slope Region from South Lake Tahoe, we used teleconferencing equipment for almost all of the planning meetings. MHSA PEI training took place in person in SLT, as well, on two occasions. The Western Slope Region is expansive and beyond the County seat of Placerville, includes a community in the east (Pollock Pines), a community in the southern region (Somerset), a community to the north (Georgetown Divide), and one to the west (Cameron Park-EI Dorado Hills). In addition to what is outlined below, outreach to existing community collaboratives did occur in Georgetown and EI Dorado Hills. Greater efforts to identify effective ways to reach Pollock Pines and Somerset need to be made in the future.

Age Groups

Middle school, TAY, and high school students were reached via targeted outreach and/or participation in the planning meetings. There is an active EDC youth voice - they participate on their own commission (for example, giving feedback to the County regarding safety issues related to the Skate Board Park) and as full members on the EI Dorado Hills Vision Coalition – and these groups were accessed as part of the MHSA PEI CPP process.

Gender and LGBT

Targeted outreach served to solicit feedback from representatives of two Women's Centers and PFLAG. The issues of personal safety and outreach to enhance access to services were important themes relevant to PEI planning.

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Please note:

As part of our efforts to improve the Cultural Competence of the Division, and all of our PEI plans and MH services, a staff member will be attending CBMCS training for trainers in December. She has previously attended the 32-hour California Brief Multicultural Assessment Scale (CBMCS) Training and this “train the trainers” workshop will provide her with the competence to become a “Master Trainer” in a standardized evidence-based practice with effective measurable outcomes. An action plan for implementation of Staff Training delivered as part of a Regional Collaborative will result to ensure effective implementation of this program. The MHD will make this training available to MHA PEI program staff among others.

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County Demographics by Race/Ethnicity – YOUTH & TAY

	County Poverty Population		County Population		County Poverty Population			County Population	
	Number	%	Number	%	TAY	Number	%	Number	%
CHILDREN AND YOUTH									
TOTAL	10,384	100.0	41,239	100.0	TOTAL	8,340	100.0	22,695	100.0
African American	26	0.2	358	0.9	African American	76	0.9	207	0.9
Asian Pacific Islander	319	3.1	1,098	2.7	Asian Pacific Islander	224	2.7	609	2.7
Latino	3,114	30.0	6,465	15.7	Latino	1,129	13.5	3,071	13.5
Native American	312	3.0	623	1.5	Native American	129	1.5	351	1.5
White	6,366	61.3	31,337	76.0	White	6,554	78.6	17,833	78.6
Other	398	3.8	1,358	3.2	Other	229	2.7	624	2.8

*County Poverty Population based on the U.S. Bureau, Census 2000, 200% of Federal Poverty Level and applied to the projections for 2005 by the State of California, Department of Finance, Race/Ethnic with Age and Sex Detail, 2000-2050

*County Population data is based on projections for 2005 that are benchmarked to Census 2000: State of California, Department of Finance, Race/Ethnic with Age and Sex Detail, 2000-2050

*The age groups are not mutually exclusive and thus do not add up to 100% of the total

*Because of the manner in which the estimates were calculated, estimates do not add up to 100% or the column totals

****The county poverty and prevalence rates are the blended rates for the 18-20 group and the 21-24 group.**

****The population projections are based on the 16-24 age group.**

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County Demographics by Race/Ethnicity – ADULTS & OLDER ADULTS

	Adult County Poverty Population		Adult County Population		Older Adult County Poverty Population		Older Adult County Population	
	Number	%	Number	%	Number	%	Number	%
TOTAL	27,982	100.0	101,311	100.0	10,252	100.0	31,517	100.0
African American	237	0.4	643	0.6	40	0.4	123	0.4
Asian Pacific Islander	823	2.1	3,073	3.0	237	2.3	728	2.3
Latino	5,336	9.7	10,574	10.4	413	4.0	1,270	4.0
Native American	609	0.7	1,383	1.4	106	1.0	326	1.0
White	20,886	85.8	84,050	83.0	9,327	91.0	28,673	91.0
Other	687	1.8	1,588	1.6	129	1.3	397	1.3

*County Poverty Population based on the U.S. Bureau, Census 2000, 200% of Federal Poverty Level and applied to the projections for 2005 by the State of California, Department of Finance, Race/Ethnic with Age and Sex Detail, 2000-2050

*County Population data is based on projections for 2005 that are benchmarked to Census 2000: State of California, Department of Finance, Race/Ethnic with Age and Sex Detail, 2000-2050

*The age groups are not mutually exclusive and thus do not add up to 100% of the total

*Because of the manner in which the estimates were calculated, estimates do not add up to 100% or the column totals

****The county poverty rate and the prevalence rate are the rates for the 65+ group**

****The population projections are based on the 60+ age group**

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During Phase II, targeted outreach (focus groups, key informant interviews, and use of written and on-line surveys) to the following groups was used to ensure input reflecting the diversity of the demographics of the County. As in Phase I, focus groups typically targeted more than one individual with similar characteristics (youth, teachers, parents) to ask for their input regarding needs and proposed ideas for PEI services. Key Informant Interviews were 1:1 interviews often targeting a content expert, or someone who was difficult to reach in the context of a group, to ask for feedback regarding PEI needs and services. These strategies, like the surveys, were used to obtain feedback from parties who might otherwise not attend a planning meeting, community meeting, or public hearing.

Early Care and Education Council representative	1
First 5 commission representative	1
Youth commission members	9
Church youth group	46
TAY supported education class	9
TAY court volunteers	15
High School Youth panels	57
Teen court representative	1
Juvenile Hall representative	1
PFLAG members	2
Women’s Center	19
Native American individuals	22
Native American Resource Collaborative	11
Caregivers Support Group members	10
Headstart, parents, Latino	8
Incredible Years parents	4
Church-based ESL class students	25
Latino Family Resource Center	2
EDCMHD Children’s Services	5
High School Superintendent	1
SELPA	1
Tahoe Collaborative	13
SLT MH Commission	12
SLT Community Meeting	37
SLT Stakeholder Meeting	8
SLT High School Superintendent	1
SLT Women’s Center	1
SLT City Police	1
SLT Lt Sheriff	1
SLT County Court	1
SLT Public Defender	1
SLT District Attorney	1
SLT State Voc Rehab Representative	1
SLT Barton Clinic	1

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SLT Churches	2
EI Dorado Hills Vision Coalition	1
EI Dorado Community Foundation (older adult project)	1
Project Uplift (Older Adults MHSa Services)	1
Public Guardian representative	1
PHF All Staff	8

(Bold lettering indicates participation in Planning and/or Advisory capacities.)

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

In addition to the targeted outreach specified below, as noted earlier, homeless individuals not yet engaged in treatment (outreach clients) and those receiving MHSa services were engaged in a drop in and treatment setting; consumers receiving services – including those in Board and Care placements – were reached in connection with their participation in Community Integration activities; and MHSa information exchange occurred regularly in a local consumer support group.

Consumer family member participation and support has also been quite consistent, represented in community, planning, and advisory meetings, as well as in the Mental Health Commission meetings in which MHSa updates are routinely provided. In addition, family members are increasingly contributing their time on a voluntary basis in the MHSa Adult Wellness Center thereby engaging actively in the day-to-day development of these new programs, witnessing the results, and reporting back to the Mental Health Commission and community. This dialogue has contributed significantly to the MHSa PEI planning process.

During Phase I, we actively promoted use of stipends to facilitate attendance and to address the costs incurred for transportation and childcare. This effort was met with minimal interest and mixed results given the logistics of the County accounting process. As a result, in Phase II we significantly increased our targeted outreach to the community to address these issues, to increase the range of participation, and to enhance active participation. Some individuals attending larger community and planning meetings have been hesitant to speak in public. In a more familiar group setting or on a 1:1 basis, consumers in particular have felt more at ease to share their thoughts.

During Phase II, targeted outreach (focus groups, key informant interviews, and use of written and on-line surveys) to the following groups was used to ensure input from clients with serious mental illness and/or serious emotional disturbance and their family members:

Developmentally disabled population	1
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Youth commission members	9
Church youth group	46
TAY court volunteers	15
TAY supported education class	9
High School Youth panels	57
Teen court representative	1
PFLAG members	2
MHSA Homeless TAY and adults consumers	7
Women’s Center	19
NAMI	14
Caregivers Support Group members	10
Headstart, parents, Latino	8
Incredible Years parents	4
Native American individuals	22
Church-based ESL class students	25
Oasis consumer group	20

(**Bold lettering** indicates participation in Planning and/or Advisory capacities.)

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

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

During Phase II, targeted outreach (focus groups, key informant interviews, and use of written and on-line surveys) to the following groups was used to ensure input from the required stakeholders (and beyond):

Consumers

Developmentally disabled adults	1
MHSA Homeless Program Consumers	7
Women’s Center	18
Native American Rancheria members	22
Youth Commission	9
Mother Lode Rehabilitation Enterprises	1
PFLAG	2

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Church Youth Group	46
Adult Drug Court	3
Church ESL class	25
TAY support group	9
High school youth panels	57
TAY member	
<u>Family members</u>	
Caregivers	2
Headstart parents	8
Incredible Years parent participants	4
NAMI	1
Foster parents association	1
Mental Health Providers	97
Social Services Providers	4
Physical Health Providers	28
Educators	19
Law Enforcement	9
<u>Other organizations</u>	
Homeless Service Providers	2
Commission Members	34
Women’s Center	19
PFLAG	2
Advocates	15
Caregivers	10
Alcohol and Drug Treatment providers	32
Collaboratives (5 groups)	39
Faith-based service providers	74
Developmentally disabled service providers	3
Vocational services providers	3
Other Community-based organizations	27

Membership of the MHSAs Advisory Committee was also constructed for the CSS Community Program Planning process to ensure representation from these groups. This committee is represented by the following groups:

- El Dorado County Mental Health Division
- El Dorado County Public Health Division
- El Dorado County Department of Human Services

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- El Dorado County Sheriff Department
- El Dorado County Probation Department
- El Dorado County Office of Education
- First 5 Commission
- Parent volunteer
- Foster Parent Association
- NAMI – Western Slope and South Lake Tahoe Chapters
- Oasis – Consumer Support Program
- Mental Health Commission – Western Slope and South Lake Tahoe
- Shingle Springs Rancheria
- (Latino) Family Resource Center
- Marshall Hospital (physical health)
- Community Health Center
- Sierra Recovery Center (substance abuse treatment)
- The Center for Violence-free Relationships (formerly Women’s Center)

The MHSA mailing list also includes many representatives from the required stakeholder groups.

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

MHSA Prevention and Early Intervention Training was provided for the Targeted Outreach Team (1 session), EDCMHD staff (3 sessions), Mental Health Commissions (2 sessions), MHSA Advisory Committee (1 session), EDCMHD Leadership Team (1 session), in Regional Community Meetings (4), in Focus Groups (39), and in Community Planning Meetings (4).

The initial training covered the MHSA PEI framework and application requirements provided by the State DMH. Additional trainings in open community meetings conducted midway through the planning process (2) included expanded information regarding Resiliency. Further training in open community meetings was provided at the end of the planning process (4) which included findings from resiliency research relevant to the development of the EDC MHSA PEI plan proposal.

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.

Our Phase I Community Program Planning experience taught us the following:

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Use targeted community-based outreach

The use of targeted outreach (focus groups and key interviews) to under-represented groups and content experts is essential to ensure the necessary representation and feedback required for collaborative community planning. Open community meetings, planning groups, and written surveys are not sufficient to capture all the critical voices.

As a result, we were able to focus our limited resources and make good use of our time by focusing on the need to go to groups such as the Native American population, the Latino population, and places where LGBT individuals and/or advocates would meet with us. The youth voice was directly captured, as well as individuals who work closely with this population. We connected with family and caregivers in various contexts with our outreach efforts and we broadened our vision of where and how to connect with the consumer population. Finally, as a result of accomplishments achieved during the CSS planning and program implementation process, we were able to connect more effectively with our partners in the criminal justice system, as well.

Synthesize information between meetings

In an effort to be collaborative and transparent, an extreme level of detailed planning occurred in the community planning meetings during the CSS process. The local feedback and the observations from other counties suggested that this approach was not necessary to ensure quality and authentic community collaboration. In fact, some community members indicated that they would have liked to see increased leadership from the MHD during the planning process to inform the process, facilitate forward movement, and decision-making.

As a result, there was a shift to a model of planning in which information was largely synthesized by the Project Management Team staff between meetings and presented to the community planning group for feedback and discussion which would inform next steps. This approach did not require that participants prepared for the meetings by reading materials or researching information or data from their agencies, as was done during the CSS planning phase.

While this relieved a level of workload for community participants, acquiring local community data was more difficult. In addition, the shift from a treatment approach to a prevention framework was challenging for most of the planning members. In hindsight, it may have been a worthwhile investment to have spent more time on PEI education.

Avoid meeting overload

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A key consideration from the CSS planning experience was to try to strike an effective balance between quality community collaborative planning and meeting overload. We received feedback regarding the strain from both the time commitment and the weariness experienced by a protracted planning process over time.

As a result, we shortened the planning meetings from 2 hours to 1 ½ hours at a time and met no more frequently than monthly (compared to the weekly or bimonthly meetings of the CSS planning process). We also skipped a month on a couple of occasions to both provide a break and to do more extensive research between meetings to ensure that the next meeting was a fruitful one for participants.

- 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.

As indicated earlier, El Dorado County's efforts to ensure a comprehensive and representative MHSA planning process included the following accomplishments during Phase I:

- 82 focus groups and readiness trainings reaching 925 respondents
- 23 key informant interviews
- 5 written surveys with a total of 545 responses
- An MHSA mailing list of 390 individuals used to send out announcements, surveys, meeting notifications, and update.
- Local media (newspapers, cable television and radio) were used to announce community meetings and to inform the public of the MHSA planning activities and contact information.
- The development of an MHSA website providing the public with:
 - MHSA Facts Sheets
 - MHSA announcements
 - MHSA meetings schedule
 - Meeting minutes
 - Forms for consumers and families to request financial assistance for travel and childcare
 - Surveys
 - MHSA updates
 - Information regarding how to get involved, including direct e-mail link
 - Contact information for the Project Management Team
 - A link to the DMH website

Mental health consumers (94) and TAY (116) were among the focus group participants that were included as a result of targeted outreach efforts. Many of these groups were conducted by a TAY facilitator who was a member of the MHSA Project Management and Outreach Team.

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During Phase II, mental health consumers (26) and TAY (68) were among the focus group or key interview participants that were included as a result of targeted outreach efforts.

The MHSA mailing list comprised of 450 members was used to send out surveys, meeting announcements, MHSA updates, and notices regarding documents posted for public review. The website was maintained and used to post interactive surveys, meeting announcements, MHSA updates, and various MHSA documents for public review. When documents were posted for a 30-day review, the local newspapers were issued press releases. In addition, in November 2007, the Project Management Team began hosting quarterly, county-wide MHSA Community Meeting Updates which included both ongoing CSS program information as well as updates regarding new community planning processes, such as for PEI. One page handouts outlining the news and updates were produced since the inception of MHSA Community Program Planning for CSS on an intermittent basis, but were formalized for quarterly production to coincide with these Community Update Meetings.

Targeted outreach via focus groups and key informant interviews were conducted to ensure participation by under-represented and relevant populations – including content experts. Training regarding the MHSA PEI program component was provided, as well. Some of the highlights include: focus groups conducted at high schools by the Mental Health Director, a full-day convening conducted with representatives from the Native American community to address improved partnership in the interest of mental health service delivery to this population, and many youth and Latino community members were reached through the church community.

Training regarding the MHSA Prevention and Early Intervention component was hosted by the MHD in both Placerville and South Lake Tahoe in open community meetings. These meetings were followed by monthly Community Planning Meetings which focused on the PEI needs assessment findings, asset mapping, and problem-solving discussions to identify intervention strategies for use of the EI Dorado County MHSA PEI allocation. These meetings were conducted via teleconference technology to include the joint participation of both the Western Slope and South Lake Tahoe regions.

The results of the Phase II Community Planning Process contacts specific to Prevention and Early Intervention were as follows:

FOCUS GROUPS TOTALS

- Total Focus Groups completed: 39
- Total Attendees for Focus Groups: 456

KEY INFORMANT INTERVIEWS TOTALS

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- Total Key Interviews completed: 47
- Total Attendees for Key Interviews: 59

PEI SURVEYS COMPLETED – 185

COMMUNITY MEETING TOTALS

- Total Community Meetings held: 11
- Total attendees for Community Meetings: 183

PEI Priority Populations Inclusion:

Based on the PEI Priority Populations criteria, the following contacts were made via focus groups and key informant interviews to ensure input and participation in the planning process. In addition, **all** of these groups had representatives participating in the community planning and/or advisory process.

- **Underserved cultural populations** (68)
- **Onset of serious psychiatric illness** (26)
- **Children and youth in stressed families** (104)
- **Trauma-exposed** (103)
- **Children and Youth at-risk for school failure** (68)
- **Children and Youth at-risk for juvenile justice involvement** (68)

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

Overview:

In compliance with CCR, Title 9, Chapter 14, Section 3315, the PEI plan (based on the extensive Community Program Planning process), was posted for a 30-day public review and comment period. Notification of this review period was widely disseminated. During this time, a quarterly MHSA Community Meeting update was held to review the plan and address questions and feedback. The MHSA Project Management team made contact with the program staff of the proposed programs to ask for feedback regarding the document. Feedback and clarification questions were received, as outlined below. Clarification on a number of points and minor adjustments in the plan (such as a project name change) were made in response to the feedback, also noted below. Substantive changes were not made as a result of the public review process. The responses to the feedback were given verbally and directly to the parties, initially. Two public hearings were held before the finalized version was presented to the County Board of Supervisors for approval to submit to the State Department of Mental Health. At this time, the final version was also made available to the public.

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- a. Two public hearings were held in October, 2009. The first one was held on October 21, 2009 and addressed the PEI program, recurring budget and the PEI Training and Technical Assistance application. The second one was held on October 26, 2009 and addressed the use of PEI funds from FY 07-08 to contribute to the MHSA Prudent Reserve.
- 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.

