

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

**Fiscal Years 2009-10 and 2010-11 (using FY 2007-2008 and FY 2009-2010 MHSA
PEI Funds)**

County Name: Tehama County	10/29/2009
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COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):

County Mental Health Director	Project Lead
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AUTHORIZING SIGNATURE

I HEREBY CERTIFY that I am the official responsible for the administration of Community Mental Health Services in and for said County; that the county has complied with all pertinent regulations, laws and statutes. The county has not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and the administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2007-08, 2008-09 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief the administration budget and all related program budgets in all respects are true, correct and in accordance with the law. I have considered non-traditional mental health settings in designing the County PEI component and in selecting PEI implementation providers. I agree to conduct a local outcome evaluation for at least one PEI Project, as identified in the County PEI component (optional for "very small counties"), in accordance with state parameters and will fully participate in the State Administered Evaluation.

Signature _____

County Mental Health Director

Date

Executed at _____, California

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 was the responsibility of the MHSA Steering Committee, chaired by Steve Chamblin, LMFT, MHSA Coordinator. The MHSA Steering Committee is a subcommittee of the Tehama County Interagency Coordinating Council (IACC). Valerie S. Lucero, Executive Director, Tehama County Health Services Agency, is the IACC representative on the committee. The committee members included Mental Health staff, consumers, family members, other county agency staff, non-profit organization representatives, law enforcement, and school representatives. This group was representative of the community in terms of cultural backgrounds as well as type of service provider, age ranges, etc.
- b. Coordination and management of the Community Program Planning Process was overseen by Steve Chamblin, LMFT, MHSA Coordinator. Ann Houghtby, LMFT, Mental Health Director, Susan Murphy, Community Health Education Supervisor, Fernando Villegas, Health Educator, Theresa Greer, Health Educator, and Jesse Porter, (a consumer employee) Consumer Support Worker, provided additional assistance in coordination and management.
- c. Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process was accomplished by a variety of methods.
 1. There were three stakeholder meetings in three separate geographic areas to attempt to reach out to the entire county. The first stakeholder meeting was held on April 8, 2009 at the Corning Family Resource Center, in the south part of the county. This group represented our Latino Community, including monolingual participants. The Family Resource Center is located in 3 geographical areas in the county, run by a non-profit organization, with a mission of providing a safe neighborhood based place where individual, families and organizations have access to resources that support children, families and community. The services focus on prevention such as playgroups and parenting education, early intervention such as oral health treatment and kindergarten transition activities, and treatment such as case management and substance abuse treatment. The Corning office primarily provides services to our Latino community, as the majority of the Latino community currently resides in the Corning area. This is why we

chose to do the stakeholder meeting at this site, to attempt to reach out successfully to the Latino community in a meaningful way. The stakeholder group was Latino community members that have accessed the Family Resource Center for parenting or other resources. They were not mental health consumers. Tehama County Mental Health has done outreach at the Family Resource Center through our Latino Outreach Coordinator, as well as our Spanish speaking therapist has done educational presentations at the Center, as part of our MHSA CSS plan. For this reason, the stakeholders were comfortable in meeting with our MHSA Coordinator and our Latino Outreach Coordinator.

The second stakeholder meeting was held on April 9, 2009 in Red Bluff, the county seat, located in the middle of the county, at the Mental Health Drop In Center. This group was a wide representation of consumers, family members, advisory board members, other agency representatives, and Mental Health staff. There was a great deal of discussion, and numerous ideas were presented. Many consumers commented about the need for further support for the 16 to 25 year old population. They also voiced support for parents in dealing with aberrant adolescent behavior and support when young people and their families experience early signs of mental illness. Several consumers suggested more outreach in school setting. The highest priorities at this stakeholder meeting were for adolescents and their families. The Mental Health Advisory Board member representatives expressed interest in evidence based interventions for youth.

The final stakeholder meeting was held on April 9, 2009 at Evergreen School in Cottonwood, at the north end of Tehama County. Unfortunately, no stakeholders came to this meeting. The MHSA Coordinator and the Latino Outreach Coordinator did seek out input from administration staff at the school. Input received was that they would welcome support services and prevention services for the elementary school. The elementary principal indicated she would like to see friendship or peer support groups for kindergarten through fourth grade.

2. We actively recruited consumers and family members for our Steering Committee and were able to recruit an adolescent consumer and parents that lost a daughter to suicide. Our adolescent consumer was an active participant throughout the process, including organizing a focus group for adolescents. He was also able to represent a multi-cultural perspective as he is African American living in a home with his Caucasian mother and East Indian practicing Hindu stepfather. Our family members, Mike

and Mary Gonzales, recently lost their youngest daughter to suicide while she was attending college. They are very involved in mental health advocacy and have spearheaded the “Suzanne Gonzales Suicide Prevention Act of 2009, also known as “Suzy’s Law- HR 853. This proposed bill is attempting to address the issue of suicide assistance on the Internet. They were active participants throughout the process. In addition, one of our many consumer employees, Jesse Porter was an active participant throughout the process. He is extremely active in Mental Health advocacy and was instrumental in the development of the local chapter of NAMI, and was the first president as well. He is also the lead consumer employee, participating in all levels of Mental Health Administration to provide the consumer voice. All of these individuals have committed to ongoing involvement in the implementation and evaluation phases of this project.