Following completion of the community program planning process, the proposal was presented to the MHSA Advisory Committee. Membership of the Advisory Committee consists of 20 representatives of community groups that have been involved since the early phase of MHSA planning.

A complete draft of the Prevention and Early Intervention Plan that included all exhibits was posted for a 30-day public review and comment period on September 21, 2009. An electronic copy was posted on the County's website at www.edcgov.us/mentalhealth and an electronic notification was sent to the MHSA e-mail group, the MHSA Advisory Committee, the Mental Health Commission, the County Board of Supervisors and Chief Administrators Office, and all of the Health Services Department staff informing them of the start of the 30-day review with a link to the document for review and comment. A press release announcing the posting and including the website link was issued to two local EI Dorado County newspapers and the Sacramento Bee. The press release included a phone number and an e-mail address for requesting a copy of the plan.

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

The public review and comment period closed with two public hearings held by the Mental Health Commission in October, 2009 at the EI Dorado County Mental Health facilities located at 670 Placerville Drive, Suite 1B, Lake Tahoe Conference Room, Placerville and 1900 Lake Tahoe Blvd, Video Conference Room, South Lake Tahoe.

General Comments:

It was recommended that funding allocation methodologies be clearly identified in the future – including to address regional or geographic equity. The community in EI Dorado Hills, according to the Vision Coalition, is concerned that while they have a larger population than Placerville, they have no locally established County mental health services and lack public transportation from their community to Placerville where services are found. A letter of interest relative to PEI funding had not been submitted as there had been an expectation that the school-based services model would bring services to EI Dorado Hills. There is now concern

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that this is not in the plan. This community group is interested in collaborating with the MHD in order to make services locally available. They have been successful in obtaining grant funding and using these dollars to purchase limited services at a more cost effective rate than those listed in the PEI application. In addition, they see the PEI proposals as lacking in capacity building, leveraging of funds/resources, and continuing to focus more on treatment and less on (cost-effective) prevention strategies. Greater detail is needed regarding how these services will come down to the community level.

Collaboration with the Community Strengthening groups will need to occur more directly in order to ensure mutual understanding regarding their role in the MHA PEI program process.

Outcome measures must be used for MHA programs – including PEI programs.

Clarification was sought regarding the citation of many and varied individuals in the community planning process – particularly since some of the community update meetings or the MHA public hearings do not have large attendance consistently.

A few community members found the description of the Phase I CSS CPP process confusing because the narrative listed names of staff who are no longer with the Division. Clarification in the document to this end was specifically requested.

Response:

Funding allocation methodologies have been used in the past with the CSS funding and can be revisited for PEI funds in the future.

Collaboration with the Vision Coalition and the EI Dorado Hills community is clearly important. Specifically, the application of the Incredible Years program at White Rock Village is envisioned. The School-based Mental Health Promotion and Service Linkage program is available for all school districts – the licensed clinicians will go to the school or families identified for screening, assessment and service linkage. The location of the service provision will vary by program. Continued community planning in regard to implementation can take place upon receiving approval by the Board of Supervisors to submit the plan as written.

Preliminary discussion had transpired with the First 5 Commission and additional discussions do need to occur. The general thinking is that these locally established groups will provide a means for ongoing community input and transparency once the PEI programs are implemented. Feedback from these groups would then be relayed to the MHA Advisory Group allowing them to be more informed in how they advise the Health Services Department Director regarding MHA services and funding.

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Measurement of PEI program outcomes will be challenging but are clearly important. The Healthy Kids survey, as an existing tool, will be explored for use in the school-based programs.

Part of the MHSA philosophy is to ensure inclusion of un-served and under-served populations. To do so, various methods for inclusion are needed. As a result, the MHD has used strategies such as a phone line, e-mail box, written and on-line surveys, large e-mail distribution group, readiness trainings, focus groups, key informant interviews, and quarterly community update meetings. “Targeted outreach” includes going out to individuals who might otherwise not participate to ask for their feedback (homeless individuals, consumer groups, school-classrooms, etc.). We have documentation of these efforts and summarized our findings in the section on Community Program Planning. One of the questions we typically ask those that we encounter is whether they know of anyone or any groups that we should also approach. Therefore, those individuals who attend public hearings, community meetings or regular planning meetings do not fully represent all individuals who have participated in the MHSA planning process.

Clarification regarding the MHSA CSS CPP process was written into the final version for submission to the State (please see page 2, the last comment in paragraph 1a).

Comments on Program 1 – School-based Mental Health Promotion and Service Linkage:

Feedback was received regarding the need to ensure that there is capacity to provide sufficient treatment if there is increased capacity to identify needs, and if the designation of two assessment clinicians is adequate. In addition, the need for evidence-based practices that can address the needs of adolescents was identified. Concern was raised that MHD children’s services section is already “overburdened and underfunded”. Clarification regarding the purpose of the project (increased access versus increased treatment provision) was requested and the suggestion was made that the Screening Committee not duplicate already existing committees.

In addition, feedback was given that the school personnel should be providing education to students allowing mental health personnel to provide mental health services. Hence, caution/concern was expressed to ensure that mental health dollars are applied effectively to provide mental health services by trained personnel.

It was suggested that MHD should consider a change in the name of Program 1 from “School Based Mental Health Specialists” to a name that would better clarify the purpose of this program.

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Clarification was requested to confirm that the School System Behaviorist would not be automatically included as a required participant in the pre-referral process.

Response:

The service capacity for the needs identified via this PEI program includes evidence-based services (Incredible Years, Primary Intervention Project, Trauma-focused Cognitive Behavior Therapy) that are both MHSA CSS funded and proposed for PEI funding. The “mental health personnel” are licensed, masters level clinicians. A group in Dialectical Behavior Therapy targeting adolescents is also in development. Group models are being encouraged as both a clinically effective and cost-effective means of using precious mental health staff resources. The purpose of this project is to both increase access and utilization of early intervention services, as appropriate. During the planning process, it was acknowledged that the MHD has always recognized that MHSA funds (including PEI funds) are not sufficient to fully meet the community needs. Further, that insufficient data was available in the school system and the MHD to clearly identify the volume of need and/or demand for these services. Therefore, the plan is to implement the programs and continuously evaluate the demand and effective strategies by which to use the PEI resources to meet the community needs. The Screening Committee is an extension of an existing committee meeting, the Placement Committee (which does not automatically include the School Behaviorist), and was therefore not seen as a duplication of services.

The mental health PEI strategies will be either provided by mental health clinicians or, as in the PIP program, by individuals hired to specifically apply a recognized mental health intervention strategy for which they will be trained.

The name of this program has been changed from "School Based Mental Health Specialists" to "School Based Mental Health Promotion and Service Linkage".

Comments on Program 2 – Primary Intervention Project:

Feedback was received to both look realistically at start up time – particularly in South Lake Tahoe – and to ensure that all program costs are included to ensure fidelity to the model. Further, it was suggested that El Dorado Hills does not have any locally provided MHSA services and is very interested in this model. A request was submitted asking for meetings to address possible models of sharing this opportunity for piloting PIP services with South Lake Tahoe and Georgetown.

Additional feedback was received that it is difficult to detect a mental health problem at the young ages of K-3.

Response:

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Adjustments have been made accordingly to address the numbers of clients to be served in the first 6 months of operations and to include the purchase of supplies relevant to the model for each year of operation. MHD will set up a meeting to facilitate a discussion regarding potential PIP service delivery in other geographical areas; however, the PEI proposal as discussed during the Community Program Planning process does need to move forward. It is important to note that the planned PIP programs are specifically designated as pilot programs and that the PEI programs in general are intended to be re-evaluated continuously for changes – which includes where the programs are offered.

The identified behaviors that are addressed in this young age group by this model are school adjustment behaviors. As a prevention model, this approach does not “treat” mental illness.

Comments on Program 3 – The Incredible Years (IY):

Feedback was received that El Dorado Hills continues to be interested in having this program provided locally – potentially at White Rock Village where there are suitable facilities and low income families who might otherwise not attend if the classes were at a distance. The Vision Coalition has offered to assist in facilitating the connection between the MHD and the facility, registering families, and hosting the event if it can be provided at this site.

Response:

The intention has been for the PEI-funded Incredible Years classes to be provided in the community at sites, such as White Rock Village. While implementation of an IY class at this site will be pursued in the first round of funding, it is important to recognize that as a mobile model, the funding and capacity to provide three classes a year will be applied County-wide. How often the class can be provided in El Dorado Hills on an ongoing basis is unclear at this time.

Comments on Program 4 – Community Education Project:

NAMI’s Family-to-Family:

Feedback was received indicating different points of view regarding what costs are already covered for the NAMI Family-to-Family train the trainer program and the issue of whether increased capacity for trainers is needed.

Response:

The funds will continue to be made available to address unmet costs associated with the training for at least the first year of funding. The local need can then be re-evaluated in regard to future funding.

PFLAG - Our House to the School House Project:

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Feedback was received to broaden the approach of this program and to work with the Gay-Straight Alliance Groups.

Response:

This model will be amended to provide community education through the MHD MHSA team in collaboration with PFLAG. The target audience will include MHD staff and the general public who will be invited to participate in community education forums regarding the needs and services for the LGBT populations. Funding for materials will continue to be provided. The program name will be changed to PFLAG-Community Education.

Parenting Wisely CD-ROM:

Questions were received asking for clarification regarding the identified community need, measures, target population, access, and how to evaluate if consumers want and will use this program? A concern was expressed regarding the amount of funds designated for this program.

Response:

The identified community need and target population is stressed families. Parenting Wisely is a parent training program that targets parents with children ages 5-18. The Parenting Wisely Program uses a self-administered, interactive and multimedia CD-ROM as the training vehicle and thereby overcomes illiteracy and transportation barriers. This program is based on social learning theory, family systems theory, and cognitive theory and seeks to help families improve relationships and decrease conflict by improving parenting skills and enhancing family communication, mutual support, supervision and discipline. This program is recognized by SAMHSA as a model program; by the Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice as an Exemplary II Program – Family Strengthening; and by the Youth Justice Board, London, England, Pathways Project. The CDs and training materials are available in Spanish and will be accessed locally.

This tool was specifically designed with the critical goals of being:

- Brief;
- Flexible;
- Non-stigmatizing;
- Low cost;
- Not dependent upon training or continued supervision but with high treatment integrity;
- Appropriate for families with diverse ethnic, education and socioeconomic characteristics; and,
- Effective.

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The content focus is in relationship to alcohol use, anti-social/aggressive behavior, social and emotional competence, and violence.

This PEI approach addresses both protective and risk factors. It can be used in agency settings, home visits, group settings, as a tool to loan to families, as a complement to family therapy, and in juvenile detention centers, child protective services agencies, schools, libraries, adult literacy/education locations, community centers, homeless shelters, and public housing offices.

Thirteen evaluations of this program have been conducted – five of which involved random assignment to treatment and control groups. Represented in these studies were approximately 990 families of various ethnic groups and predominantly from lower income homes. The studies are available for review at www.parentingwisely.com and will be referenced when looking at how to evaluate use in El Dorado County. Utilization of the tool and satisfaction surveys for those who have used it will be included in the implementation, as well.

Comments on Program 5 and 7 – Wennem Wadati and the Health Disparities Initiative:

Several parties expressed concern regarding the amount of resources dedicated to ethnic services programs relative to the population size.

Response:

The MHSA Health Disparities Initiative is currently funded under the Community Services and Supports (CSS) component and was previously conceived of and approved by the local community, Board of Supervisors, and the State Department of Mental Health. These programs have been active since 2006 and have increased access for the Latino population to mental health funded services. The local analysis indicated that the Latino population in this County has been significantly un-served and under-served in every age group. Similarly, there are disparities in health status and outcomes for the Native American population and local advocates believe the community's Native American population's size is under-reported. Feedback from the providers has indicated that the effective practices for these populations include outreach, engagement, and early intervention services. As a result, the PEI plan includes, as is allowable, a transfer of the existing CSS program to PEI funding – it does NOT represent an increase in services.

There is an increase in service delivery to the Native American population as a function of the PEI program, Wennem Wadati. The MHSA CSS-funded contract with Shingle Springs Tribal Health is in early implementation and will continue to be evaluated. This program partially funds an outreach worker/case manager serving Native American adults with serious mental illness who are at risk of homelessness. The PEI proposed program, Wennem Wadati, uses various prevention strategies to address all age groups in maintaining mental health and

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well-being with culturally specific strategies. Both programs will be evaluated continuously, as will all MHA programs, for need and effectiveness to ensure the appropriate use of the MHA funds.

Comments on Program 6 – Home Delivered Meals Wellness Outreach Program for Older Adults:

Feedback was received that this was a good program.

Comments received regarding use of the FY 07-08 allocation to partially fund the MHA prudent reserve fund:

Feedback received was positive and in support of this use of these funds.

d. The estimated number of participants:

Public comments were received from nineteen (19) individuals via the Public Hearings, MHA Advisory Meeting, e-mails, phone calls and face-to-face.

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County: EI Dorado **PEI Project Name:** Program # 1 - School-based Mental Health Promotion and Service Linkage

Date: November 10, 2009

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Psycho-Social Impact of Trauma	x	x	<input type="checkbox"/>	<input type="checkbox"/>
3. At-Risk Children, Youth and Young Adult Populations	x	x	<input type="checkbox"/>	<input type="checkbox"/>
4. Stigma and Discrimination	x	x	<input type="checkbox"/>	<input type="checkbox"/>
5. Suicide Risk	x	x	<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
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	x	x	<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	<input type="checkbox"/>	<input type="checkbox"/>
4. Children and Youth at Risk for School Failure	x	x	<input type="checkbox"/>	<input type="checkbox"/>
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	<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).

The following is a detailed description of the planning process that resulted in the selection of the priority populations for all of the programs. *Therefore, this full description applies to the other programs but will not be repeated in each section.*

Strategic Prevention Framework Planning Process (Assessment, Capacity Building, and Planning phases) was used and is outlined below. Through targeted outreach (focus groups and key informant interviews), use of written and on-line surveys, open community meetings/training sessions, open community planning meetings, and an advisory review process, county-wide stakeholder input interfaced with the growing information that emerged from our research on prevention, early intervention, and resiliency models. An assessment of the community's existing capacity or assets was included and further informed the priorities and strategies identified for this plan. Finally, various evidence-based PEI models were reviewed and considered for a best fit for identified needs. The process and findings resulted in the EI Dorado County Behavioral Health Promotions Strategic Plan that is composed of seven MHSA PEI projects.

ASSESSMENT

Community health indicators suggesting problems in the areas of stress, aggression and violence, require integrated efforts to improve the community overall mental health.

The following CPP events took place to specifically address the MHSA PEI plan development: 11 Community Meetings and Planning meetings generating 183 community contacts (some participants may have been counted multiple times if they attended more than one meeting); Focus Groups (39) generating 456 community contacts; and, Key Interviews (47) generating 59 community contacts. Written surveys were disseminated via mail, e-mail, during community meetings, focus groups and planning meetings. The MHSA PEI survey was also made available on-line. This was an anonymous survey. 185 completed surveys were received.

Together, the community feedback gathered by the various targeted outreach techniques applied during Phase II of the Community Program Planning process identified the following priorities for the MHSA PEI component:

- *Priority community mental health need:* At-risk children, youth and young adults and individuals at suicide risk
- *Priority population:* Children and youth in stressed families
- *Priority outcome:* Reduction of suicide

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- *Priority age group:* Youth (and transition age youth and older adults due to the high suicide risk in these populations)
- *Priority strategy:* Prevention, selectively targeting those at risk in both the school and healthcare settings.

CSS CPP data and Community Health Indicators

The community population and needs assessment data collected during the MHSA CSS community program planning process was reviewed and considered, as well. The local community health indicators that were reviewed during MHSA Community Assessment process in 2004/5 and 2007/8 indicate some alarming trends:

- ***The key population health indicators*** where our County fares the worst relative to other California counties are related to ***violence and abusive behaviors***: our measurements for ***child abuse and neglect, domestic violence, suicide, drug abuse, firearm-related deaths, and unintentional injuries*** are poor and worsening in the 2008 County Health Status Report. In addition,
 - 38% of 11th grade respondents in EDC said they had been offered drugs on school property in the past year – one of the higher rates in the region.
 - Elder abuse in the County has increased and not met the national benchmark and, at 9.6 per 1,000 in 2006, is the highest rate in the region.

Suicide as a critical mental health outcome was discussed at length:

- 11th leading cause of death in the US and the 10th leading cause of death in California.
- Among ages 15-24, it's the 3rd leading cause of death.
- Between 1991-1997, the EI Dorado County youth suicide rate was 3 per year. Following an intervention conducted by the County Office of Education (the creation of a Suicide Response Prevention Handbook and related training), the youth suicide rate decreased in 1998 to 2 per year and, over the last five years, the rate was further reduced to 1 per year.
- The County older adult suicide death rate exceeds the Healthy People 2010 objective (individuals between the ages of 75-84 have the highest reliable suicide death rate).
- **EI Dorado County ranked 39th in California (only 19 other counties have lower per capita suicide rates than ours) – our suicide rate is close to 3 times higher than the Healthy People 2010 rate and has increased while the State rate has decreased.**

This community data paints a picture consistent with the risk factors that exist among the priority population of children and youth in stressed families – neglect, conflict, abuse, and violence. The lessons learned from a US Air Force suicide prevention program was informative to our local situation (ED Caine and GL Spielmann, 2005, A Public Health Strategy

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for Suicide Prevention). The etiology of a suicide involves marker conditions (family disputes, school absenteeism, violence, abuse, injurious behavior) that co-occur with stressors such as intoxication, domestic distress, and pain caused by medical conditions, thereby resulting in self-destructive behaviors, such as suicide.

The sobering news for El Dorado County's state of mental well-being, therefore, is that the disproportionately high suicide rate suggests that multiple markers and conditions co-exist unchecked in our community with tragic results.

Lessons learned from this study for local application:

- There appears to be a connection between different types of social pathology and therefore it was possible to impact several conditions (violence, abuse, homicide) while targeting one issue, like suicide.
- The benefits of the intervention were seen equally in multiple areas (reduced suicide rate by 33%, while reducing the amount of severe family violence, homicides, and accidents by equally wide margins).
- Therefore, the investigators support a public health approach whereby intervening with a larger number of people at small risk may address more causes of a problem, such as suicide, than targeting a small number of those at high risk).
- ***In other words, improving the overall community mental health can reduce the numbers of suicide more effectively than selective strategies limited to targeting individuals at imminent risk of suicide.***
- Furthermore, a well-designed prevention strategy must address both individual and social influences that shape suicidal behavior – for example, five domains of suicide risk have been identified, as follows:
 - Biological: aging, environment
 - Psychiatric: depression, drug abuse, alcohol dependence, etc.
 - Psychological: personality, coping
 - Medical: illness, treatment, pain
 - Social: loss, life changes
- ***In summary, this effort to reduce the suicide rate was done most effectively by means of an integrated approach rather than different agencies trying to combat different pathologies with different strategies.***

CAPACITY BUILDING

A review of the community assets and relative need for capacity building further suggests that the community perspective relative to Priority Needs is consistent - addressing stressed families and youth.

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Resource Assessment/Asset Mapping

Two written questionnaires and multiple key interviews were conducted to gather information regarding existing community resources providing health promotions, prevention and/or early intervention services.

PEI Community Asset Survey Results

Purpose:

The purpose of this survey was to provide an overview of the current Prevention and Early Intervention (PEI) Programs that are currently operating in EI Dorado County. It was also intended to identify populations that do not have access to existing Prevention and Early Intervention programs

Overview:

EI Dorado County Mental Health surveyed our community partners and received 19 responses encompassing 29 programs. This is not viewed as an exhaustive list, but was a reflection of feedback from parties engaged in the CPP process.

Results:

Most of the Prevention and Early Intervention Programs that are currently in place in EDC are Selective Interventions. The Priority Community Need targeted by most of the programs is at-risk children, youth, and young adults. The Priority Population most often served is children and youth in stressed families. The Priority Outcome most frequently addressed is the reduction of out-of-home placement. These are consistent with the priorities identified by the community in the MHSA CSS and PEI planning processes. The community feedback indicates that while these programs are helpful, they are not sufficient in quantity and sufficiently accessible. Please see full details listed below.

Total Surveyed 19

Prevention and Early Interventions:

Universal programs	8
Selective programs	19
Early Intervention	3

*some programs covered multiple intervention types

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PEI community MH needs addressed:

Disparities in access to mental health services	5
Psycho-social impact of trauma	0
At-risk children, youth, and young adult populations	14
Stigma and discrimination	2
<i>Suicide risk</i>	0
Physical health/concerns	3

PEI Priority populations targeted:

Underserved cultural populations	5
Individuals experiencing onset of serious psychiatric illness	1
Children/youth in stressed families	11
Trauma-exposed	1
Children/youth at risk for school failure	4
Children/youth at risk of juvenile justice involvement;	2
General population	5

PEI Priority Outcomes

Reduction of school failure	2
Reduction of homelessness	1
Reduction of prolonged suffering	5
Reduction of unemployment	0
Reduction of incarceration	0
Reduction of removal of children from their homes	10
Reduction of suicide	0
General outcome	7

PEI Priority Age Groups

___ 0-25	2
___ 26-49	0
___ 50+	0
___ All ages	10
___ Families	13

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The School Districts conducted an internal survey which further enriched our assessment. At this more detailed level, the priorities identified by the MHSAs PEI assessment (violence, anger management, and resiliency) were also identified as areas of need.

School-based services

of PEI programs – 117

of schools who responded – 33

<u>Program type</u>	<u># of programs</u>
Counseling (ind/gp)	20
Student training	20
Mentoring	17
Social Interaction	14
Class lectures	13
Parent Participation	6
Youth advocate	5
Encourage Positive Environment	4
Transportation	3
Community Collaboration	3
Therapy	2
Violence Prevention/Anger Mgmt	2
Problem solving/Resiliency	2
Misc (1 each)	6

PLANNING

Community proposals for PEI strategies, in the context of a mental health promotions model and the resiliency research, did identify programs with demonstrated effectiveness in addressing determinants of characteristics found among stressed families (conduct disorder, depression, anxiety, substance abuse, family conflict and aggression).

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Identifying PEI Strategies: Needs and Interest Survey

Due to the widespread interest that had already developed among community members in using these MHSAs PEI dollars to fund specific programs, the community was invited to submit simple letters of interest which would serve to provide further community feedback into this planning process; namely, how to best serve the identified priority populations with the limited resources available. The following questions were posed based on the DMH MHSAs PEI application guidelines:

In regard to the proposed intervention strategy, please provide the following information:

1. Brief program description (including where the service will be delivered)
2. Budget for proposal
3. Leveraged resources
4. Prevention or early intervention target population and the number of clients who will be served
5. Outcomes the project will achieve
6. Evidence-based practice proposed

Fifteen letters of interest were received which represented a total request for funding that exceeded our allocation by 39.2%:

<u>Population</u>	<u>Funds Proposed</u>	<u>Programs</u>
Ages 0-5	\$38,000	Infant Development
Youth	\$424,029	PIP, IY, PCIT
TAY	\$70,000	TAY Engagement/Resiliency Training
Adult	\$24,593	MH services in the primary care setting
Older Adult	\$92,500	Wellness Outreach Program for Older Adults
Latino	\$40,000	FAST
Native American	\$192,726	Native Path to Healing
Families	\$120,000	Home visiting program
Anti-stigma	\$7,000	NAMI and PFLAG

The needs and interests contained in the completed surveys provided community-level feedback that again was consistent with the emphasis on youth/family-stress and strengthening, and school-based service delivery. In addition, the need to address health disparities and populations at high risk for suicide emerged more clearly (Latino families, Native American, older adults, LGBT). Thereby, our assessment of priority population needs was further enriched.

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The challenge that we were faced with was to further prioritize and identify the most effective strategies to fund. Therefore, the next phase of the community program planning process included a review of the literature in the arena of public health and youth resilience. The conceptual frameworks and research findings were shared with the community.

Review of the literature

The World Health Organization summary reports, *Prevention of Mental Disorders: Effective Interventions and Policy Options (2004)*, and *Promoting Mental Health: Concepts, Emerging Evidence and Practice (2005)*, were helpful in providing a framework in which to conceptualize the spectrum of mental illness and mental health and the related strategies for use of resources.

The following quote nicely captures the challenge before our existing *treatment* system as a function of the outcomes experienced in the arena of mental illness - further emphasizing the need to look through a lens of “help first”.

“...it will not be possible to move forward into promoting the mental health of individuals, communities and populations without going beyond solely a disease-based view of mental health...perhaps the majority of mental health problems encountered are the result of difficult life events, conditions and environments that diminish or disable people’s resourcefulness or capacity to cope and access to social supports. Furthermore, the burden of mental health problems not meeting the criteria of a disorder may be similar to or even bigger than the actual disease burden.”

- *Promoting Mental Health: Concepts, Emerging Evidence and Practice (2005)*, World Health Organization, Page 227.

As a community, we reviewed the findings that 1) five of the ten leading causes of disability and premature death worldwide are psychiatric conditions, 2) mental disorders thereby represent an immense social burden, and 3) there is now substantial evidence that prevention and mental health promotion interventions can influence risk and protective factors and thereby can reduce the incidence and prevalence of some mental disorders (WHO, 2005). The critical need and value for PEI approaches was better understood. As a result, the following framework was adopted for our MHSA PEI plan development:

PEI Framework

Mental Illness **Prevention** reduces

- incidence, prevalence and recurrence of mental disorders,

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- the frequency of mental illness symptoms, and
- the risk of occurrence of mental illness conditions – including the reoccurrence and the impact of the illness on the individual, their family, and society.

Mental Health **Promotion** targets the determinants of mental HEALTH to increase

- positive mental HEALTH.

The focus of prevention or health promotion is the malleable determinants - individual, family, social, economic, and environmental...they can be disease-specific or generic Risk or Protective Factors. This shifts the arena for intervention to increasing protective and/or decreasing risk factors that contribute to negative health indicators (e.g., suicide rates)– not mental health diagnoses or profile. The findings also suggest that most individual level interventions to promote mental health have the dual effect of reducing problems while increasing competencies.

“... there is a risk that human suffering, a likely reaction in extreme circumstances, is categorized as a mental problem and thus medicalized. When people are facing major stresses caused by unstable family, social, economic and political conditions, when their basic physical and mental needs are threatened, and when they are stigmatized and isolated while facing such situations, the suffering and the distress is tremendous. The reactions that individuals may display when they are distressed or are fighting for their lives are frequently confused with mental disorders. However, a considerable body of longitudinal research shows that when their basic life conditions are restored, when the suffering experienced is recognized and legitimized, and when it is possible to count on family and social support, the capacity to recover – the resiliency – and the capacity to build meaning out of suffering is astonishing.”

- *Promoting Mental Health: Concepts, Emerging Evidence and Practice (2005), World Health Organization, Page 227.*

Resiliency Research

Similarly, the past twenty years of resiliency research is both inspiring and informative. This research indicates that risk factors account for only 20-49% of outcomes while protective factors predict outcomes for anywhere from 50-80% of high risk populations. These findings transcend ethnic, social, class, geographical and historical boundaries, as well.

The transactional-ecological model of human development identified by Bonnie Benard (Resiliency: What We Have Learned, WestEd, 2004) is a resiliency framework that takes into account a broader landscape over time and a

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strengths-based perspective: resilience as normative – a universal capacity. In order to produce the good developmental outcomes (which can occur even under conditions of risk) a nurturing environment that provides *caring relationships, high expectations messages, and opportunities for participation and contribution* is required. The provision of these conditions contributes to the vital sense of hope that is considered critical to the recovery process, as well.

These broad areas of Protective Factors should be found and fostered within families, schools and communities. Therefore, one of the many exciting challenges before us is to examine how our mental health resources can best be used to this end. The MHSA Prevention and Early Intervention funding will be used in this manner – looking proactively at the question of “How can we PROMOTE mental HEALTH and well-being in our community by focusing on protective factors at individual, group and community levels? The next step was then to look to the research regarding specific approaches relative to our community mental health needs and priorities.

Review of the evidence-based practice (EBP) models

We reviewed numerous EBP models from resources such as the following:

- DMH MHSA PEI Resource Listing
- CIMH MHSA PEI webcast training information
- Prevention of Mental Disorders (WHO, 2004) and Promoting Mental Health (WHO, 2005)
- SAMHSA National Registry of Evidence-based Practices and Programs (NREPP)
- Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Program Guide
- SAMHSA CSAP toolkit for Communities that Care (CTC) which has a glossary that categorizes prevention strategies by target population.

Relevant strategies and those proposed by the community were compared to a table in a working paper on “Resilience-Building Prevention Programs that Work: A Federal Perspective”, Curie, C.G., Brounstein, P.J., and Davis, N.J., 2003 (<http://www.dhh.louisiana.gov/offices/publications/pubs-142/Resilience%20Building%20Prevention%20Programs.doc>) that identified models that served multiple diagnostic categories that are 1) most commonly found and 2) consistent with our community health indicator profile.

We thereby selected strategies (from those recommended/requested by our local community members) which, consistent with the priority needs identified by our community, address many of the following issues:

- Address determinants of conduct disorders;

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- Simultaneously address determinants of other common mental health concerns such as depression and anxiety;
- Simultaneously address determinants of substance abuse;
- Involve family members;
- Are school, healthcare, or home-based; or,
- Address both risk and protective factors related to family conflict and aggression.

IMPLEMENTATION AND EVALUATION

As we begin to think forward toward the implementation and evaluation phases, it is helpful to keep in mind the research findings regarding what is needed to be successful (i.e., to have an impact in the world of prevention).

- Package of coordinated, collaborative programs
- Multi-year programs are more likely to foster enduring benefits
- An approach that targets risk and protective factors at the institutional, environmental, and individual levels.

Over time, the EDC MHSA PEI plan intends to aspire to these goals.

PEI Program Summary

In moving forward with the seven proposed PEI Programs, there was a clear acknowledgement that ongoing CPP was needed and would shape changes in the current level of our understanding and the related planning for the use of the MHSA PEI funds. The proposed vehicle for this process is participation in the local Community Strengthening Collaboratives by all of the MHSA PEI-funded programs (one serving the Georgetown Divide, one serving South Lake Tahoe, and another serving the Western Slope Region) which provides an established arena in which to incorporate future planning discussions. Furthermore, this forum will serve as an avenue for ensuring oversight in a collaborative setting for the effectiveness of the PEI-funded programs. It is anticipated that over time, program changes will occur to ensure continuous improvement and adjustments experienced in the funding amounts. This possibility will be further explored during the early phase of implementation.

Program 1 – School-based Mental Health Promotion and Service Linkage

In this strategy, County Mental Health clinical staff are assigned to participate in a school-based screening team thereby providing for early identification, assessment, and referral to PEI-funded services, such as the PIP, Incredible Years, and other MHSA and Medi-Cal funded programs, such as, Teaching Prosocial Skills, and Trauma-focused Cognitive

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Behavioral Therapy. All school-age groups will be considered. The target population is youth struggling with school success assessed to be related to family stress.

Program 2 – Primary Intervention Project

This early intervention strategy will be available on a pilot basis in two regions of the county serving youth in grades K-3. The continued use of this model and potential future pilot sites will be a subject for further discussion. Youth experiencing classroom difficulties that may be a function of family stress are the target population.

Program 3 – Incredible Years

PEI-funded parenting skills classes will occur three times a year in community-based settings applied as a universal strategy. Families may be referred from the School-based Mental Health clinicians, from the MHD, school districts and community partners. The MHD will provide the trained facilitators; community-based partners who wish to host the classes will provide the site, and PEI-funded meals, childcare, and the related operational materials. The intention is to provide this class on a mobile basis thereby reaching the outer lying communities over time.

Program 4 – Community Education Project

The Community Education Project seeks to promote community mental health through knowledge, education and skills training and to build the community's capacity to promote mental health through community education. The Community Education Project will apply three community educational strategies: Parenting Wisely – a multi-media CD-ROM educational tool, Family to Family – a parent education program specifically targeting families of individuals with serious mental illness, and a PFLAG-sponsored outreach (Parents, Families, and Friends of Lesbians and Gays), education and training program designed to decrease stigma and discrimination related to the LGBT (Lesbian, Gay, Bisexual and Transgender) population.

Program 5 – Wennem Wadati

The Native American Resource Collaborative has developed a culturally-specific strategy by which to engage and strengthen the mental health of youth and families. Wennem Wadati – A Native Path to Healing applies a combination of mental health early intervention strategies, traditional cultural teachings, and crisis intervention support for youth. Specifically, this program will provide outreach to American Indian youth by inviting their participation in traditional talking circles. In addition, outreach to American Indian families to participate in monthly traditional gatherings designed to spread cultural knowledge and family preservation will be conducted. Finally, during school hours, a phone line will provide access to an American Indian mental health specialist who will be available via answering service to respond to

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school sites in situations where American Indian students are experiencing a mental health crisis. Foothill Indian Education Alliance, a non-profit organization, will serve as the fiscal agent for this project.

Program 6 – Home-Delivered Meals Wellness Outreach Program for Older Adults

Community-based outreach, engagement and early intervention services targeting the Older Adult population will be integrated with the existing Home-Delivered Meals program provided by the County Department of Human Services. As a result, the ability to provide mental health early detection and intervention to many older adults and caregivers will be greatly enhanced. This program targets a high-risk population for depression and suicide.

Program 7 – Health Disparities

The existing MHSA CSS plan includes a workplan designed to address Health Disparities for the Latino and Native American populations. The efforts in these areas have been largely in the areas of outreach, engagement, and early intervention. MHSA PEI funding, therefore, is proposed to be used for these programs upon PEI plan approval.

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This project, **School-based Mental Health Promotion and Service Linkage**, addresses the PEI target population of *children and youth in stressed families* and, as such, is intended to address the community mental health needs surrounding *at-risk children, youth and young adults*. Early identification and prevention strategies serve to strengthen youth, families and the community and will ultimately reduce the rate and risk of destructive behaviors – such as suicide and aggression.

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

Program Name and Number: **Program #1 - School-based Mental Health Promotion and Service Linkage**

Mental Health Prevention Goal - Early identification, assessment, and linkage to the appropriate level of mental health interventions – including prevention models.

Approach – Targeted prevention.

Age group – Youth, all school ages.

Determinants to be addressed:

- Determinants of conduct disorders
- Determinants of other common mental health concerns such as depression and anxiety
- Determinants of substance abuse
- Both risk and protective factors related to family conflict and aggression

Intervention Strategy/Model and Provider/Location:

PEI-funded Mental Health Licensed Clinicians from the County Mental Health Division will be identified to respond County-wide to school referrals for assessment and appropriate mental health service linkage. The mental health service options include PEI and non PEI-funded treatment options. Culturally and linguistically appropriate services will be identified. These individuals will be trained in mental health assessment, treatment engagement skills, and resource

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brokerage. They will also provide psycho-educational interventions targeting the students, family members, and school faculty to address issues of stigma and discrimination in an effort to increase access and interventions at a prevention stage. Alternative recommendations for youth who are not identified for mental health or prevention services will be provided by the screening team who will partner with the referring teacher and family toward a solution.