3. Surveys were provided at all the stakeholder meetings, at our various sites, and were sent out electronically to a variety of list serves that reached a broad range of individuals. 100 individuals completed the survey on-line and an additional 37 individuals completed the survey during the stakeholder meetings, Mental Health Advisory Board meetings, National Alliance for the Mentally Ill (NAMI) meetings, etc. Although this number may seem small, responses to surveys in this community has been historically minimal. It is often difficult to get people to participate in stakeholder meetings as well. Information often has to be sought on an individual basis, therefore this response is significantly improved from previous attempts to gain input from the community. Additionally, we now have an unlimited subscription to Survey Monkey and will be developing ongoing surveys in a way that is easy to complete to address a variety of issues including client satisfaction, MHSA input, etc.

In the survey, we asked the participants to rank the priority areas by age range. The priority areas included disparities in access to mental health services, psycho-social impact of trauma, at-risk children, youth and young adult populations, stigma and discrimination among age groups, suicide risk, and underserved cultural populations. Next, we asked, “What is the most important Mental Health Prevention or Early Intervention need in Tehama County?” The final question was, “Are you aware of any evidence-based programs that you would like to see implemented in Tehama County to address the needs you have identified?” The results are summarized in the project descriptions that follow.

During the Stakeholder meetings, the questions were discussed and explained and input was also sought verbally. Examples were provided, and all questions were answered as they arose. When developing the survey, our consumer employee expressed that he felt it was important that consumers be given the opportunity to answer the same type of questions that we might ask service providers. In addition, when discussing whether or not to include a question about evidence based practices, he felt it was an important question, as he wanted us to develop the best program possible to obtain the best outcomes for all consumers. During the stakeholder meetings, it appeared that consumers were comfortable answering the survey questions, and providing input.

4. As the MHSA Steering Committee noted areas needing additional information, staff contacted people in the community and did key informant interviews and/or invited individuals to speak to the Steering Committee directly. During the public comment process, input from adolescents was actively sought.

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

Tehama County is considered a “very small” county, with a current estimated population of 61,000. According to the census bureau, the ethnic breakdown is as follows: 73.3% “White persons not Hispanic,” 0.9% African American, 2.3% Native American, 1.2% Asian, 0.1% Native Hawaiian/Pacific Islander, and 20.5% “Persons of Hispanic or Latino origin”. 14.4% speak a language other than English at home. 24% of the population is under 18 and 15.3% are over 65. 50.5% are female and 49.5% are male. The population we are primarily attempting to reach is the Latino population, but are also attempting to engage the Native American community as well.

- a. All participants in the Corning stakeholder meeting were Spanish speaking adult females. Tehama County continues to strive to increase access to the Latino population, but they remain an underserved population. The majority of participants at the Red Bluff stakeholder meeting were consumers or family members from a variety of cultural backgrounds. We attempted to include representatives of underserved populations within our Steering Committee as well. The demographics of the Steering Committee are summarized in the next section. We specifically chose to have our stakeholder meetings in Corning (south county) and Cottonwood (north county) to attempt to reach out to the unserved in those areas, as transportation is often a barrier to receiving services.

- b. Tehama County attempted to provide 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. As stated previously, the initial stakeholder meeting was with Spanish speaking adult females representing the needs of the south county. This group was able to provide helpful feedback regarding ways to effectively reach the Spanish speaking community in a meaningful way. Also, as stated previously, we strategically scheduled the stakeholder meetings in three sites representative of the geographic area. Unfortunately, the north county stakeholder meeting was not successful in reaching out to the area.

We also attempted to find participants for our MHSA Steering Committee that were representative of the diversity of this county. Unfortunately, we were not successful in recruiting a representative from the Native American community. This is an area that we have been striving to improve. In Tehama County, there are some unique aspects of the native community. The Nomlaki Tribe is the recognized tribe, based out of Paskenta, a very small community in the southwest corner of the county. This tribe operates the Rolling Hills Casino. When doing initial outreach during the MHSA CSS planning process, we discovered that the Nomlaki Tribe is very small, and not organized in terms of health care or social supports. The Casino has been an excellent partner to the community, and we have partnered with them on numerous occasions to do outreach to the community. However, we have not been able to arrange for a representative that can participate in our planning process.

In order to better understand how to understand Native American culture and how to partner with this culture, we have taken several steps to reach this goal. We facilitated a one-day workshop with the Indian Dispute Resolution, Inc, which was attended by Mental Health staff, mental health consumers, staff from other health care settings and staff from social service settings. We learned of the Indian Dispute Resolution through interactions with youth involved in the child welfare system, as they advocated for those youth. Also, a Native American MHSA Stipend Social Work intern made the original outreach to this group to invite them to our community. In addition, we applied to participate in a nationwide fellowship that focuses on Native American Health Communities building effective collaborations and communities that promotes wellness through the Health Native Communities Fellowship, funded by Indian Health Services. We were able to apply based on one of our employees, Avery Vilche, being a member of the CIRI based Yupik Eskimos. It was an extremely competitive process, looking at the level of a community plan of action for bettering the health of Native Americans. We were the only group chosen from California. We sent a team of four individuals, including Avery, to 4 week-long training modules that focused on ways to

build effective collaborations that promotes wellness in the Native American community. We gained many tools to assist us in building a fellowship within our community and therefore we hope that, in future MHSA planning processes, we will be able to fully engage the Native American community.