Specific strategies to support the integration of PEI services into the existing systems include the following:

- The establishment of an interdisciplinary Screening Committee comprised of a PEI Mental Health clinician, School Representative, and potentially the County Office of Education Behaviorist, as needed.
- Proposed participation in the local Community Strengthening Group to report on the project progress, participate in program monitoring and evaluation, and to address PEI planning issues.
- Initial triage to determine if interventions should be provided at the school, by referral to mental health counseling, or via mental health prevention services.
- It is anticipated that family visits may be needed for PEI referrals to determine the optimal strategy for referral. Such visits will be coordinated with other partner agencies who may be involved with the child and the family. Mental health intervention strategy options will include:
 - Individual family sessions (brief treatment, up to 10 sessions) to address problem-solving and communication skills.
 - Youth Pro-social Skills Group
 - Youth Emotional Regulation Group
 - Trauma-focused cognitive behavioral therapy
 - Parent Education (Incredible Years)
 - Primary Intervention Project (available only at certain sites)

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4. Programs

Program Title	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	
School-based Mental Health Services Linkage	Individuals: Families:	Individuals: 25 Families: 25	6
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: Families:	Individuals: 25 Families: 25	6

While the cost per youth served may appear high when compared with broader-based prevention programs, it should be noted that this relatively intense, early intervention program is intended to be short term; that is, up to six months. We will be targeting for services younger children not yet “in the system”, but who have been identified by school personnel and mental health professionals as being at high future risk for school failure, trouble with the law, and/or out of home placement. As a result of our community planning process, our school partners identified this population as most in need of effective early intervention as a cost-effective use of resources. In most cases we expect that these youth will not be covered by Medi-Cal and so, without this program, they would receive limited or no mental health services until such time as they are under the custody of Probation or Children’s Protective Services. We should add that our projection of 25 youth served was intended to be a conservative figure, estimating only for the first six month period. Over time, we would expect to see the numbers increase.

5. Alternate Programs

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- Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3). N/A

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

This strategy specifically targets early intervention and linkage to County Mental Health services which will be broadened to include prevention programs. The Mental Health clinicians will receive training related to the available mental health services – including other MHSA services and services for adults – in order to ensure effective service brokerage. Linkage to other needed services may be improved as a function of the proposed participation in the Community Strengthening Group in which collaboration with other providers is enhanced.

Linkage to culturally-specific services for the Latino, Native American, African American, and Asian populations, among others (include LGBT specific services) is critical to effective PEI service delivery. The MHSA programs provide some valuable options (see the Health Disparities Program and the Community Education Program). However, additional research and networking will need to occur in order to address a broader range of racial and ethnic groups and other groups who experience disparities in access and outcomes. Outreach and engagement efforts to these groups will be explored, through vehicles such as the high school youth groups.

7. Collaboration and System Enhancements

This program will build on the existing partnership between the MHD and the County Office of Education. As a result of the active participation that may occur between the Mental Health clinicians in the local collaboratives, this strategy represents an enhancement to existing assets within our community: the regional Community Strengthening Collaboratives. Collaboration is inherent in this design as these groups specifically bring together a wide range of local agencies intended to support the health, safety and well-being of the community. Mental Health clinician participation in these groups establishes a mechanism for ongoing community collaboration in relationship to this MHSA PEI project and, in general, to the enhancement of the service delivery system.

Collaboration with community providers will occur at many levels: information-sharing, referrals, collaborative service planning, and cross training. On a client by client basis, collaboration may occur with a Community-based organization (CBO) that provides culturally-specific services – perhaps for a family member, a health provider, a church or group that sponsors youth activities, in addition to the school or other county service agencies. Use of an early intervention model that provides brief treatment targeting youth and family strengthening typically requires or benefits from collaboration and linkage to (natural) resources within the client’s community for ongoing support. To be effective in this collaborative work,

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MHSA PEI staff will be provided training in cultural competence, use of interpreter services and cultural brokers, and resource brokerage.

8. Intended Outcomes

The fundamental goal is to establish school-based mental health services linkage for children in order to increase school success and provide early intervention and prevention efforts that strengthens youth and families and will thereby impact and decrease destructive social conditions, such as suicide and aggression.

High risk populations to be targeted include the Latino, Native American, other ethnic minority groups, and the LGBT populations. Targeted cultural goals and desirable outcomes include linkage with culturally-specific services, identification of culturally familiar support, and resources by which to recognize, return to, can celebrate cultural identity and traditions.

9. Coordination with Other MHSA Components

Integration with the MHSA CSS programs will occur as a result of marketing the availability of the school-based linkage services to all MHSA program staff. Individualized discussions between programs will occur to identify effective mechanisms for referrals, relevant collaboration and problem-solving. The Workforce Education & Training (WET) Coordinator will look for opportunities to merge workforce development and the need for capacity building in the arena of prevention and health promotions in collaboration with the MHSA Project Coordinator. The other MHSA components are still under development.

10. Additional Comments (optional). None.

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County: EI Dorado

PEI Project Name: Program # 2 - Primary Intervention Project (PIP)

Date: November 10, 2009

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	x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Psycho-Social Impact of Trauma	x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At-Risk Children, Youth and Young Adult Populations	x	<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
B. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	x	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Children and Youth at Risk for School Failure	x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	x	<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).

A detailed description of the planning process that resulted in the selection of the priority populations for all of the programs was provided under Program #1 and reflects the stakeholder input, data, and process used to arrive at this priority population, as well.

This project, **Primary Intervention Project (PIP)**, targets the PEI target population of *children and youth in stressed families* and, as such, is intended to address the community mental health needs surrounding *at-risk children*.

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

Program Name and Number: **Program #2 - Primary Intervention Program (PIP) Project**

Mental Health Prevention Goal – To decrease school adjustment difficulties at an early age and build protective factors to foster youth resilience and mental health.

Model – targeted prevention.

Age group – Youth, ages 4-9.

Determinants to be addressed:

- Determinants of conduct disorders
- Determinants of substance abuse
- Both risk and protective factors related to family conflict and aggression

This strategy addresses determinants that, when addressed in a health promotions/prevention approach, diminish along with the rates of suicide.

Intervention Strategy/Model:

The Primary Intervention Program (PIP) Project is an evidence-based practice that has been supported by the California Department of Mental Health since 1983 and is part of the California Early Mental Health Initiative (EMHI). Staff involved

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in this project will plan to attend the annual EMHI training conference, which provides training in various aspects of program implementation and skills development. The PIP's goal is to increase school adjustments as school-adjustment difficulties have been linked to later delinquency, substance abuse and drop-out rates.

The program provides screening to identify children with mild aggression, withdrawal and/or learning difficulties. It is a Mental Health Promotion model with behavioral control and adaptive assertiveness among the outcomes achieved.

Provider/Location:

The PIP project is a school-based collaboration between the affected County school district and the County Mental Health Division (MHD). Teachers and a screening team identify children (K-3) who are "at risk" of developing emotional problems as indicated by their school adjustment difficulties. Alternative recommendations will be provided for youth screened out and the screening team will partner with the referring teacher and family to this end. Trained school aides provide the PIP intervention in the form of 1:1 non-directive play for approximately 30-45 minutes per week for 12-15 weeks. This proposal includes a 12-15 week skills training group intervention strategy at some sites called "Second Step" – a violence prevention program which is also a part of the California Early Mental Health Initiative.

The PIP Program will:

- Serve students in kindergarten through third grade in public schools experiencing mild to moderate school adjustment difficulties. The services are school-based and low cost. Supervised and trained child aides provide weekly play sessions with the selected students.
- Ensure that students are selected for program participation through a systematic selection process that includes completion of standardized assessments and input from the school-based mental health professional and teachers.
- Encourage the involvement of parents/guardians and teaching staff to build alliances to promote student's mental health and social and emotional development. Parental consent is required for student participation.
- Have a core team consisting of school-based, credentialed mental health professionals, local mental health professionals (from a cooperating mental health entity) and child aides.
- Ensure that credentialed school-based mental health professionals provide ongoing supervision/training of child aides.
- Provide ongoing monitoring and evaluation of program services.

Two school districts (six school sites) will provide the appropriate space for this project, an MHSA-funded, school-employed mental health professional who will participate in the screening and training sessions, and a coordinator to manage the collection and submission of program data. Appropriate sized playrooms will be provided, along with supplies, telephones, and workstations. The intention is to ensure that this program is available in two regions of the

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County (the communities of South Lake Tahoe and the Georgetown Divide are the target regions at this time) for a pilot of up to two years. This approach provides an opportunity to use MHSAs funds to incubate efforts as the funds are not sufficient to provide for County-wide programs. The continued use of this model and the locations for use of these funds will be re-evaluated continuously as the community engages in ongoing MHSAs PEI planning.

4. Programs

Program Title	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	
Primary Intervention Program (PIP)	Individuals: 50 Families:	Individuals: Families:	6 - in Georgetown. Training & program set-up will occur in the latter part of FY 09-10 for SLT.
	Individuals: Families:	Individuals: Families:	
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 50 Families:	Individuals: Families:	6 - in Georgetown. Program start up is anticipated in Sept. 2010 for SLT.

5. Alternate Programs

Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3). NA

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

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PIP and Second Step Child Aides will be trained regarding referral and access to County Mental Health Services, including the School-based Mental Health clinicians and services for adults. Linkage to other needed services may be improved as a function of the potential participation in the Community Strengthening Group in which collaboration with other providers is enhanced.

Linkage to culturally-specific services for the Latino, Native American, African American, and Asian populations, among others (include LGBT specific services) is critical to effective PEI service delivery. The MHSA programs provide some valuable options (see the Health Disparities Program and the Community Education Program).

7. Collaboration and System Enhancements

This strategy involves a mental health – school district collaboration, an interdisciplinary team screening process, and enhances mental health service access. As such, it represents a key system enhancement related to health promotion and the enhancement of protective factors that target areas of concern in EDC (family stress and the youth delinquency).

Collaboration with community providers will occur at many levels: information-sharing, referrals, collaborative service planning, and cross training. On a client by client basis, collaboration may occur with a Community-based organization (CBO) that provides culturally-specific services – perhaps for a family member, a health provider, a church or group that sponsors youth activities, in addition to the school or other county service agencies. Use of an early intervention model that strengthens youth typically requires or benefits from collaboration and linkage to (natural) resources within the client's community for ongoing support. To be effective in this collaborative work, MHSA PEI staff will be provided training in cultural competence, use of interpreter services and cultural brokers, and resource brokerage.

8. Intended Outcomes

The fundamental goals are to:

- Provide prevention and early intervention services at a young age.
- Provide services in a school-based setting to enhance access.
- Build protective factors by facilitating successful school adjustment.
- Target violence prevention as a function of a skills training.

High risk populations to be targeted include the Latino, Native American, and other ethnic minority groups. Targeted cultural goals and desirable outcomes include accessing the School-based Mental Health clinicians to explore work with

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the parents and/or family to promote linkage with culturally-specific services, identification of culturally familiar support, and resources by which to recognize, return to, can celebrate cultural identity and traditions.

9. Coordination with Other MHSAs Components

The MHSAs CSS programs will be accessed through the School-based Mental Health clinicians proposed under Program #1 as the need arises – this may include the need for adult services. The WET Coordinator will be looking for opportunities to merge workforce development and the need for capacity building in the arena of prevention and health promotions in collaboration with the MHSAs Project Coordinator.

The other MHSAs components are still under development.

10. Additional Comments (optional). None.

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County: EI Dorado **PEI Project Name:** Program # 3 - Incredible Years Program
Date: November 10, 2009

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	x	<input type="checkbox"/>	x	<input type="checkbox"/>
2. Psycho-Social Impact of Trauma	x	<input type="checkbox"/>	x	<input type="checkbox"/>
3. At-Risk Children, Youth and Young Adult Populations	x	<input type="checkbox"/>		
4. Stigma and Discrimination	x	<input type="checkbox"/>	x	<input type="checkbox"/>
5. Suicide Risk	x	<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"/>	x	<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	<input type="checkbox"/>		
4. Children and Youth at Risk for School Failure	x	<input type="checkbox"/>		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	x	<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).

A detailed description of the planning process that resulted in the selection of the priority populations for all of the programs was provided under Program #1 and reflects the stakeholder input, data, and process used to arrive at this priority population, as well.

The **Incredible Years Program**, targets the PEI target population of *children and youth in stressed families* and, as such, is intended to address the community mental health needs surrounding *at-risk children, youth and young adults*.

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

Program Name and Number: **Program #3 - Incredible Years Program**

Mental Health Prevention Goal – To promote emotional and social competence and prevent behavioral and emotional problems in young children by impacting multiple risk and protective factors that impact the development of conduct problems.

Approach – universal and selective prevention.

Age group – Youth, 2 - 12.

Determinants to be addressed:

- Determinants of conduct disorders
- Determinants of other common mental health concerns such as depression and anxiety
- Determinants of substance abuse
- Both risk and protective factors related to family conflict and aggression

The protective factors that will be addressed include bonding, opportunities, recognition and skills.

The risk factors that will be addressed include early and persistent antisocial behavior, family conflict, family management problems, favorable parental attitudes and involvement in problem behaviors, and lack of commitment to school.

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This strategy addresses determinants that, when addressed in a health promotions/prevention approach, diminish along with the rates of suicide.

Intervention Strategy/Model:

The **Incredible Years Program** is a set of comprehensive, multi-faceted, and developmentally-based curricula targeting 2-12 year old children, their parents, and school teachers. This strategy addresses the role of multiple interacting risk and protective factors in the development of conduct disorders. This intervention strategy thereby serves as a violence prevention strategy. Each program component is designed to work interactively with the others to promote emotional and social competence and prevent, reduce and treat behavioral and emotional problems in young children. This is a 12-14 week program with an estimated cost per un-insured family of \$1000.

Provider/Location:

The County Mental Health staff will provide classroom facilitators and seek to work with community and/or school agencies to provide the space and PEI-funded childcare, meals and operational materials.

As a mental health promotion strategy, the goal is to bring this program to various community-based settings three times a year in order to make this effective program available to stressed families County-wide. These classes are envisioned as providing opportunities to bring this program, one series at a time, to the outer-lying communities. The determination of the specific sites for these services is still under evaluation but the goal is to ensure some capacity for bilingual/bicultural services for the Latino community.

The host site will advertise the class series and will register clients. Along with the host site, the Mental Health clinician, other MHD personnel, and potentially school personnel will provide referrals and complete a pre-screening form with the family in the event that priority decisions need to be made for applicants. A representative from the host site will partner with the assigned class facilitators to serve as a screening committee. Alternative recommendations will be provided for families screened out and the screening team will partner with the family to this end.

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4. Programs

Program Title	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	
Incredible Years Program	Individuals: 72 Families: 24	Individuals: 0 Families: 0	6
	Individuals: Families:	Individuals: 0 Families: 0	6
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 72 Families: 24	Individuals: 0 Families: 0	6

5. Alternate Programs

Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3). NA

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

The interdisciplinary screening team proposed under Program #1 comprised of Mental Health and County Office of Education personnel will serve as a key referral source to this program and the participating Mental Health clinicians (Program #1) will be charged with providing linkage to services for children and families in need. The Mental Health clinicians will receive training related to the available mental health services – including other MHSAs services and services for adults – in order to ensure effective service brokerage. The clinicians’ potential participation in the Community Strengthening Groups will also facilitate enhanced access to a range of services. Client participation in this program will serve to break down barriers, reduce stigma, and increase access to mental health and other services. The availability of this program will be marketed to community partners by the host sites.

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Linkage to culturally-specific services for the Latino, Native American, African American, and Asian populations, among others (include LGBT specific services) is critical to effective PEI service delivery. The MHSA programs provide some valuable options (see the Health Disparities Program and the Community Education Program). However, additional research and networking will need to occur in order to address a broader range of racial and ethnic groups and other groups who experience disparities in access and outcomes. Outreach and engagement efforts to these groups will be explored, as well.

7. Collaboration and System Enhancements

This program will be executed in collaboration with the County Office of Education and represents a systems enhancement in the form of increased school and community-based prevention services. Furthermore, this program builds on the current success of the MHSA CSS and SB163-funded Incredible Years classes which have been limited to families involved in the Specialty Mental Health level of treatment. Enhanced access for families (at the stage of PEI and including non-MediCal families) is intended with this expansion effort.

Collaboration with community providers will occur at many levels: information-sharing, referrals, collaborative service planning, and cross training. On a client by client basis, collaboration may occur with a Community-based organization (CBO) that provides culturally-specific services – perhaps for a family member, a health provider, a church or group that sponsors family activities, in addition to the school or other county service agencies. The MHSA PEI School-based Mental Health Clinicians will be accessed for much of this work. Use of an early intervention model that provides brief treatment targeting youth and family strengthening typically requires or benefits from collaboration and linkage to (natural) resources within the client’s community for ongoing support. To be effective in this collaborative work, MHSA PEI staff will be provided with training in cultural competence, use of interpreter services and cultural brokers, and resource brokerage.

8. Intended Outcomes

The fundamental goals are to increase:

- Positive and nurturing parents
- Child positive behaviors, social competence, and school readiness skills
- Parent bonding and involvement with teachers/school
- Teacher classroom management skills

The goals also are to decrease:

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- Harsh, coercive and negative parenting
- Children behavior problems

The Youth Outcome Questionnaire (YOQ) will be applied on a pre and post class basis.

High risk populations to be targeted include the Latino, Native American, other ethnic minority groups, and the LGBT populations. Targeted cultural goals and desirable outcomes include linkage with culturally-specific services, identification of culturally familiar support, and resources by which to recognize, return to, can celebrate cultural identity and traditions.

9. Coordination with Other MHSA Components

The School-based Mental Health Clinicians will be accessed to assist with service brokerage. Coordination with the MHSA CSS program staff and the SB163 program staff will be critical to ensure effective leveraging of the staff trained in this intervention strategy. Information regarding the availability of this program will be provided to MHSA CSS and WET program staff and participants as potential sources of referrals.

The WET Coordinator will be looking for opportunities to merge workforce development and the need for capacity building in the arena of prevention and health promotions in collaboration with the MHSA Project Coordinator.

The other MHSA components are still under development.

10. Additional Comments (optional) – None.

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County: El Dorado **PEI Project Name:** Program #4 - Community Education Project
Date: November 10, 2009

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

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	x	x	x	x
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	x	x		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	x	x		

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

A detailed description of the planning process that resulted in the selection of the priority populations for all of the programs was provided under Program #1 and reflects the stakeholder input, data, and process used to arrive at this priority population, as well.

This project, **Community Education Project**, targets the PEI target population of *children and youth in stressed families* and, as such, is intended to address the community mental health needs surrounding *at-risk children, youth and young adults*. This program will also address stressed families that include caretaking of adult children and/or older adults with mental illness through the NAMI Family to Family program.

For youth, this strategy addresses determinants that, when addressed in a health promotions/prevention approach, diminish along with the rates of suicide. In addition, the Family-to-Family and PFLAG programs more directly serve to provide education, access, and stigma-reduction for populations at risk of depression and suicide.

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

Program Name and Number: **Program #4 - Community Education Project**

The Mental Health Promotions or Prevention Goal - Promotion of mental health through knowledge, education and skills training and the building of community capacity to promote mental health through community education. This strategy emphasizes the key role of family in strengthening communities.

Intervention Strategies/Models - The Community Education Project will apply three community educational strategies:

Parenting Wisely Program (Selective and Indicated Prevention Approaches)

This parent training program targets parents with children ages 5-18. The Parenting Wisely Program uses a self-administered, interactive and multimedia CD-ROM as the training vehicle and thereby overcomes illiteracy and transportation barriers. This program is based on social learning theory, family systems theory, and cognitive theory and seeks to help families improve relationships and decrease conflict by improving parenting skills and enhancing family communication, mutual support, supervision and discipline. This program is recognized by SAMSHA as a model

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program. The CDs and training materials are available in Spanish and will be purchased for use locally. In addition, cultural brokers in our Health Disparities Program will be access to assist in facilitating culturally-competent access of this resource. The utility of this intervention strategy targets the barriers inherent in a geographically disperse rural communities and addresses literacy barriers, as well.

Protective Factors addressed – Individual, Family, School and Peers

- Accepting personal responsibility
- Personal power
- Self-esteem
- Attachment to parents
- Problem-solving skills
- Family support and cohesiveness
- Parent-child bonding
- Clear and positive communication
- Clear rules and consequences
- Monitoring
- Parental involvement in schoolwork
- Parent-teacher communication
- Parental monitoring of peer activities
- Healthy communication with peers
- Parental networking with peers' families

Risk Factors addressed - Individual, Family, School and Peers

- Lack of bonding to parents
- Aggressive or disruptive behavior
- Poor supervision and control
- Inconsistent rules and consequences
- Poor communication and support
- Child abuse or neglect
- Domestic violence
- Favorable attitudes toward substance use

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- Lack of parental support and involvement in schoolwork
- Truancy
- Academic failure
- Lack of parental supervision of peer activities

Parenting Wisely can be used in variety of ways:

- Agency settings – including the juvenile hall and mental health clinics
- Home visits
- Groups
- Loaned to parents for use at home

Provider/Location:

In order to facilitate successful application, a member of the MHSA Project Management Team will be assigned to serve as the coordinator and will seek to:

- Identify multiple sites for use of this tool;
- Ensure that leadership supports implementation; and,
- Ensure that evaluation is conducted.

The program requires only 1-2 sessions for a total of 3 hours. The program is designed for parents who are unfamiliar with computers and findings indicate that parents prefer to do the sessions with their teens or pre-teens. There are no licensing fees. One time costs for materials and start up training do apply. By purchasing 10 CD-ROMs, many families can be served as these tools will be made available in a Community Education Library.

A protocol for each user site will be developed before the resource is released. The protocol will address outreach/marketing, terms for use, prioritization for use (if necessary), responsibilities and options provided if a need cannot be met, and data collection and evaluation.

NAMI Family to Family training capacity building (Selective and Indicated Prevention Approaches)

The National Alliance on Mental Illness (NAMI) serves to provide awareness, education and advocacy as a means to offer hope, reform and health to the community. This group began in 1979 and represents families, friends and individuals affected by mental illness.

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The NAMI Family to Family Program is a 12-week course provided to families, friends, and caregivers and community members by NAMI volunteers free of cost. The family education approach is based on theories of stress, coping, and adaptation. The primary outcome of concern in family education is the well-being of the family and the program is not diagnosis-specific. This family education model provides information, coping skills training, and collaboration skills training. Enhancement of protective factors for family members serves as an early intervention strategy that positively impacts the recovery process of mental health consumers.

This 12-week program is taught by trained family member volunteers with the use of a highly structured, scripted manual. In weekly two- to three-hour sessions, family caregivers receive information about mental illnesses, treatments and medication, and rehabilitation. They learn self-care and communication skills as well as problem-solving and advocacy strategies.

While the research on the Family-to-Family Education Program is limited, a few studies have found that family members who participate in family education programs have greater knowledge and self-efficacy and are more satisfied with the patient's treatment than those who do not. In addition, the participants experienced significantly greater family, community, and service system empowerment and reduced displeasure and worry about the family member who had a mental illness.

Provider/Location:

MHSA funding is proposed to enhance the trainer capacity of the local county NAMI chapter by covering unmet travel expenses for the training of two new instructors per year and the costs of classroom materials for one additional class per year. The increased number of trainers will increase access to this program geographically and in the number of classes offered which will serve an additional 25 families. This is a popular class and family members often request to attend more than once to improve their knowledge and skill base. A protocol which includes data collection regarding referrals and a protocol for enrollments that cannot be met will be required.

PFLAG Community Education (Universal, Selective and Indicated Prevention Approaches)

PFLAG is a national organization that started in 1972, and has since opened affiliate chapters in more than 460 communities across America. PFLAG stands for Parents, Families, and Friends of Lesbians and Gays (and also includes and supports bisexual and transgendered individuals.) PFLAG's mission is to promote the health and well-being of gay, lesbian, bisexual, and transgendered persons, and their families and friends.

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PFLAG works to fulfill this mission through:

- **Support** to cope with an adverse society.
- **Community** involvement to build understanding.
- **Education** to enlighten the public and dispel stereotypes.
- **Advocacy** to end discrimination and ensure equal civil rights.

PFLAG provides an opportunity for dialogue about sexual/affectional orientation and gender identity, and acts to create a society that is healthy and respectful of human diversity.

Provider/Location:

Therefore, this project seeks to achieve the following:

- Increase awareness of mental health stressors and protective factors
- Develop suicide awareness and prevention approaches among mental health providers and the local community
- Foster tolerance and understanding of diversity
- Identify problems early and intervene quickly
- Provide linkage services to those with mental health needs outside of the scope of PFLAG services.

MHSA funding will be used to start an outreach, education and training program for mental health providers and interested community members by funding the information packets that PFLAG volunteers will present to participants of their program. Outreach costs such as mileage reimbursement, postage, and food costs may be paid for, as well.

Based on a target goal of reaching 200 individuals, the cost per person is \$10.

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4. Programs

Program Title	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	
Parenting Wisely Program	Individuals: 0 Families: 50	Individuals: 0 Families: 0	6
NAMI Family to Family Program	Individuals: 0 Families: 25	Individuals: 0 Families: 0	6
PFLAG Community Education Program	Individuals: 50 Families: 0	Individuals: 0 Families: 0	6
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 50 Families: 75	Individuals: 0 Families: 0	6

5. Alternate Programs

Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3). NA

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

Community education, capacity and asset-building is the theme of this Community Education Program. Each of these programs will serve to decrease stigma, remove barriers, and to provide information regarding access to the county mental health and other services in an extremely cost-effective manner. Training regarding the available mental health and MHSAs services will be provided as well as a designated contact person for inquiries.

Linkage to culturally-specific services for the Latino, Native American, African American, and Asian populations, among others (include LGBT specific services) is critical to effective PEI service delivery. The MHSAs programs provide some

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valuable options (see the Health Disparities Program and this program). However, additional research and networking will need to occur in order to address a broader range of racial and ethnic groups and other groups who experience disparities in access and outcomes. These strategies serve to provide outreach and engagement to these groups.

7. Collaboration and System Enhancements

This strategy represents a commitment to collaboration with parents and advocacy groups, as well as an effort to support independent learning. Capacity building among families and advocacy groups serves to enhance the community safety net system.

Collaboration with community providers will occur at many levels: information-sharing, referrals, collaborative service planning, and cross training. On a client by client basis, collaboration may occur with a Community-based organization (CBO) that provides culturally-specific services – perhaps for a family member, a health provider, a church or group that sponsors family activities, in addition to the school or other county service agencies. The MHD staff will be accessed to address these needs. Use of a community education model requires collaboration and linkage to (natural) resources within the client’s community for ongoing support. To be effective in this collaborative work, MHSA PEI staff will be provided with training in cultural competence, use of interpreter services and cultural brokers, and resource brokerage.

8. Intended Outcomes

Overall – Increased knowledge, skills, and decreased stigma by use of cost-effective strategies that address barriers and under-served populations.

Parenting Wisely:

- Improvements in behaviors related to protective factors – general family functioning, family cohesion and parent-child bonding, family organization and unity, effectiveness of discipline, parental involvement with children and their schoolwork, supervision of school and peer activities, school grades, knowledge and use of good parenting skills, problem solving, and clear expectations.
- Reductions in behaviors related to risk factors - child problem/conduct behavior, maternal depression, parental use of physical punishment and yelling, spousal violence and violence toward children.
- Other outcomes include high parental ratings of interest, relevance, ease of use, and confidence in using parenting skills taught; increased participation in further parent education classes, teaches parents effective child supervision and disciplinary skills, resulting in increased bonding; improves family problem solving, which decreases conflict and improves family cohesion; increases parents’ self-efficacy and validates their strengths;

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decreases coercive and authoritarian parenting practices, thereby reducing conflict; reduces blaming attributions, thereby increasing cooperative interactions; teaches a family systems perspective to reduce scapegoating.

- For children, clinically significant behavior improvement occurred during the time that their parents used the program.
- **Program completion rates for parents ranged from 83-91%.**

NAMI's Family to Family:

- Increased knowledge and coping skills thereby enhancing family resilience to deal with serious mental illness.

PFLAG's Community Education Program:

- Increased knowledge, sensitivity and awareness designed to decrease stigma and increase tolerance and acceptance, and ultimately access to services for the LGBT population.
- Reduction of risk factors for depression and suicide and improved mental and emotional health of an extremely high-risk population.
- Fewer incidents of harassment

High risk populations to be targeted include the Latino, Native American, other ethnic minority groups, and the LGBT populations. Targeted cultural goals and desirable outcomes include linkage with culturally-specific services, identification of culturally familiar support, and resources by which to recognize, return to, can celebrate cultural identity and traditions.

9. Coordination with Other MHSA Components

MHSA CSS program staff will be provided with information regarding this program and the referral process via outreach and education trainings given by the providers. Discussions between programs will occur to identify effective mechanisms for referral, collaboration and problem-solving, as issues arise. This program will serve to enhance the work done in the Wellness Centers.

The WET Coordinator will be looking for opportunities to merge workforce development and the need for capacity building in the arena of prevention and health promotions in collaboration with the MHSA Project Coordinator.

The other MHSA components are still under development.

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10. Additional Comments (optional). None.

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County: EI Dorado **PEI Project Name:** Program # 5 - Wennem Wadati **Date:** November 10, 2009

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

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
E. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	x	x	x	x
2. Individuals Experiencing Onset of Serious Psychiatric Illness				x
3. Children and Youth in Stressed Families	x	x		
4. Children and Youth at Risk for School Failure	x	x		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	x	x		

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

A detailed description of the planning process that resulted in the selection of the priority populations for all of the programs was provided under Program #1 and reflects the stakeholder input, data, and process used to arrive at this priority population, as well.

This project, **Wennem Wadati – A Native Path to Healing**, targets the PEI target population of *children and youth in stressed families* and, as such, is intended to address the community mental health needs surrounding *at-risk children, youth and young adults*. This program was designed of and for the local American Indian community thereby addressing the community mental health need of disparity in access. As a comprehensive program serving youth and families and individuals of all ages, this program also addresses populations of trauma-exposed individuals and children and youth who are at risk for school failure and at risk of juvenile justice involvement. Finally, given the disproportionately high rates of suicide among this population, this culturally-specific program is designed to address a high-risk population.

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

Program Name and Number: **Program #5 - Wennem Wadati – A Native Path to Healing.**

The Native American Resource Collaborative (NARC) designed this proposal and the Foothill Indian Education Alliance, a non-profit organization, serves as the fiscal agent. This Collaborative is comprised of representatives from four local agencies: Foothill Indian Education Alliance, Inc. (which provides academic and culturally related services to the Native communities of El Dorado and Amador counties), Native TANF (providing temporary assistance to needy families for eligible members of federally recognized tribes and descendants of the California Judgment Roll), two Native American therapists active in the Native community, and the Shingle Springs Tribal Health Program (the Behavioral Health Department offers many different types of programs and treatments for individual mental, emotional, and spiritual needs). This collaborative represents members of the local American Indian community who are also service providers and therefore well aware of gaps in service, health disparities, and the effects of traumatic stress within the home and community at large. The program proposed intends to use specific culturally-based intervention on multiple levels and includes a process for agencies to refer American Indian clients into the program as a result of the agency collaborative structure. A needs assessment of the local American Indian community was conducted by this group which informed the design of this program, which serves as a locally designed and culturally-specific intervention strategy.

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Local Native American community self-assessment:

Local Native American service providers collaborated in conducting a written survey of their community. They issued 1,000 surveys, offered raffle tickets as an incentive for return, and got a 25% response rate. The form for parents had 34 questions on two sheets of paper.

Preliminary findings shared in the June 2007 Native American partnership gathering include the following highlights:

Of the adults surveyed:

- >50% made \$20k/year or less
- >50% had a 12th grade education or less
- 97% felt that after school academic services were needed

The following questions, received the responses, as indicated:

- Are mental health services needed for grades 7-12 (86% Y, 14% N)
- How many have heard that students have suicidal thoughts (38% Y, 62% N)
- How many feel that use of a talking circle to discuss issues is needed (89% Y, 11% N)
- How many parents feel that they are unable to deal with the problems experienced by their youth (77% Y, 23% N)
- How many parents feel that family education would be helpful (67% Y, 4% N, 29% Maybe)

The respondents were asked to rate (1 very important to 4 not important) the following areas:

	1	2	3	4
Indian cultural values	64%	21%	8%	7%
American Indian Classrooms	75%	23%	0%	2%
Indian Education Resources	76%	19%	4%	1%
Academy Tutoring	85%	11%	2%	2%
College Career Motivation	83%	10%	5%	1%
Positive Indian Parenting	83%	12%	4%	1%

	Y	N
Feel their children enjoy AI activities	86%	
Participate w/children in AI activities	53%	

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When asked about unmet social needs, mental health counseling ranked 11th of 15.

Mental Health Prevention Goal – Mental health promotion through a combination of mental health services and traditional cultural teachings unique to the local American Indian community.

Approach -Universal, Selective, and Targeted Prevention.

Priority population/Age group:

The overall program goal is to improve the mental, physical, social and spiritual health of the 6,000 American Indians living in El Dorado County. Individuals of all ages who experience trauma can benefit from the universal family component. Children and youth who are in stressed families, at risk for school failure, and at risk of or experiencing juvenile justice involvement will be served by the selective approach of providing outreach to engage youth in traditional talking circles and in the indicated approach of providing culturally specific crisis intervention response to youth. The family program which includes an outreach component will address adults and older adults, as well.

Determinants to be addressed:

- Determinants of other prevalent mental health concerns such as depression, anxiety and post traumatic stress.
- Determinants of substance abuse

This strategy addresses determinants that, when addressed in a health promotions/prevention approach, diminish along with the rates of suicide.

Intervention Strategy/Model:

American Indians suffer from a disproportionate level of health-related problems and shorter life spans. Traumatic stress issues, depression, anxiety and low self-esteem are focal issues in the management of self-care among American Indian families. As such, a community and culturally-based PEI program serves as a critically needed strategy.

NARC has been working together toward the development of an innovative community-based approach to address alcohol, substance abuse, and mental health issues that is integrated and shaped by the values and traditions of American Indians and their cultures. Another identified need was for a centralized location for American Indian youth and families to get information about resources and how to access them.

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Wennem Wadati – A Native Path to Healing applies a combination of mental health early intervention strategies, traditional cultural teachings, and crisis intervention support for youth within the public school system. Specifically, this program will provide outreach to American Indian youth by inviting their participation in traditional talking circles (selective). In addition, outreach to American Indian families to participate in monthly traditional gatherings designed to spread cultural knowledge and family preservation (universal) will be conducted. Finally, during school hours, a phone line will provide access to an American Indian mental health specialist who will be available via answering service to respond to school sites in situations where American Indian students are experiencing a mental health crisis (indicated).

Provider/Location:

This program leverages staff resources of the four collaborative agencies, access to local community cultural presenters, and use of the Foothill Indian Education Alliance facility for activities and events. As such, this program represents a community-based intervention strategy that is fully embedded in an existing community collaborative. It is proposed that a representative of NARC will participate in the local Community Strengthening Group in Placerville as a function of being funded as a MHSA PEI program.

The school district, Juvenile Courts, and County Departments of Human Services and Health Services, along with the agencies that comprise NARC, will serve as referral sources and partners.

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4. Programs

Program Title	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	
Monthly Family Traditional Gatherings	Individuals: 168 Families: 56	Individuals: 0 Families: 0	6
Youth Talking Circles	Individuals: 105 Families: 0	Individuals: 0 Families: 0	6
Youth Crisis Response	Individuals: 0 Families: 0	Individuals: 42 Families: 0	6
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 273 Families: 56	Individuals: 42 Families: 0	6

5. Alternate Programs

Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3). NA

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

The Behavioral Health Personnel are well-established providers in the community and thereby will be able to take advantage of their previous experience and professional relationships by which to link clients served to the needed services – including the County Mental Health Division. Other agencies that they anticipate working closely with based on the needs presented include Foothill Indian Education Alliance, Inc., Shingle Springs Tribal Healthcare, New Morning

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Counseling Services, School counselors for testing, the local food bank, foster care and CPS services, Kinship Care, parenting classes, anger management classes, probation and substance abuse treatment services.

Linkage to culturally-specific services for the Native American population is critical to effective PEI service delivery. Outreach and engagement strategies inherent in this model serves to enhance the ability to identify needs and link individuals to the appropriate services.