Since completing the fellowship process, we have utilized the tools within our division, our Health Agency, and with our consumers. We are utilizing the Cultural Competency Committee to pursue this relationship on an ongoing basis. We have been able to connect with other tribe members that reside in our community, but are not part of the Nomlaki tribe. A Native American employee provided an inservice on her culture, and we were able to have a Native American Elder storyteller tell stories at our Health Agency staff meeting. Please see tables that summarize the make-up of the MHSA Steering Committee.

<u>Gender</u>	
Male	6
Female	10

<u>Ethnicity</u>	
Hispanic: Persons having origins in any of the Mexican, Puerto Rican, Cuban, Central or South American or other Spanish Cultures, regardless of ethnicity.	2
African American (not of Hispanic origin): Person having origins in any of the black ethnic groups.	1
Caucasian (not of Hispanic origin): Persons having origins in any of the original peoples of Europe, North Africa or the Middle East.	13
Asian or Pacific Islander: Persons having origins in any of the peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.	1

<u>Designation</u>	
Consumers	2
Family members	2
Mental Health staff	4
Other community providers or government agency staff	8

Tehama County also included outreach to clients with serious mental illness and/or serious emotional disturbance and their family members, to ensure the opportunity to participate. As stated previously, the Red Bluff Stakeholder Meeting was held at the Mental Health Vista Way Drop In Center and all consumers were encouraged to participate. Input was also

sought from the local chapter of NAMI, as well as the Mental Health Advisory Board, which includes at least 50% consumers and family members. In addition, a consumer employee was part of the entire planning process. It should be noted that the Tehama County local NAMI chapter is unique in that it is made up primarily of consumers, rather than family members. Many of the active members of NAMI are also employees at Mental Health. NAMI is very involved in educating the community and reducing the stigma related to mental health issues. The Mental Health Director and the MHSA Coordinator attend NAMI business meetings to obtain input. The group is very encouraged about how MHSA programs can help to address the issues of stigma and access to services.

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 - As stated in the previous section, we involved consumers and family members in the stakeholder meetings, survey completion and as members of the Steering Committee. This included consumers from all age ranges, and their families.
 - Providers of mental health and/or related services such as physical health care and/or social services - Many providers of mental health, substance abuse, public health nursing, physical health care, parenting group providers, social services, non-traditional therapeutic venues such as equine therapy, etc. were involved in the stakeholder process, completion of surveys, and MHSA Steering Committee participation. Steering Committee members included Public Health, Drug and Alcohol, Addus Health Care, Daystar Ranch (equine therapy), Social Services, Family Service Agency, First 5 Commission, New Directions to Hope (organizational provider), Mental Health staff, NCCDI (Head Start), etc.
 - Educators and/or representatives of education - One of the stakeholder meetings was held at a school. The Department of Education had an active representative on the Steering Committee and local schools were engaged in the process by seeking input through the surveys, key informant interviews coordinated by Mental Health and Education working together, and periodic participation in the MHSA Steering Committee.
 - Representatives of law enforcement - Probation and the Sheriff's Department were invited to join the Steering Committee. Probation

- Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families - Organizational providers participated, as well as Head Start, Addus Health Care, etc. In addition, there was a NAMI representative on the Steering Committee.
- b. Training for county staff and stakeholders participating in the Community Program Planning Process is provided on an ongoing basis and information is shared in a variety of venues. Examples include the weekly clinical meeting, monthly staff meetings, MHSA team meetings, etc. The initial MHSA Steering Committee meetings focused on training regarding the MHSA planning process, MHSA guiding principles, and MHSA Prevention and Early Intervention (PEI) specific guidelines. Continuing education is part of Design Team meetings, interagency meetings, triage staffings and trainings with other private and governmental entities. Countywide training occurs with calendared events like May is Mental Health Month, Red Ribbon Week, October is Domestic Violence Awareness, etc.

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

- a. The lessons learned from the Community Services and Support (CSS) process and how these were applied in the PEI process: The most important lesson learned in the CSS process was how critical it is to have consumer involvement throughout the process. We did this fairly extensively in the CSS process, in a very informal manner. In the PEI process, we attempted to be more organized and expand the group involved to include at least one adolescent. We were successful in having regular participation from one adolescent throughout the process. Another lesson learned was the importance of having family members involved in the process, which was difficult in the CSS process. We were successful in having regular participation from two family members on the Steering Committee. Other lessons learned were the importance of including individuals from underserved populations throughout the process. We were successful in having Latino participation, as well as other ethnic groups, but continued to struggle with fully engaging the Native American community. We have taken steps in the last year to increase our understanding and skills to successfully outreach to this community. We had three staff participate in an intensive national fellowship focused on

building healthy Native American communities and have made some significant connections to our local Native American community. Therefore, we believe that we will reach our goal of Native American community involvement in future MHSA planning processes. When we begin to provide drop-in activities at the Transition Age Youth (TAY) building we can be more inclusive of all cultures.

Measures of success that outreach efforts produced consist of an inclusive and effective community program planning process with participation by individuals who are part of the PEI priority populations, including Transition Age Youth. The primary measure of success was that we had an adolescent actively participate in the planning process and actively sought additional feedback during the public hearing process from the adolescent population. On December 9, 2009 we had a special meeting with adolescents from the local High School to review the plan and provide input. In Tehama county there are 3 high schools. Red Bluff High School is the largest, and has students from 11 elementary school sites in the county, representing the largest geographical area. The adolescent consumer member of the Steering Committee attends this High School, and organized this meeting. He was the only Mental Health consumer that participated. 4 students participated and provided input. The ethnic make up of the group was 1 African American and 3 Caucasian males. One student thought everything mentioned would be very beneficial and will help out a lot of youths in need in our area. When discussing the TAY drop in center, all the students thought it was awesome that it was going to be consumer driven. The students also thought that it was great that there was someone that really cared for youth in need of these services. They also said they would be willing to volunteer at the TAY center with cooking classes or help run a group. They also recommended having an Air Hockey table for another activity for the kids to keep them busy.

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

- a. The date of the public hearing: December 9, 2009
- 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. The PEI Component work plan was published on the Tehama County Health Services Agency website. The plan was forwarded to the MHSA Steering Committee, Health Partnership, and Mental Health Advisory Board. It was made available at three Health Agency sites - Mental Health Outpatient, Vista Way Drop In Center, and the South County Agency building. A notice was put in the local paper advising the community that it was available on the website, at the specific sites identified above, and could also be copied or emailed upon request. There were two requests for the

plan from the community. The public hearing was also advertised in the local paper.

c. A summary and analysis of any substantive recommendations for revisions. There were no major recommendations for revision, however two suggestions were made and were incorporated into the plan. The first suggestion was that in-service training be made available to teachers to increase their knowledge of what signs or symptoms to look for when considering a referral to any of the programs. The second suggestion was to do presentations about the programs to a variety of community service organizations to provide education and seek potential assistance in making the programs successful. Specific comments were as follows:

1) Virginia Mohler (family member of the Advisory Board) asked about identifying depression in teens, and noted that Red Bluff High School has a newspaper online that could be utilized.

2) Mike Gonzales (family member of the Advisory Board and MHSA Steering Committee member) clarified that the questions in the Teen Screen tool help identify kids who may otherwise “fall through the cracks”.

3) George Russell (Board of Supervisor’s Advisory Board member) stated involving kids in the process is smart. He suggested providing training to teachers about signs and symptoms to be aware of. He also said if children are in the right frame of mind, it makes it easier to learn. He stated the MSHA steering committee did a good job of identifying needs.

4) Nancy Stratton (Advisory Board member) agreed with George about training for teachers. She noted that society has changed and that values and expectations are different now. She said children are more verbal now, will tell you things they would have hidden years ago. She also said it’s important to reach out to the faith community, and is glad that is a component.

5) Susan Murphy (Public Health employee) liked idea of training teachers because vocabulary has changed over the years.

6) Clay Parker (Sheriff and Advisory Board member) asked to have the Teen Screen tool e-mailed to the MH Board members. He also suggested using the “Fight Crime, Invest in Kids” website for information when implementing the programs.

7) Jean Shackelford (Advisory Board Chair) stated outreach will be vital. She suggested sharing information with volunteer organizations, such as Soroptomists, and getting them involved.

d. The estimated number of participants: 12

Note: County mental health programs will report actual PEI Community Program Planning expenditures separately on the annual MHSA Revenue and Expenditure Report.

County: Tehama

PEI Project Name: Nurturing Parent Programs

Date: 10/29/09

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

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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Individuals Experiencing Onset of Serious Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Children and Youth in Stressed Families	<input checked="" type="checkbox"/>	<input checked="" 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 checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
6. Underserved Cultural Populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

The Mental Health Division of the Tehama County Health Services Agency requested that the Interagency Coordinating Council develop a subcommittee that would have the responsibility for the development of the MHSA Prevention and Early Intervention component. The Steering Committee reports to the Interagency Coordinating Council and also provides updates to and obtains input from the Mental Health Advisory Board. The MHSA Steering Committee is comprised of consumers (including an adolescent),

family members, and representatives from public and private agencies. The public and private agencies include: First 5 of Tehama County, Head Start, Department of Education, Law Enforcement, National Alliance for the Mentally Ill (NAMI), Public Health, Drug and Alcohol, Mental Health, Probation, Family Resource Centers, Northern Valley Catholic Social Services, Family Service Agency, and New Directions to Hope.

The MHSA Steering Committee utilized several methods to obtain stakeholder input. Online surveys were provided throughout the community, as well as stakeholder community meetings and key informant interviews. Stakeholder community meetings were held in three locations, in an attempt to provide the opportunity for input from all geographic areas. Meetings were held at the Family Resource Center in Corning with monolingual Spanish speaking mothers from the Latino community, the Vista Way Drop-In Center in Red Bluff, and Evergreen School in Cottonwood. Participants included consumers, family members, mental health staff, advisory board members, parents, community organization staff, NAMI, Drug and Alcohol services and other community service providers. Participants were encouraged to provide verbal input, and complete a written survey.

The online survey was provided through “Survey Monkey.” Participants included community members, consumers, family members, service providers, Steering Committee members, which included, but were not limited to, Department of Education, Department of Social Services, Probation, Mental Health, Public Health, Law Enforcement, Drug & Alcohol and community-based organizations. The survey was followed by one-on-one key informant interviews consisting of a school psychologist, speech and occupational therapist, school administrators, school nurses and teachers. Meetings were held with Mental Health consumers, parents and community agencies.