7. Collaboration and System Enhancements

NARC was established as a culturally-specific collaborative to improve collaboration and avoid duplication of services. One specific goal for this group is to work with other agencies to offer education regarding the American Indian population in order to enhance the cultural competence of the community's system of mental health care.

Collaboration with community providers will also occur via referrals, collaborative service planning, and cross training. On a client by client basis, collaboration may occur with a Community-based organization (CBO) to provide an additional range of needed services beyond what is provided by Wennen Waditi. Linkage with Native TANF, Indian Education, Shingle Springs Tribal Health, and community-based mental health providers with culturally specific competencies is designed into the program and these providers are well-versed in the network of services available in the local community.

8. Intended Outcomes

This program is designed to –

- Improve the overall mental health care of American Indian individuals, families, and communities;
- Reduce the prevalence and incidence of alcoholism and other drug dependencies;
- Maximize positive behavioral health and resiliency in American Indian individuals and families thereby reducing the suicide risk, prolonged suffering, unemployment, and incarceration.
- Reduce school drop out rates.

This program will incorporate cultural, traditional and spiritual prevention interventions that have been proven effective in many American Indian communities throughout tribal Nations in the United States. Continuous needs assessment and client surveys will be used to evaluate effectiveness. Evaluation will be ongoing throughout the program. NARC will conduct reviews of service documentation, participant data, and survey results. The results and efficacy of the program will be shared with all participating agencies, including the MHD.

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High risk populations targeted are Native American of all ages. Targeted cultural goals and desirable outcomes include linkage with culturally-specific services, identification of culturally familiar support, and resources by which to recognize, return to, can celebrate cultural identity and traditions which are inherent in the design of this program. Ultimately, the disproportionately high rate of suicide is positively impacted by enhancing mental well-being through a culturally-specific approach.

9. Coordination with Other MHSA Components

MHSA CSS and PEI programs are available to serve the Native American population, as well. The Wennen Waditi program staff members serve as critical cultural brokers to identify appropriate referrals and to assist with access and effective service delivery for this population.

MHSA CSS program staff will be provided with information regarding this program and the referral process. Discussions between programs will occur to identify effective mechanisms for referral, collaboration and problem-solving. This program will enhance the outreach and case management services for American Indian adults funded under Program #7.

The WET Coordinator will be looking for opportunities to merge workforce development and the need for capacity building in the arena of prevention and health promotions in collaboration with the MHSA Project Coordinator. The other MHSA components are still under development.

10. Additional Comments (optional) – None.

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County: EI Dorado
for Older Adults

PEI Project Name: Program # 6 - Home-Delivered Meals Wellness Outreach Program
Date: November 10, 2009

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

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
F. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	<input type="checkbox"/>	<input type="checkbox"/>	x	x
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	x	x
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"/>		

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

A detailed description of the planning process that resulted in the selection of the priority populations for all of the programs was provided under Program #1 and reflects the stakeholder input, data, and process used to arrive at this priority population, as well.

This project, **Home-Delivered Meals Wellness Outreach Program for Older Adults**, targets the following PEI target population of *individuals (older adults and caregivers) experiencing the onset of serious mental illness (typically major depression and trauma)* and, as such, is intended to address the community mental health needs of *suicide risk, stigma and discrimination, the psycho-social impact of trauma, and disparities in access to mental health services.*

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

Program Name and Number: **Program #6 - Home-delivered Meals Wellness Outreach Program for Older Adults**

Mental Health Prevention Goal – Community education, early identification and intervention to mitigate the impact of late onset depression.

Approach – Selected and Indicated Prevention.

Age group – Older adults – generally age 60+

Determinants to be addressed: Risk factors associated with suicide – depression and isolation, limited social supports, and exposure to trauma.

Intervention Strategy/Model:

The Home Delivered Meals Wellness Outreach Program for Older Adults will address two serious public health issues faced by older Americans: depression and suicide. Depression is one of the most common mental disorders found in this age group with serious effects: depressed older adults tend to use health services at higher rates, are under-served by the public mental health system, engage in poorer health behaviors, and are at risk of premature or inappropriate institutionalization. Major depression is a significant predictor of suicide, as well, and older adults have the highest rate of

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successful suicide among all age groups. Locally, this population has also been identified as a seriously under-served population. Based on these factors, older adults have been identified as a prevention priority population.

Provider/Location:

This program will enhance the existing Home-Delivered Meals program provided by the County Human Services Department – which currently serves approximately 800 seniors - by funding Health Services Specialist services to 1) provide education and training related to mental health issues to staff, volunteers, clients and community members, 2) screen for older adults and caregivers for depression, and 3) provide brief treatment and/or referral, as appropriate. This model serves to decrease risk factors, increase protective factors, and provides community-based support. Programs and tools with demonstrated success will be applied in this program:

- Outreach, Training (for drivers and volunteers of the meals program), and Community Education - The Gatekeepers program model, previously under the CSS Project Uplift Program.
- Screening - The PHQ-9 will be used as the screening tool for depression.
- Early Intervention - The cognitive behavioral problem-solving treatment model will be used as an efficacious brief intervention strategy for older adults with depression.

The Home Delivered Meals Program has a full time Program Coordinator who recruits, schedules, and supervises a team of more than 100 volunteers who deliver meals Monday through Friday. The volunteers are often the first people to alert the Program Coordinator when there are concerns that need to be addressed. Training to better identify and provide assistance in screening individuals for depression and anxiety or other indicators of mental distress provides an extremely cost-effective mechanism by which to both promote mental health and prevent the progression of mental illness.

4. Programs

Program Title	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	
Home Delivered Meals Wellness Outreach Program for Older Adults – Identifying and Addressing	Individuals: 350 Families: 88	Individuals: 76 Families: 22	6

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	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		
Depression and Suicide Risk			
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 350 Families: 88	Individuals: 76 Families: 22	6

5. Alternate Programs

Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3). NA

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

Many resources will be leveraged to provide services to address identified mental health needs:

- The MHSAs WET-funded Friendly Visitor Program will continue to recruit and train volunteers to provide in-home support for interested and appropriate candidates.
- The MHSAs CSS-funded Wellness and Recovery Services Program will provide assessment, brief treatment, and case management, as appropriate.
- The County Mental Health Division will be accessed for specialty mental health services.
- The Area Agency for Aging (AAA) service delivery system will be accessed for health and social services.
- The existing Senior Peer Counselor Program will be accessed to provide peer support, as appropriate.

Furthermore, linkages to resources in support of sustaining healthy community-based living will be accessed, as well. This may include supports for physical health, financial, transportation, and social and culturally-specific support.

Linkage to culturally-specific services for the Latino, Native American, African American, and Asian populations, among others (include LGBT specific services) is critical to effective PEI service delivery. The MHSAs programs provide some valuable options (see the Health Disparities Program and the Community Education Program). However, additional

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research and networking will need to occur in order to identify a broader range of racial and ethnic groups and other groups who experience disparities in access and outcomes. Outreach and engagement efforts to these groups will be explored, as well.

7. Collaboration and System Enhancements

This strengths-based strategy represents an enhancement to existing assets within our community – the Home-Delivered Meals Program and the MHSA CSS Wellness and Recovery Services Program. The existing adult and older adult systems of care will be utilized for referrals and service delivery collaboration – both have well-attended monthly collaborative meetings. Participants include the Human Services, Health Services, including Public Health and Mental Health, Sheriff, and Probation Departments.

The outreach and community education component serves as an effective collaboration mechanism for this population in the primary care setting, as well. Efforts to bring this component to the local Community Health Center in which increased collaboration is currently in early stages will be pursued.

Collaboration with community providers will occur at many levels: information-sharing, referrals, collaborative service planning, and cross training. On a client by client basis, collaboration may occur with a Community-based organization (CBO) that provides culturally-specific services – perhaps for a family member, a health provider, a church or group that sponsors family activities, in addition to the school or other county service agencies. Use of an early intervention model that provides brief treatment typically requires or benefits from collaboration and linkage to (natural) resources within the client's community for ongoing support. To be effective in this collaborative work, MHSA PEI staff will be provided with training in cultural competence, use of interpreter services and cultural brokers, and resource brokerage.

8. Intended Outcomes

The fundamental goals are:

- To provide early detection and increased access to screening, assessment, and early intervention for depression and suicide.
- To prevent the onset of major depression, to reduce the negative outcomes of untreated depression, and to prevent the tragic consequences of suicide.
- To reduce the risk of institutionalization and homelessness among older adults with depression.
- To provide linkage to the appropriate level (least restrictive) of mental health and other needed services.

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- To provide training, knowledge and skills related to mental health for clients, family members, and the broader community, thereby promoting mental health and independent living.
- To provide these services in a proactive (outreach) and community (home-based) model thereby reducing disparities in service access for older and isolated adults.

High risk populations to be targeted include the Latino, Native American, other ethnic minority groups, and the LGBT populations. Targeted cultural goals and desirable outcomes include linkage with culturally-specific services, identification of culturally familiar support, and resources by which to recognize, return to, can celebrate cultural identity and traditions.

9. Coordination with Other MHSA Components

Integration with the MHSA CSS programs will occur as a function of incorporating the Hero's Community Education and Training Program under the PEI component. In addition, referrals to the MHSA CSS-funded Wellness and Recovery Services Program will offer opportunities for further assessment, specialty mental health treatment, and case management for appropriate individuals. Finally, under MHSA Workforce Education and Training, the Friendly Visitor Program will offer options for volunteer and peer support for appropriate older adults.

The other MHSA components are still under development.

10. Additional Comments (optional) – None.

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County: El Dorado **PEI Project Name:** Program # 7 – Health Disparities Initiative
Date: November 10, 2009

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

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
G. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	x	x	x	x
2. Individuals Experiencing Onset of Serious Psychiatric Illness	x	x	x	x
3. Children and Youth in Stressed Families	x	x		
4. Children and Youth at Risk for School Failure	x	x		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	x	x		

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

A detailed description of the planning process that resulted in the selection of the priority populations for all of the programs was provided under Program #1 and reflects the stakeholder input, data, and process used to arrive at this priority population, as well.

This project, **the Health Disparities Initiative**, serves as a comprehensive outreach, engagement, and early intervention strategy that for all ages of the Latino community and for the American Indian adult population, and therefore targets the following PEI target populations: *trauma exposed individuals, individuals experiencing onset of serious psychiatric illness, children and youth in stressed families, children and youth at risk for school failure and at risk of or experiencing juvenile justice involvement.* As a result, this program is intended to address the community mental health needs of *disparities in access to mental health services, psycho-social impact of trauma, at-risk children, youth and young adult populations, stigma and discrimination, and suicide risk.*

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

Program Name and Number: **Program #7 - Health Disparities Initiative**

Mental Health Prevention Goal – Decrease disparities in access to mental health services.

Approach – Selective and Indicated.

Age Groups:

- Latino Initiative – all ages.
- Native American Outreach and Engagement Services – adults.

Determinants addressed:

- Risk factors for Latino and Native American individuals due to disparities in access to mental health services.

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Intervention Strategy/Model - Latino Engagement Initiative:

The Latino Engagement Initiative was designed and approved in April 2006 as a MHSA CSS workplan to address isolation in the Latino adult population, and peer and family problems in the Latino youth population. The primary goal was to engage Latino families and thereby to provide greater access to culturally competent mental health services.

Desired Outcomes:

- Increased mental health service utilization by the Latino community.
- Decreased isolation which results from unmet mental health needs.
- Decreased peer and family problems which result from unmet mental health needs.
- Enhanced community mental health of the targeted ethnic groups thereby decreasing the risk and negative outcome of suicide which occurs at disproportionately high rates among the target populations.

The MHSA vision for the Latino population in El Dorado County is one in which there is community awareness and understanding regarding mental illness and mental health thereby removing the stigma that creates barriers to service access. Further, the vision reflects an integrated system of service delivery that provides the necessary services and supports to successfully address all of the mental health needs of the Latino community. Finally, outcomes, such as hopefulness, wellness, and self-efficacy, the meaningful use of time and capabilities, safe and adequate housing, and a network of supportive relationships, result from MHSA service use.

Location/Providers - Latino Engagement Initiative:

Two community-based agencies provide the services for this workplan – one in the Western Slope and another in South Lake Tahoe. In the Western Slope, the Promotoras (peer outreach workers) provide the majority of the services. Consistent with the Prevention Model, the agency findings were that proactive support served to alleviate symptoms of emotional distress and the need for more extensive services. In South Lake Tahoe, while the emphasis started with the provision of bicultural and bilingual mental health services, the effectiveness of psycho-education, support groups, and peer counseling initially for women, but later for men and for children emerged. In addition, the unanticipated need for expanded outreach and engagement to address the many barriers to healthcare access became apparent by the second year of operation.

Intervention Strategy/Model and Provider/Location – Native American Outreach and Engagement:

In addition, an approved MHSA CSS plan amendment subsequently incorporated funding for a Native American outreach worker/case manager position via contract with Shingle Springs Behavioral Healthcare. The goal was to provide

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MHSA PEI Component Three-Year Program and Expenditure Plan
Form No. 3**

culturally-relevant and accessible services to high risk adults (including adults with families involved in the system) to prevent destabilization and ultimately homelessness.

Lessons learned:

The goal of the EI Dorado County Health Disparities Program is to collaborate with existing agencies in the areas of outreach, engagement and provision of support services while adding the availability of culturally-relevant services for the Latino and Native American communities. Each of these strategies is intended to build on the strengths and self-determination of the community, families and individuals.

The effective features of outreach and engagement services:

- The outreach workers were a part of an agency with an established positive relationship with the priority population;
- Services are provided in the natural setting;
- The outreach worker is responsive to address a wide range of real life issues – rather than being categorically limited based on funding;
- Trust and communication is facilitated by the use of a culturally-relevant individual (which typically includes experiential relevance held by peer and family members);
- As a result, disclosure regarding issues, such as mental health issues that carry tremendous stigma, occurs.

The effective features of case management services:

- Trust, credibility, and persistence is provided to help individuals navigate challenging systems;
- Support is provided to remove multiple barriers to services;
- Linkage to a range of services – including those that address basic needs – are a priority;
- As a result, disparities to mental health care access is reduced.

The effective features of the mental health services:

- Emotional support was provided in non-traditional settings as part of the process of outreach and case management;
- Support groups are critical as they build connection within the community;
- Basic mental health education is provided to eliminate misconception and barriers;
- Peer to peer and family to family support and counseling is highly valued;
- Brief and early intervention strategies are effective in engaging clients and producing results.

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As a result, this workplan is now proposed for inclusion as part of the PEI component allowing the emphasis, goals, and evaluation process to focus on the influence of protective and risk factors as opposed to the alleviation of symptoms or the elimination of functional impairment as measured by Medi-Cal medical necessity guidelines.

4. Programs

Program Title	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	
Latino Engagement Initiative	Individuals: 50 Families: 50	Individuals: 50 Families: 50	6
American Indian Outreach/Case Management	Individuals: 0 Families: 0	Individuals: 25 Families: 0	6
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 50 Families: 50	Individuals: 75 Families: 50	6

5. Alternate Programs

Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3). NA

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

Linkages for mental health treatment with the County MHD, Shingle Springs Behavioral Healthcare, and community-base providers has been occurring with varying levels of success, to date. The goal of achieving a seamless and diverse system of care remains. Monthly service integration team meetings will be a mandatory component of this plan bringing together the PEI program and MHD staff.

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Linkage to culturally-specific services for the Latino, Native American, African American, and Asian populations, among others (include LGBT specific services) is critical to effective PEI service delivery and these MHSA programs provide some valuable options (including the Community Education Program). However, additional research and networking will need to occur in order to address a broader range of racial and ethnic groups and other groups who experience disparities in access and outcomes. Outreach and engagement and the use of focus will be explored as part of an ongoing effort to do Community Program Planning for the MHSA programs.

7. Collaboration and System Enhancements

This program continues to provide mental health system enhancements by incorporating three community-based agencies that serve the Latino and Native American communities. Prior to the MHSA, the MHD did not have service contracts with them. Each of these agencies has established working relationships with a wide range of service providers thereby further diversifying the reach of the mental health system. At this time, membership and participation in the Community Strengthening Collaborative by each of these providers will be explored to further enhance system collaboration.

Collaboration with community providers will occur at many levels: information-sharing, referrals, collaborative service planning, and cross training. On a client by client basis, collaboration may occur with a Community-based organization (CBO) that provides culturally-specific services – perhaps for a family member, a health provider, a church or group that sponsors family activities, in addition to the school or other county service agencies. Use of a prevention and early intervention model typically requires or benefits from collaboration and linkage to (natural) resources within the client's community for ongoing support. The Health Disparities program providers serve as experts, consultants and trainers to this end and will assist in providing training for the MHSA PEI staff and others in cultural competence, use of interpreter services and cultural brokers, and resource brokerage, as well.

8. Intended Outcomes

The fundamental goals are to:

- Continue to provide a recognized and trusted access point for the Latino and American Indian populations for mental health services;
- Engage previously un-served or under-served individuals in need of mental health services;
- Provide identification, screening, referral and linkage to support services that will influence the determinants of health indicators, such as suicide.

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- Provide support, education, and early intervention strategies that are culturally relevant and focused on building protective factors and decreasing risk factors;
- Reduce the barriers of stigma and discrimination among the Latino and American Indian populations related to mental health services; and,
- Decrease the disparity in mental health access among the Latino and American Indian populations.

High risk populations to be targeted in this program are to the Latino and Native American populations. Targeted cultural goals and desirable outcomes include linkage with culturally-specific services, identification of culturally familiar support, and resources by which to recognize, return to, can celebrate cultural identity and traditions.

9. Coordination with Other MHSA Components

Familiarity with the Health Disparities programs among CSS program staff exists. Improvement related to referral and communication mechanisms will be the focus on the upcoming year. The recently approved WET plan provides an opportunity to involve the funded WET Coordinator and Volunteer Coordinator in relevant ways with the Latino and Native American populations via these programs. There is a critical need to increase the mental health workforce capacity with bilingual and bicultural Latino and Native American individuals. The WET Coordinator will also look for opportunities to merge workforce development and the need for capacity building in the arena of prevention and health promotions in collaboration with the MHSA Project Coordinator. The other MHSA components are still under development.