The MHSA Steering Committee also reviewed the Healthy Kids Survey for youth at Tehama County Schools in the 5th, 7th, 9th and 11th grades. Feeling safe at or outside of school, depression and suicide were three of the areas addressed in the survey that related to our priority populations. The survey was done in 2004, 2006 and 2008. Data regarding feeling safe at or outside of school for 5th graders in 2008 indicated that 11% never feel safe away from home, and 18% only feel safe some of the time. When asked, “During the past 12 months, did you ever feel so sad and hopeless almost every day for two weeks or more that you stopped doing some usual activities?” the data is as follows:

	Feelings of Sadness	No Feelings of Sadness
7 th grade 2004	23%	77%
9 th grade 2004	29%	71%
11 th grade 2004	32%	68%
7 th grade 2006	24%	76%
9 th grade 2006	31%	69%
11 th grade 2006	32%	68%
7 th grade 2008	30%	70%
9 th grade 2008	35%	65%
11 th grade 2008	34%	66%

Clearly, the risk for depression/suicide increases with age, but also, the percentage of youth experiencing depression has increased over the five-year time span of the survey. This information helped to clarify the need for a suicide risk/depression reduction program for Tehama County youth, which ultimately led to the development of the YES component. This survey also looked at resiliency factors, including external and internal assets. External assets included caring relationships, high expectations, meaningful participation in activities (in school and home), personal school connectedness, and pro-social peers. Internal assets included empathy, problem solving, and goals/aspirations. In the 5th grade survey, the scores were broken down into High, Moderate and Low levels of assets. For overall external assets, 65% were high, 35% were moderate, and 0% were low. 75% were in the moderate range for meaningful participation (67% at school and 78% in the home), 20% were in the moderate range for having caring relationships at home. In the internal assets category, empathy was rated 37% in the high range, 57% in the moderate range, and 6% in the low range, problem solving was rated 33% in the high range, 59% in the moderate range, and 8% in the low range, goals/aspirations was rated 82% in the high range, 17% in the moderate range, and 0% in the low range. These scores could be interpreted in a variety of ways, but one conclusion could be that the high goals/aspirations scores indicate a high degree of hope in the youth and therefore, with intervention to build the other weaker areas, overall resiliency could be increased. Looking at the resiliency components of this survey, as well as other research done as part of the planning process, led the Steering Committee to discuss the importance of resiliency in prevention and early

intervention services, which then led to the inclusion of resiliency scales in each PEI Component.

Results from the surveys, key informant interviews and stakeholder meetings were analyzed to determine the age group and focus areas of greatest concern to the community. The results are summarized below:

PEI Priority Populations	Targeted Age Group - Top Priority per Survey
Disparities in Access to Mental Health Services	51%- Children and Youth
Psycho-Social Impact of Trauma	<u>70.7%- Children and Youth</u>
At-Risk Children, Youth and Young Adult Populations	68.1%- Children and Youth
Stigma and Discrimination	51.2% Transition Age Youth
Suicide Risk	<u>70.1%- Transition Age Youth</u>
Underserved Cultural Populations	40.7% Transition Age Youth

The MHSA Steering Committee evaluated these results, and then voted on the primary age group to focus the Prevention and Early Intervention project. Children age 6-11 were the primary target age group, with 12-18 as the secondary target age group. The Steering Committee also chose the priority population focus areas of psycho-social impact of trauma and suicide risk as indicated in the table above. Once these target areas and age groups were identified, evidence-based programs with a focus on these areas of concern were researched and presented to the Steering Committee for review and discussion. If an evidence based program had not been found to be relevant or successful with other ethnic groups, primarily focusing on the Latino community, then it was not considered as an option.

Presentations were given by the following organizations: “Girls Inc./Boys Council,” “Nurturing Parent,” “Triple P,” “Suzy’s Law,” “First 5,” “FAST,” “Search Institute: Forty Developmental Assets.” Packets of research and information were provided to Steering Committee members for reference about other evidence-based programs being considered. Members suggested possible evidence-based programs, and a small subcommittee completed a thorough review of all programs suggested. Summaries of these reviews were then presented to the Steering Committee for review, discussion, and ranking of importance. Areas that were assessed/evaluated included costs (ongoing consumables, staffing, program costs, sustainability), evidence-based rating,

flexibility, portability, adaptability (including flexibility in delivery site), evaluation rating, parent/family friendly involvement component, proven effectiveness across ethnicity groups, and whether program targets identified age group and target area of need. If a program was not proven to be effective with the Latino population, it was not considered to be appropriate. As a result of the ranking process, the top 8 programs were: Girls Inc/Boys Council, Nurturing Parent Programs, Second Step, Real Life Heroes, Seeking Safety, TeenScreen, Trauma Focused Cognitive Behavioral Therapy (TF-CBT), and Triple P.

This list of 8 programs was then reduced to five possible evidence-based programs for implementation. Seeking Safety was eliminated for this project as there is limited evidence-based research about the effectiveness for the targeted age group. Second Step was eliminated due to the time requirement for school personnel to implement. Girls Inc/Boys Council was eliminated, as it is not currently accepted as an evidenced-based program with the SAMHSA registry and there was not sufficient research to show that it is effective across ethnic groups. Of the remaining five, there were two parenting programs, two early intervention programs that address the impact of trauma, and one program that provides screening for suicide risk and other mental health issues. The Steering Committee voted to develop a three-pronged approach to address the areas that were identified through the stakeholder process. This approach included a parenting component to focus on the prevention and treatment of child abuse/neglect, an early intervention treatment program to address the impact of trauma, and a standardized screening tool and stigma reduction program targeting adolescents at risk for suicide and other mental health issues.

Further evaluation of the possible programs was completed and it was determined that the Nurturing Parent Programs was the most appropriate and culturally sensitive option for the parenting component for the targeted population group of families exposed to trauma that may be geographically or culturally isolated. This appeared to be an especially appropriate program as it allows the flexibility to provide the program in any setting, to any group, etc. Therefore, we will be able to utilize this program in underserved/unserved areas and with underserved/unserved groups that have not accessed traditional parenting programs in the community in the past. In addition this program has the flexibility of being facilitated by professionals, paraprofessionals, or parent partners. This program currently exists in at least two venues within the County, but both, although voluntary, have possible sanctions attached for non-participation. The MHSA PEI Nurturing Parent Programs would be completely voluntary. The ultimate decision to choose this parenting program was based on the following factors: This program currently exists in a limited fashion in the community, ease of implementation, flexibility, cost, sustainability, outcome process, and specialized modules for a variety of special groups. Some examples of these

specialized modules include: Crianza con Carino para Padres Ninos program, Crianza con Carino para Padres e Hijos, Teen Parents and Their Families, Nurturing Fathers Program, Families in Substance Abuse Treatment and Recovery, Nurturing Skills for Hispanic Families, Nurturing America's Military Families, Parents and Their Children with Health Challenges, Nurturing God's Way Parenting Program for Christian Families, and an African-American Supplemental Lesson guide. Sustainability appears to be very likely with this program, even if funding is significantly reduced. Once the initial costs of training have occurred, the ongoing costs include the consumable materials and staff time. If funds are decreased, the number of classes can be decreased accordingly, but the program can continue at some level. In addition, this program could qualify for other funding sources as well, so sustainability is highly likely with this program.

Therefore, through this process, a consensus was reached to choose the programs that best meet the needs identified by the Steering Committee – trauma (Nurturing Parent Programs as prevention and TF-CBT as early intervention), suicide risk (TeenScreen), and the targeted age range of 6-18. In addition, the MHS Steering Committee felt strongly that resiliency was an area that was important to focus on in any program developed. It was the consensus of the group that all three of these programs could help to build resiliency in our youth, which also increases positive outcomes for youth and their families. Resiliency can be described as the ability to bounce back, and/or the ability to face, overcome and be strengthened or transformed by the adversities of life. Resiliency comes from children having people that they trust, structure and boundaries for their safety, good role models, encouragement to do things on their own, and access to health, education and social services. A child is more likely to be resilient if he/she has good self-esteem, is able to do kind things for others, has empathy for others, takes responsibility for what he/she does, has hope, faith and trust, can communicate, solve problems, manage their feelings and impulses, understand how other people are feeling, and develop and keep trusting relationships. Our goal was to develop programs that will build this resiliency.

3. PEI Project Description:

The Nurturing Parent Programs' purpose is to build nurturing skills as an alternative to abusive parenting and child-rearing attitudes and practices. This program targets families with children ages 0 through 19 at risk of abuse or neglect. The program is based on a re-parenting philosophy. Desired outcomes are to stop the generational cycle of child abuse, reduce recidivism, reduce juvenile delinquency and alcohol abuse, and reduce teen pregnancy.

Parents and children attend separate groups engaging in cognitive and affective activities that build awareness, self-esteem, and empathy. They learn alternatives to yelling and hitting, enhanced family communication

patterns, and expectations that are realistic in terms of the child's stage of development.

The Nurturing Parent Programs include 13 different versions that target specific age groups, cultures, and needs. For example, there are special programs for infants, school-aged children, and teens, cultural groups such as Latinos, Southeast Asians, or African Americans, children with special learning needs, Christian families, and families in recovery. Group sessions are held weekly for two to three hours, and for a period of 12 to 45 weeks. Programs can be held in a group or home setting. Parenting programs will be chosen according to the parenting needs of the chosen target population. Which population being chosen will be done through a consensus approach by the MHSA PEI team, including consumers, family members, and individuals from ethnic populations in the community. Once programs are established, then participants in the programs will be actively involved in ongoing planning. We plan to include parent partners in this component, and will stipend those involved as well as provide the opportunity for employment, as we are currently doing in the MHSA CSS plan.

In Tehama County, we are proposing to implement the Nurturing Parent Programs in geographically isolated areas and alternative sites within the community. For example, we will offer the program in Rancho Tehama, a small isolated area with no services available, and Cottonwood, a rural area with very limited services. In addition, we will collaborate with the spiritual community and provide services in that alternative setting. We plan to utilize a multidisciplinary model, using public health nursing staff, mental health staff, and substance abuse counselors to provide the service to the geographically isolated areas and at alternative sites, including home visits when appropriate. In addition, we plan to offer specialized contracts to organizational providers that may identify a special population for this program.