10. Additional Comments (optional) – None.

PEI Revenue and Expenditure Budget Worksheet Form No. 4

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

County

Name: El Dorado

Date: 11/10/2009

PEI Project Name: School-based Mental Health Promotion and Service Linkage

Provider Name (if known): El Dorado County Health Services Dept, Mental Health Division

Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 08-09	0	FY 09-10	25
Total Number of Individuals currently being served:	FY 08-09	0	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	0	FY 09-10	25
Months of Operation:	FY 08-09	0	FY 09-10	6

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			
• Mental Health Clinician	1.0 FTE	0	\$65,962
• Mental Health Program Coordinator	0.1 FTE	0	\$8,402
b. Benefits and Taxes			
	0	\$31,153	\$31,153
c. Total Personnel Expenditures			
	0	\$105,517	\$105,517
2. Operating Expenditures			
a. Facility Cost			
	0	\$13,709	\$13,709
b. Other Operating Expenses			
	0	\$22,857	\$22,857
c. Total Operating Expenses			
	0	\$36,566	\$36,566
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
	\$0	\$0	\$0
a. Total Subcontracts			
	\$0	\$0	\$0
4. Total Proposed PEI Project Budget			
	\$0	\$142,083	\$142,083
B. Revenues (list/itemize by fund source)			
1. Total Revenue			
	\$0	\$0	\$0
5. Total Funding Requested for PEI Project			
	\$0	\$142,083	\$142,083
6. Total In-Kind Contributions			
	\$0	\$6,000	\$6,000

**PEI Revenue and Expenditure Budget Worksheet
Form No. 4**

BUDGET NARRATIVE

PEI Plan #1: School-based Mental Health Promotion and Service Linkage

Costs for salaries were in the amount of \$74,364 to fund the following positions for the 6-month period of operation:

- Mental Health Clinicians (\$65,962) PEI-funded Mental Health Licensed Clinicians from the County Mental Health Division will respond County-wide to school referrals for assessment and appropriate mental health services in an effort to increase access and interventions at a prevention stage. Alternative recommendations for youth who are not identified for mental health or prevention services will also be provided in partnership with the referring teacher and family.
 - Assessment: 0.5 FTE (1040 hrs) assigned to WS and 0.3 FTE (625 hrs) assigned to Tahoe
 - Follow-Up: 0.2 FTE (415 hours) assigned as needed to conduct Pro-Social Skills Workshops and/or provide Trauma-focused Cognitive Behavioral Therapy and possibly other evidence-based PEI strategies.
- Mental Health Coordinator (\$8,403) 0.1 FTE (208 hours) to establish and coordinate an interdisciplinary screening committee, provide any necessary training, participate in the local Community Strengthening Group, report on project progress, and participate in program monitoring and evaluation.

Cultural competence training, interpretation services, and access to cultural brokers will be provided.

Costs of benefits and taxes in the amount of \$31,153 include FICA, health, vision and dental coverage, disability, workers' compensation insurance, state and federal payroll taxes.

Operating Expenditures in the amount of \$36,566 include indirect expenditures as allocated based on the former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225), including facility expenses such as rent, utilities, and janitorial services, as well as programmatic costs such as food, incentives, supplies and workshop materials and other indirect expenditures such as clinical management and support technical communication equipment, support and licensing.

Subcontractors/Professional Services: None for this project

Total Proposed PEI Project Budget:

- The overall expenditure level for this project is \$142,083
- No revenue from other sources has been identified
- Total funding request for this PEI project is \$142,083

Identified in-kind contributions: Appropriate space for this project will be provided by participating school partners. (Estimated value \$6,000)

**PEI Revenue and Expenditure Budget Worksheet
Form No. 4**

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

County

Name: El Dorado

Date: 11/10/2009

PEI Project Name: Primary Intervention Project (PIP)

Provider Name (if known): El Dorado County Health Services Dept, Mental Health Division
and El Dorado County Department of Education

Intended Provider Category: PreK-12 School

Proposed Total Number of Individuals to be served:	FY 08-09	0	FY 09-10	50
Total Number of Individuals currently being served:	FY 08-09	0	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	0	FY 09-10	50
Months of Operation:	FY 08-09	0	FY 09-10	6

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			
• 3 MH Aides 0.65 FTE	\$0	\$16,292	\$16,292
• Mental Health Program Coordinator 0.05 FTE	\$0	\$4,261	\$4,261
b. Benefits and Taxes	\$0	\$2,086	\$2,086
c. Total Personnel Expenditures	\$0	\$22,639	\$22,639
2. Operating Expenditures			
a. Facility Cost	\$0	\$14,105	\$14,105
b. Other Operating Expenses	\$0	\$8,107	\$8,108
c. Total Operating Expenses	\$0	\$22,212	\$22,213
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
• El Dorado County Department of Education	\$0	\$42,000	\$42,000
a. Total Subcontracts	\$0	\$42,000	\$42,000
4. Total Proposed PEI Project Budget	\$0	\$86,851	\$86,851
B. Revenues (list/itemize by fund source)			
	\$0		
1. Total Revenue	\$0		
5. Total Funding Requested for PEI Project	\$0	\$86,851	\$86,851
6. Total In-Kind Contributions	\$0	\$22,100	\$22,100

**PEI Revenue and Expenditure Budget Worksheet
Form No. 4**

BUDGET NARRATIVE

PEI Plan #2: Primary Intervention Project (PIP)

Costs for salaries were in the amount of \$20,553 to fund the following positions for the 6-month period of operation:

South Lake Tahoe

- **Mental Health Aides (\$16,292)** Three PEI-funded Mental Health Aides will be trained in this intervention strategy to provide early intervention services to children (K-3) who are identified and screened to be “at risk” of developing emotional problems as indicated by difficulty in school adjustment. Staff involved in this project plan to attend the annual California Early Mental Health Initiative (EMHI) training conference.
Trained aides will provide the PIP intervention in the form of 1:1 non-directive play for approximately 30-45 minutes per week for 12-15 weeks. (0.65 FTE, equivalent to 1352 hours)
- **Mental Health Coordinator (\$4,261)** 0.05 FTE (104 hours) to screen youth, supervise the Mental Health Aides, conduct program evaluation, and to coordinate services at four school sites.

Costs of benefits and taxes in the amount of \$2,086 include FICA, health, vision and dental coverage, disability, workers’ compensation insurance, state and federal payroll taxes for the Mental Health Coordinator. Mental Health Aides will be hired as extra help; costs for benefits and taxes are limited to FICA, disability, workers’ compensation insurance, state and federal payroll taxes.

Operating Expenditures in the amount of \$22,212 include indirect expenditures as allocated based on the former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225), including facility expenses such as rent, utilities, and janitorial services. Operating expenditures also include programmatic costs such as materials, food, and toys (\$1,050), transportation and staff training and travel (\$1,700).

- **Subcontractors/Professional Services: Georgetown Divide - El Dorado County Department of Education** in the amount of \$42,000. Funding will be used to support a school-employed mental health professionals who will be trained in this intervention strategy at two school sites to provide early intervention services to children (K-3) who are identified and screened to be “at risk” of developing emotional problems as indicated by difficulty in school adjustment. Staff involved in this project plan to attend the annual California Early Mental Health Initiative (EMHI) training conference. Mental Health Professionals will provide the PIP intervention in the form of 1:1 non-directive play for approximately 30-45 minutes per week for 12-15 weeks, and a coordinator will provide supervision, student screening, and program evaluation.

Total Proposed PEI Project Budget:

- The overall expenditure level for this project is \$86,851
- No revenue from other sources has been identified

**PEI Revenue and Expenditure Budget Worksheet
Form No. 4**

- Total funding request for this PEI project is \$86,851

Recruitment will target diverse populations and cultural competence training, interpretation services, and access to cultural brokers will be provided.

Identified in-kind contributions: Two school districts (six school sites) will provide the space for this project, including appropriate sized playrooms. (Estimated value \$19,800) In addition, the school sites will provide supplies, telephones, and workstations. (Estimated value \$2,300)

**PEI Revenue and Expenditure Budget Worksheet
Form No. 4**

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

County Name: El Dorado Date: 11/10/2009

PEI Project Name: Incredible Years Program

Provider Name (if known): El Dorado County Health Services Dept, Mental Health Division

Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 08-09	<u>0</u>	FY 09-10	<u>72</u>
Total Number of Individuals currently being served:	FY 08-09	<u>0</u>	FY 09-10	<u>0</u>
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	<u>0</u>	FY 09-10	<u>72</u>
Months of Operation:	FY 08-09	<u>0</u>	FY 09-10	<u>6</u>

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			
• Mental Health Clinician 0.07 FTE	\$0	\$4,633	\$4,633
• MH Worker 0.16 FTE	\$0	\$4,894	\$4,894
b. Benefits and Taxes	\$0	\$2,174	\$2,174
c. Total Personnel Expenditures	\$0	\$11,701	\$11,701
2. Operating Expenditures			
a. Facility Cost	\$0	\$3,065	\$3,065
b. Other Operating Expenses	\$0	\$6,594	\$6,594
c. Total Operating Expenses	\$0	\$9,659	\$9,659
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$0
4. Total Proposed PEI Project Budget	\$0	\$21,360	\$21,360
B. Revenues (list/itemize by fund source)			
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$21,360	\$21,360
6. Total In-Kind Contributions	\$0	\$3,000	\$3,000

**PEI Revenue and Expenditure Budget Worksheet
Form No. 4**

BUDGET NARRATIVE

PEI Plan #3: Incredible Years Program

Costs for salaries were in the amount of \$9,527 to fund the following positions for the 6-month period of operation:

- **Mental Health Clinician (\$4,633)**
A Clinician will administer a set of comprehensive, multi-faceted, and developmentally-based curricula targeting 2-12 year old children, their parents, and school teachers. Two classes are planned for the initial 6 months of operation (Two classes, each 6 hours/week for 12 weeks, equivalent to 144 hours or 0.07 FTE)
- **Mental Health Worker (\$4,894) 0.16 FTE (333 hours)** to assist with program coordination, set-up, and to provide childcare and supervision of age-appropriate activities during class sessions.

Costs of benefits and taxes in the amount of \$2,174 include FICA, health, vision and dental coverage, disability, workers' compensation insurance, state and federal payroll taxes for the Mental Health Clinician. A Mental Health Worker will be hired as extra help; costs for benefits and taxes are limited to FICA, disability, workers' compensation insurance, state and federal payroll taxes.

Operating Expenditures in the amount of \$9,659 include indirect expenditures as allocated based on the former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225), including facility expenses such as rent, utilities, and janitorial services. Operating expenditures also include programmatic costs, including curriculum costs (\$1,000 per class), transportation and program materials, food, prizes, and toys (\$1,850).

Subcontractors/Professional Services: None for this project.

Total Proposed PEI Project Budget:

- The overall expenditure level for this project is \$21,360
- No revenue from other sources has been identified
- Total funding request for this PEI project is \$21,360

Identified in-kind contributions: The goal is to bring this program to various community-based settings in order to make this effective program available to stressed families County-wide. The host site will advertise the class series and will register clients. A representative from the host site will assist with referral and pre-screening activities. (Estimated value \$3,000)

Cultural competence training, interpretation services, and access to cultural brokers will be provided for program personnel.

**PEI Revenue and Expenditure Budget Worksheet
Form No. 4**

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

County Name: El Dorado Date: 11/10/2009

PEI Project Name: Community Education Project
 Provider Name (if known): El Dorado County Health Services Dept, Mental Health Division and local chapters of National Alliance on Mental Illness (NAMI)

Intended Provider Category: Ethnic or Cultural Organization

Proposed Total Number of Individuals to be served:	FY 08-09	<u>0</u>	FY 09-10	<u>50</u>
Total Number of Individuals currently being served:	FY 08-09	<u>0</u>	FY 09-10	<u>0</u>
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	<u>0</u>	FY 09-10	<u>50</u>
Months of Operation:	FY 08-09	<u>0</u>	FY 09-10	<u>6</u>

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
b. Benefits and Taxes			\$0
c. Total Personnel Expenditures	\$0	\$0	\$0
2. Operating Expenditures			
a. Facility Cost	\$0	\$0	\$0
b. Other Operating Expenses			
• Parenting Wisely (CD ROM Program)	\$0	\$10,000	\$10,000
c. Total Operating Expenses	\$0	\$10,000	\$10,000
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
• NAMI Training	\$0	\$2,000	\$2,000
• PFLAG Community Education	\$0	\$2,000	\$2,000
a. Total Subcontracts	\$0	\$4,000	\$4,000
4. Total Proposed PEI Project Budget	\$0	\$14,000	\$14,000
B. Revenues (list/itemize by fund source)			
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$14,000	\$14,000
6. Total In-Kind Contributions	\$0	\$1,600	\$1,600

**PEI Revenue and Expenditure Budget Worksheet
Form No. 4**

BUDGET NARRATIVE

PEI Plan #4: Community Education Project

Costs for salaries: None for this project

Costs of benefits and taxes: None

Operating Expenditures: Purchase of 10 "Parenting Wisely" CD-ROMs, at \$1,000 for a total of \$10,000.

Subcontractors/Professional Services:

- The local chapter of National Alliance on Mental Illness (NAMI) will use MHSA funding to enhance the trainer capacity by covering unmet travel expenses for the training of two new instructors per year and the costs of classroom materials for one additional class per year. (\$2,000)
- The local PFLAG chapter (Parents, Families, and Friends of Lesbians and Gays) will use MHSA funding to start an outreach, education and training program for mental health providers and interested community members by funding the information packets that PFLAG volunteers will present to participants of their program. Outreach costs such as mileage reimbursement, postage, and food costs may be paid for as well. (\$2,000)

Total Proposed PEI Project Budget:

- The overall expenditure level for this project is \$14,000
- No revenue from other sources has been identified
- Total funding request for this PEI project is \$14,000

Identified in-kind contributions: Volunteer time to conduct the Family to Family classes and the Outreach, Education and Training Program sponsored by PFLAG (Estimated value \$1,600).

**PEI Revenue and Expenditure Budget Worksheet
Form No. 4**

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

County Name: El Dorado Date: 11/10/2009

PEI Project Name: Wennem Wadati - A Native Path to Healing
 Provider Name (if known): Native American Resource Collaborative - Foothill Indian Education Alliance as fiscal agent

Intended Provider Category: Ethnic or Cultural Organization

Proposed Total Number of Individuals to be served:	FY 08-09	<u>0</u>	FY 09-10	<u>315</u>
Total Number of Individuals currently being served:	FY 08-09	<u>0</u>	FY 09-10	<u>0</u>
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	<u>0</u>	FY 09-10	<u>315</u>
Months of Operation:	FY 08-09	<u>0</u>	FY 09-10	<u>6</u>

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
b. Benefits and Taxes			\$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)			
• Native American Resource Collaborative - Foothill Indian Education Alliance as fiscal agent	\$0	\$51,216	\$51,216
a. Total Subcontracts	\$0	\$51,216	\$51,216
4. Total Proposed PEI Project Budget	\$0	\$51,216	\$51,216
B. Revenues (list/itemize by fund source)			
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$51,216	\$51,216
6. Total In-Kind Contributions	\$0	\$27,800	\$27,800

**PEI Revenue and Expenditure Budget Worksheet
Form No. 4**

BUDGET NARRATIVE

PEI Plan #5: Wennem Wadati - A Native Path to Healing

Costs for salaries: None for this project.

Costs of benefits and taxes: None..

Operating Expenditures: None.

Subcontractors/Professional Services:

- Native American Resource Collaborative - Foothill Indian Education Alliance as fiscal agent: This program will provide outreach to American Indian youth by inviting their participation in traditional talking circles. In addition, outreach to American Indian families to participate in monthly traditional gatherings designed to spread cultural knowledge and family preservation will be conducted. Finally, during school hours, a phone line will provide access to an American Indian mental health specialist who will be available via answering service to respond to school sites in situations where American Indian students are experiencing a mental health crisis. (\$51,216)

Total Proposed PEI Project Budget:

- The overall expenditure level for this project is \$51,216
- No revenue from other sources has been identified
- Total funding request for this PEI project is \$51,216

Identified in-kind contributions: This program leverages staff resources of Foothill Indian Education Alliance, Inc. Native TANF, two Native American therapists active in the Native community, and the Shingle Springs Tribal Health Program, allowing access to local community cultural presenters, and use of the Foothill Indian Education Alliance facility for activities and events. The total estimated value of in-kind contributions \$27,800, as detailed below:

- Shingle Springs Behavioral Health Personnel (\$1,750)
- TANF Site Manager (\$2,650)
- TANF Program Coordinator (\$4,000)
- TANF Youth Leadership Funds (\$2,500)
- New Morning Behavioral Health Personnel (\$3,500)
- Foothill Indian Education Director (\$2,650)
- Other Foothill Indian Education Center Personnel (\$2,750)
- Local Community Cultural Presenters (\$1,000)
- Local Community Presenters/Leadership (\$1,500)
- Center Provided Materials/Supplies (\$1,000)
- Facilities (based on 60 activities/events) (\$4,500)

**PEI Revenue and Expenditure Budget Worksheet
Form No. 4**

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

County Name: El Dorado

Date: 11/10/2009

PEI Project Name: Home Delivered Meals Wellness Outreach Program

Provider Name (if known): El Dorado County Health Services Dept, Mental Health Division

Intended Provider Category: Older Adult Service Center

Proposed Total Number of Individuals to be served:	FY 08-09	0	FY 09-10	426
Total Number of Individuals currently being served:	FY 08-09	0	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	0	FY 09-10	426
Months of Operation:	FY 08-09	0	FY 09-10	6

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			
• Psych Tech 0.12 FTE	\$0	\$6,974	\$6,974
• Public Health Nurse Practitioner 0.12 FTE	\$0	\$11,573	\$11,573
• Mental Health Worker 0.25 FTE	\$0	\$9,579	\$9,579
• Mental Health Program Coordinator 0.05 FTE	\$0	\$4,141	\$4,141
b. Benefits and Taxes	\$0	\$14,997	\$14,997
c. Total Personnel Expenditures	\$0	\$47,264	\$47,264
2. Operating Expenditures			
a. Facility Cost	\$0	\$4,411	\$4,411
b. Other Operating Expenses	\$0	\$10,011	\$10,011
c. Total Operating Expenses	\$0	\$14,422	\$14,422
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
	\$0	\$0	\$0
a. Total Subcontracts	\$0	\$0	\$0
4. Total Proposed PEI Project Budget	\$0	\$61,686	\$61,686
B. Revenues (list/itemize by fund source)			
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$61,686	\$61,686
6. Total In-Kind Contributions	\$0	\$2,500	\$2,500

**PEI Revenue and Expenditure Budget Worksheet
Form No. 4**

BUDGET NARRATIVE

PEI Plan #6: Home Delivered Meals Wellness Outreach Program

Costs for salaries were in the amount of \$32,267 to provide services to 1) provide education and training related to mental health issues to staff, volunteers, clients and community members, 2) screen for older adults and caregivers for depression, and 3) provide brief treatment and/or referral, as appropriate. This project will fund the following positions for the 6-month period of operation:

- Psych Tech (\$6,974) Approximately 10 hours per week (250 hours total, equivalent to 0.12 FTE)
- Public Health Nurse Practitioner (\$11,573) Approximately 10 hours per week (250 hours total, equivalent to 0.12 FTE)
- Mental Health Worker (\$9,579) Approximately 20 hours per week (520 hours total, equivalent to 0.25 FTE)
- Mental Health Program Coordinator (\$4,141) Approximately 4 hours per week (104 hours total, equivalent to 0.05 FTE)

Costs of benefits and taxes in the amount of \$14,997 include FICA, health, vision and dental coverage, disability, workers' compensation insurance, state and federal payroll taxes for the Mental Health and Public Health personnel.