Following is an estimated timeline for implementation of the program:

Activity	Time from Initiation of the Program
Assign/hire staff	2 months
Outreach to the community to determine initial parenting module to be implemented, including consumers and family members	2-3 months
Secure sites for services based on geographical isolation or other needs	2-3 months
Purchase materials	2-3 months
RFP out to the community	RFP out to the community
Develop evaluation process, using consumers and family members, as well as representatives from ethnic	3-4 months

groups	
Train staff	2-3 months
Begin parenting modules	3-4 months
Evaluation	At completion of first module and ongoing
Continue above planning and implementation process for each module based on identified need	ongoing

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	
Nurturing Parent Programs	Individuals: Families: 25-30	Individuals: Families:	6
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: Families: 25-30	Individuals: Families:	6

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

Linkage to Mental Health and other providers in the community will be an integral component of the Nurturing Parent Programs. Facilitators will be fully trained regarding resources in the community and the referral process. As it becomes apparent that there are needs for referral we will utilize our existing multi-agency referral process. Nurturing Parent providers would also utilize the existing multi-agency treatment team process to facilitate comprehensive treatment planning as needed. Possible referral sources include: CHDP – primary care physicians, Greenville Rancheria clinics, dental referrals, Family Resource Centers, Special Education, Head Start, First 5, Substance Abuse

Treatment, Friday Night Live, Boys Council/Girls Inc, Mental Health and community-based mental health providers.

6. Collaboration and System Enhancements

Tehama County is committed to full collaboration, and has existing venues for assuring that county agencies and community partners are able to effectively collaborate. Groups that currently exist that embrace this philosophy and help to assure that collaboration occurs include the Tehama County Health Partnership, Multi-Agency Treatment Team (MATT), Advisory Boards (Mental Health, Public Health, Drug and Alcohol), NAMI, First 5 Tehama, Head Start, Department Of Education SELPA, School Attendance Review Board, Interagency Coordinating Council, Child Abuse Council, Latino Outreach, Family Resource Centers through Northern Valley Catholic Social Services, Nomlaki Tribe Of Paskenta Indians and Healthy Native Communities Partnership. Members of these various groups include county agencies, organizational providers, tribal organizations, consumer and family member groups, law enforcement and private hospital staff.

As part of the ongoing MHSA planning and implementation process, we have established goals regarding increasing/enhancing collaboration. These include: 1) successfully implementing full collaboration with the Native American Community, 2) increasing partnerships with adolescent consumers, including branching out to the other two local high schools, and middle schools, 3) implementing full collaboration with the faith based community, 4) increasing collaboration with the Latino community, and 6) increasing collaboration with consumers and family members.

The Nurturing Parent Programs component will enhance existing systems, as the focus is to expand services to unserved pocket populations of Tehama County, and utilize alternative sites for the program to reduce stigma about seeking assistance. This was a specific request from the Latino stakeholder group. Our plan is to have the MHSA PEI team, which will include representatives from underserved population groups to do further planning about which groups and where in the community to initiate the new program in order to successfully reach the underserved and unserved populations. This will also be a unique opportunity to engage the faith community. Although the faith community is very involved in providing services and supports to the community, it is not usually in partnership with governmental or non-faith-based organizations. Tehama County is participating in the statewide Mental Health and Spirituality Initiative, beginning with sending a team (including consumers) to the workshop that was held in June 2009. We have a core group that is very passionate about this philosophy, and will be excellent collaborative partners regarding the building of an effective relationship. We are also fortunate that we have employees with connections to the local ministerial association (which includes all of the local church

groups), and therefore we are confident that a positive relationship will be established. This group works well together, an example being that as we do not have a permanent homeless shelter, the churches work together to take turns opening their facilities at night during the winter months for the PATH group to run the shelters there. Our plan would be to reach out to the faith-based community, and develop a plan in collaboration with this group. This will also help to communicate the message of treating the whole person, including respecting and incorporating spiritual beliefs.

Inservice trainings will be offered to all interested teachers and other groups to assist in understanding the program, and who is appropriate to refer. In addition, presentations will be done in the community to a variety of community service organizations to provide education, and to encourage the organizations to get involved.

7. Intended Outcomes

Individual Outcomes: Improve positive family functioning to decrease the incident of trauma in youth. Reduce the incident of negative child-rearing practices in families we serve, and ultimately reduce the incident of criminal justice involvement and teen pregnancy as well as build resiliency in the clients served in this project.

System Outcomes: Improves access to isolated areas and providing services to the underserved populations. Improve collaboration with existing community partners and expand the current system to include new partners including faith-based and ministerial organizations.

Program Outcomes: Increase access to prevention focused programs, enhance comprehensiveness by adding specialized components such as parenting with Christian families, Latino families, families with special needs children, standardizing data collection across programs and expand services to geographically isolated areas.

Evaluation methods available: The Nurturing Parent Programs provide fully researched pre- and post-evaluation instruments. In addition, we will be adding a resiliency scale to this project, as well as the other components of our PEI program. Our plan is to continue to follow our families after they have completed the program, including ongoing brief surveys on status to help us evaluate the long-term impact of this prevention strategy.

What will be different as a result of the PEI project: Increased numbers of families enrolled in the Nurturing Parent Programs, expansion of geographical areas with services available and increased collaboration. Our ultimate goal is to break the generational cycle of abuse, increase resiliency and overall

functioning in our youth, and decrease the likelihood of ongoing mental health issues and juvenile justice issues.