Operating Expenditures in the amount of \$14,422 include indirect expenditures as allocated based on the former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225), including facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing.

Subcontractors/Professional Services: None for this project.

Total Proposed PEI Project Budget:

- The overall expenditure level for this project is \$61,686
- No revenue from other sources has been identified
- Total funding request for this PEI project is \$61,686

Identified in-kind contributions: This project will utilize the existing Home-Delivered Meals program provided by the County Human Services Department – which currently serves approximately 800 seniors - to access, educate and identify the target population. The Senior Nutrition Program's home delivered meals service has a full time Program Coordinator who recruits, schedules, and supervises a team of more than 100 volunteers to deliver meals Monday through Friday. These volunteers use their own vehicles with a portion of their mileage reimbursed by the County. These volunteers are the first people to alert the Program Coordinator when there are concerns that need to be addressed. (Estimated value of transportation savings and service coordination is \$2,500)

**PEI Revenue and Expenditure Budget Worksheet
Form No. 4**

This new program leverages an existing program within another County Department thereby enhancing the capacity to promote mental health and prevent mental illness within the local community. A volume of seniors are reached daily by the Home-delivered Meals program which is largely staffed by volunteers. Strategic use of mental health staff providing education to the volunteers and others (health promotions), screening and early identification of a universal population (seniors and caregivers receiving meals), and referral/linkage to early intervention/brief treatment/brief treatment services found effective with this population is proposed under this project.

PEI Revenue and Expenditure Budget Worksheet Form No. 4

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

County

Name: El Dorado

Date: 11/10/2009

PEI Project Name: Health Disparities Initiative

Provider Name (if known): Family Connections, Family Resource Center, Shingle Springs Behavioral Healthcare

Intended Provider Category: Ethnic or Cultural Organization

Proposed Total Number of Individuals to be served:	FY 08-09	0	FY 09-10	125
Total Number of Individuals currently being served:	FY 08-09	0	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	0	FY 09-10	125
Months of Operation:	FY 08-09	0	FY 09-10	6

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			
• County Liaison / Utilization Review Coordinator 0.05 FTE	\$0	\$4,461	\$4,461
b. Benefits and Taxes	\$0	\$1,801	\$1,801
c. Total Personnel Expenditures	\$0	\$6,262	\$6,262
2. Operating Expenditures			
a. Facility Cost	\$0	\$401	\$401
b. Other Operating Expenses	\$0	\$3,087	\$3,087
c. Total Operating Expenses	\$0	\$3,488	\$3,488
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
• Family Connections	\$0	\$53,750	\$53,750
• Family Resource Center	\$0	\$65,341	\$65,341
• Shingle Springs Tribal Health	\$0	\$25,000	\$25,000
a. Total Subcontracts	\$0	\$144,091	\$144,091
4. Total Proposed PEI Project Budget	\$0	\$153,841	\$153,841
B. Revenues (list/itemize by fund source)			
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$153,841	\$153,841
6. Total In-Kind Contributions	\$0	\$0	\$0

**PEI Revenue and Expenditure Budget Worksheet
Form No. 4**

BUDGET NARRATIVE

PEI Plan #7: Health Disparities Initiative

Costs for salaries in the amount of \$4,461 to coordinate mental health services with three community-based agencies that serve the Latino and Native American communities. This project will fund the following position for the 6-month period of operation:

- County Liaison/ Coordinator (\$4,461) Approximately 4 hours per week for the 6-month period of operation (100 hours total, equivalent to 0.05 FTE)

Costs of benefits and taxes in the amount of \$1,801 include FICA, health, vision and dental coverage, disability, workers' compensation insurance, state and federal payroll taxes.

Operating Expenditures in the amount of \$3,488 include indirect expenditures as allocated based on the former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225), including facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing.

Subcontractors/Professional Services total \$144,091:

- Family Connections (\$53,750) Will provide preventative mental health services to the Latino population on the West Slope (WS) of El Dorado County
- Family Resource Center (\$65,341) Will provide preventative mental health services to the Latino population in Tahoe
- Shingle Springs Tribal Health (\$25,000) Will provide preventative mental health services to the Native American population

Total Proposed PEI Project Budget:

- The overall expenditure level for this project is \$153,841
- No revenue from other sources has been identified
- Total funding request for this PEI project is \$153,841

Identified in-kind contributions: None identified at this time.

**PEI Administration Budget Worksheet
Form No. 5**

County: El Dorado

Date: 11/10/2009

	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
- Various Staff members		1.2	\$0	\$51,570	\$51,570
d. Employee Benefits			\$0	\$20,840	\$20,840
e. Total Personnel Expenditures			\$0	\$72,410	\$72,410
2. Operating Expenditures					
a. Facility Costs			\$0	\$8,225	\$8,225
b. Other Operating Expenditures			\$0	\$5,303	\$5,302
c. Total Operating Expenditures			\$0	\$13,527	\$13,527
3. County Allocated Administration					
a. Total County Administration Cost			\$0	\$19,023	\$19,023
4. Total PEI Funding Request for County Administration Budget			\$0	\$104,960	\$104,960
B. Revenue					
1. Total Revenue					\$0
C. Total Funding Requirements			\$0	\$104,960	\$104,960
D. Total In-Kind Contributions			\$0	\$0	\$0

BUDGET NARRATIVE

PEI Plan: Administrative Costs

Administrative costs in the amount of \$104,960 or 16.5% of the total work expense plan are requested. These costs were calculated based upon proposed budget, utilizing the methodology of our Health Cost Accounting System (H-CAS) that was implemented in FY 2008/09. Using the OMB A-87 (OMB 2 CFR Part 225) methodology throughout the Mental Health Division, the entire administration expenses are allocated to all programs, consistent with OMB A-87. This is also consistent with the fact that we are a small county with the same administrative requirements as a large county, but with a much smaller service basis with which to allocate administrative costs.

**PEI Budget Summary Worksheet
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:	El Dorado
Date:	11/10/2009

#	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	School-based Mental Health Promotion and Service Linkage	\$0	\$142,083	\$142,083	\$142,083	\$0	\$0	\$0
2	Primary Intervention Project	\$0	\$86,851	\$86,851	\$86,851	\$0	\$0	\$0
3	Incredible Years Program	\$0	\$21,360	\$21,360	\$21,360	\$0	\$0	\$0
4	Community Education Project	\$0	\$14,000	\$14,000	\$10,080	\$1,960	\$1,960	\$0
5	Wennem Wadati – A Native Path to Healing	\$0	\$51,216	\$51,216	\$12,804	\$12,804	\$12,804	\$12,804
6	Home-Delivered Meals Wellness Outreach Program	\$0	\$61,686	\$61,686	\$0	\$0	\$0	\$61,686
7	Health Disparities Initiative	\$0	\$153,841	\$153,841	\$76,921	\$23,076	\$38,460	\$15,384
	Administration	\$0	\$104,960	\$104,960				
Total PEI Funds Requested:		\$0	\$635,997	\$635,997	\$350,099	\$37,840	\$53,224	\$89,874

**EI Dorado County Health Services Department – Mental Health Division
MHSA PEI Component Three-Year Program and Expenditure Plan
LOCAL EVALUATION OF A PEI PROJECT
Form No. 7**

County: EI Dorado

Date: November 10, 2009

- 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: Program #6 - Home Delivered Meals Wellness Outreach Program for Older Adults

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

Program #6 - Home-Delivered Meals Wellness Outreach Program for Older Adults

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

This program has been selected for evaluation as the older adult population is under-served in relationship to mental health services and high-risk for depression and suicide. This highly leveraged program will allow us to reach approximately 800 older adults per year who tend to be economically disadvantaged, more likely to live alone or in social isolation, and are at higher nutritional risk. Furthermore, the expanded Older Adult Mental Health System of Care allows for various options or levels of care that will allow us to see progress related to decreasing the impact of depression and the building of protective factors among this population.

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

Person/family level desired outcomes:

- No successful suicides among the population targeted.
- Reduction or elimination in depressive symptoms among individuals who receive early intervention services.
- Successful linkage to support services for those identified with needs in the program.
- Reduction or elimination of stigma and an increased understanding of mental well being and illness among those who participate in mental health promotion training.
- Increased access and utilization of the appropriate level of mental health services.

EI Dorado County Health Services Department – Mental Health Division
MHSA PEI Component Three-Year Program and Expenditure Plan
LOCAL EVALUATION OF A PEI PROJECT
Form No. 7

- Satisfaction with services received – which includes satisfaction with the cultural sensitivity of the services rendered.

Program/system level outcomes:

- All clients and family caregivers contacted will receive information regarding mental well being and illness.
 - All clients and family caregivers will be screened for depression once a year.
 - Each individual who screens positively for depression will be referred for services – including collaboration and use of primary healthcare.
 - All program staff, drivers, and volunteers will receive mental health and cultural competency training.
 - Cross referrals between the Mental Health Division, the Human Services Department, and the Public Health Division will increase.
3. Describe the numbers and demographics of individuals participating in this intervention. Indicate the proposed number of individuals under each priority population to be served by race, ethnicity and age groups. Since some individuals may be counted in multiple categories, the numbers of persons on the chart may be a duplicated count. For “other”, provide numbers of individuals served for whom a category is not provided (i.e., underserved cultural populations; e.g., gay, lesbian, bisexual, transgender, questioning; hearing impaired, etc.). Please indicate at the bottom of the form an estimate of the total *unduplicated* count of individuals to be served. If the focus of the intervention is families, count each person in the family.

Data Sources

The demographic and unduplicated client count data in the chart below was provided by the Home-Delivered Meals Program in our County. The PEI estimates were obtained by extrapolating from these figures based on the experience of the Redwood Coast Seniors, Inc., which provides the model for this program.

Data Summary

The EI Dorado County Home-Delivered Meals program provides services to older adults (age 60+) throughout the County targeting those with the greatest economic or social need. In FY 2007-08, we served approximately 700 unique individuals.

There are 350 family caregivers associated with these individuals who are similarly at risk for depression and suicide and therefore are eligible for this prevention and early intervention program. Home-delivered meals clients are required to be homebound by reason of illness, incapacity, disability or who are otherwise isolated. Furthermore, family caregivers may be experiencing prolonged grief or loss associated with caring for a family member who is ill, incapacitated, or disabled. Based on the experience of the Redwood Coast

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Seniors Program, we anticipate that approximately 88 will require screening for early intervention services.

An estimated 54% of the clients served (432) will be identified via the screening process as in need of further evaluation.

An estimated 40% of these 432 clients (or 173) will screen positively for depression and will require assessment and possibly treatment services. This is the estimated population that are at risk of first onset of serious mental illness and will be referred to a mental health or primary care provider.

PERSONS TO RECEIVE INTERVENTION

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/DISCRIMINATION
<u>ETHNICITY/ CULTURE</u>							
African American	5	1				8	8
Asian Pacific Islander	8	2				15	15
Latino	15	3				10	10
Native American	10	2				760	760
Caucasian	760	160				2	2
Other (Indicate if possible)	2	1				5	5
<u>AGE GROUPS</u>							
Children & Youth (0-17)							
Transition Age Youth (16-25)							
Adult (18-59)	400	100				400	400
Older Adult (>60)	800	173				800	800
TOTAL	800	173				800	800
Total PEI project estimated <i>unduplicated</i> count of individuals to be served							<u>800</u>

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

Person/family level desired outcomes:

- Elimination of successful suicides among the population targeted.
 - How measured: Verbal report from family or healthcare provider.
 - What: Reason for discontinuing services.
 - When: Upon notification.
- Reduction in suicide attempts among the population targeted.
 - How measured: Verbal report from family or healthcare provider.
 - What: Reason for discontinuing services.
 - When: Upon notification.
- Reduction in depression symptoms among individuals who receive early intervention services.
 - How measured: Depression screening tools administered during brief early intervention services.
 - What: Objective measure of screening tool.
 - When: Regularly when seen by prevention staff for visit, peer counseling, and/or skills training or brief treatment.
- Successful linkage to support services for those identified with needs in the program.
 - How measured: Confirmation by client, family caregiver, or provider.
 - What: Verbal response during regular visits or team meetings.
 - When: During interview, visit and/or team meetings.
- Reduction or elimination of stigma and an increased understanding of mental wellbeing and illness among those who participate in mental health promotion training.
 - How measured: Questionnaire measuring attitudes regarding mental health issues and willingness to engage in treatment.
 - What: Response to questionnaire.
 - When: Pre and post – upon initial assessment and at time of re-assessment or case closure.
- Improvement in nutritional status of both the clients and the family caregivers for those identified for early intervention services.
 - How measured: Nutrition risk assessment form that is administered by home delivered meals coordinator.
 - What: Standardized risk assessment form.
 - When: Administered at the initial assessment and on an annual basis.
- Satisfaction with services received – which includes satisfaction with the cultural sensitivity of the services rendered.
 - How measured: Client survey
 - What: Survey response
 - When: At re-assessment and case closure

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Program/system level outcomes:

- All clients and family caregivers contacted will receive information regarding mental wellbeing and illness.
 - How measured: Documentation by staff.
 - What: Receptivity to information by client.
 - When: Initial eligibility assessment and on an annual basis.
- All clients and family caregivers will be screened for depression once a year.
 - How measured: Documentation of completed screening.
 - What: Depression screening score.
 - When: Initial eligibility assessment and annual assessment.
- Each individual who screens positively for depression will be referred for services.
 - How measured: Client tracking sheet.
 - What: Referral follow up data.
 - When: Upon referral, in the course of treatment, and upon treatment termination.
- All program staff, drivers, and volunteers will receive mental health and cultural competency training and a post-training evaluation.
 - How measured: Documentation of training (sign in sheets) and a post-training evaluation.
 - What: Number of attendees and the post-test scores.
 - When: Collected at end of training.
- Cross referrals between the Mental Health Division, the Human Services Department, Primary Care, and the Public Health Division will increase.
 - How measured: Referral reporting forms.
 - What: Number of referrals.
 - When: Collected throughout the year for annual data report.

5. How will data be collected and analyzed?

- The County Mental Health Division will determine the data collection needs to satisfy the MHSA PEI plan requirements.
- An MOU will be created between the Health Services and Human Services Departments to collaborate on this program.
- Data related to participants of the Home-delivered meal program will be made available to the MHD based on signed releases.
- The Home-delivered meal program staff will collect, analyze, and report mental health service utilization and outcome data to the MHD and AAA.
- A combination of data collected for the AAA and the MHD will be used for PEI program evaluation purposes.

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LOCAL EVALUATION OF A PEI PROJECT
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6. How will cultural competency be incorporated into the programs and the evaluation?

- Training related to the MHSA principles and cultural competency will be provided for all program staff, drivers and volunteers – including principles of welcoming and inclusion.
- Every effort will be made to recruit staff who reflect the diversity of the population served.
- Interpreters will be used, as appropriate – training for proper use of interpreters will be provided, as well.
- Survey questionnaires for clients and family caregivers will address issues of cultural competency.
- Client and caregiver data reflecting issues of race, ethnicity, and gender will be collected to inform the cultural needs of the program.
- The Ethnic Services Coordinator and Cultural Competency Committee will be accessed and informed regarding this new program, progress, challenges, and program evaluation findings.

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

The Home-Delivered Meals Wellness Outreach Program is modeled after the Meals on Wheels Mental Health Outreach Program developed by Joe Curren, Executive Director, Redwood Coast Seniors, Inc. Program design information will be used to develop a checklist of fidelity criteria that will be reviewed on an annual basis as part of the annual progress reporting process.

Collaboration with AAA, who has responsibility for the Home-Delivered Meals Program, will occur to ensure that the standards meet those established by the Older Americans Act. Collaboration and consultation with the California Department on Aging will occur, as well.

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

The County Mental Health Division will have primary responsibility for disseminating the results of this evaluation report to local stakeholders, including the MHSA PEI Workgroup, the MHSA Advisory Committee, and the Mental Health Commission. The findings will be posted on the Division's website, as well. The AAA will have access to distribute the report to additional stakeholders that they work with, as well.