8. Coordination with Other MHSA Components

Currently in our MHSA CSS program we have a very active Transition Age Youth Full Service Partnership. A large percentage of our current enrollees are young women raised in the foster care system that are now parents or soon to be parents. This parenting program would be an excellent strategy to help them build self-confidence, parenting skills, resiliency and break the generational cycle of abuse. In addition, as part of our CSS Access Work Plan, we provide groups in schools and, as family issues are identified, referrals can be made to the parenting program. As part of our Outreach Work Plan, our focus is to increase services for our Spanish speaking community. Having a program that is in their native language and developed specifically to address cultural issues will be a positive resource. In addition, as facilitators identify families with mental health symptoms who have other issues such as housing and employment needs, they can be referred to the appropriate CSS Work Plan.

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

County Name: Tehama
PEI Project Name: Nurturing Parent Programs

Date: 10/29/09

Provider Name (if known): Unknown
Intended Provider Category: Mental Health Provider

Proposed Total Number of Individuals to be served:	FY 09-10	<u>25-30</u>	FY 10-11	<u>100</u>
Total Number of Individuals currently being served:	FY 09-10	<u>0</u>	FY 10-11	<u>25-30</u>
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	<u>0</u>	FY 10-11	<u>0</u>
Months of Operation:	FY 09-10	<u>6</u>	FY 10-11	<u>12</u>

Client/family members

XX

		Total Program/PEI Project Budget		
Proposed Expenses and Revenues		FY 09-10	FY 10-11	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
	PH Nurse/Health Educator/SAC .4 FTE	8,888	26,664	\$35,552
	DA Substance Abuse Counselor .4 FTE	5,424	16,272	\$21,696
	Case Resource Specialist .4 FTE	5,988	17,964	\$23,952
	Licensed Clinical Supervisor .15 FTE	3,961	11,833	\$15,794
	Parent partner stipends	2,500	4,000	\$6,500
	b. Benefits and Taxes @ 45 %	10,917	32,730	\$43,647
	c. Total Personnel Expenditures	\$37,678	\$109,436	\$147,141.00
2. Operating Expenditures				
	a. Facility Cost	\$0	\$0	\$0
	b. Other Operating Expenses Materials/vehicle	\$23,000	\$6,000	\$29,000
	c. Total Operating Expenses	\$23,000	\$8,000	\$29,000
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
	RFP for specialized Nurturing Parent Programs	\$1,500	\$4,000	\$5,000
	Training for facilitators	\$4,500	\$1,000	\$7,500
		\$0	\$0	\$0
	a. Total Subcontracts	\$6,000	\$5,000	\$12,500
	4. Total Proposed PEI Project Budget	\$66,178	\$120,436	\$186,614
B. Revenues (list/itemize by fund source)				
		\$0	\$0	\$0
		\$0	\$0	\$0
		\$0	\$0	\$0
	1. Total Revenue	\$0	\$0	\$0
	5. Total Funding Requested for PEI Project	\$66,178	\$120,436	\$186,641
	6. Total In-Kind Contributions	\$10,000	\$25,000	\$35,000

Budget Narrative Nurturing Parent Programs

Initial costs for FY 2009-2010 will utilize all of FY 2007-2008 PEI funds, and some of FY 2008-2009 funds. Ongoing costs in FY 2010-2011 will utilize FY 2008-2009 funds. The plan is to request FY 2009-2010 funds during the FY 2010-2011 MHSA Update to carry the PEI activities through FY 2011-2012.

Staffing and Line Item

Public Health Nursing staff .4 FTE. This individual will provide Nurturing Parent activities in the community as part of the multi-disciplinary team. Initial activities will include needs assessment and outreach to establish where the programs can be provided, and which programs are most appropriate initially.

Substance Abuse Counselor .4 FTE. This individual will provide Nurturing Parent activities in the community as part of the multi-disciplinary team. Initial activities will include needs assessment and outreach to establish where the programs can be provided, and which programs are most appropriate initially.

Case Resource Specialist (Mental Health Rehabilitation Specialist) .4 FTE. This individual will provide Nurturing Parent activities in the community as part of the multi-disciplinary team. Initial activities will include needs assessment and outreach to establish where the programs can be provided, and which programs are most appropriate initially.

Licensed Clinical Supervisor .15 FTE. This individual will oversee the training of staff, development of the program, implementation of the program county wide, and evaluation.

Stipends for parent facilitators/partners/peer support. Utilizing our current system for stipend reimbursement, we will provide stipends to parents that have participated in the program that are interested/willing to provide peer support, guidance, and/or facilitate special modules. The goal is to build a peer support network that can continue to foster the skills and knowledge gained during the parenting program.

Non Recurring Costs

Office Supplies: Basic office supplies will be provided so that the staff can complete assigned tasks.

Training: Staff assigned to this component will receive training during FY 2009-2010 regarding this program, outreach methods, needs assessment methods, and evaluation methods.

Ongoing program resources: This program requires ongoing purchase of consumable program materials for the families served.

Vehicle: In order to do effective outreach to the geographically isolated areas, a vehicle will be necessary.

RFP for organizational providers to provide specialized Nurturing Parent Programs modules: This provides an opportunity for community providers to provide specialized modules based on needs assessment.

Approach used to estimate and source documents

Salaries and benefits are based on current actual salaries and benefits. Training and resource materials are based on information from the Nurturing Parent Programs. Vehicle cost is based on latest bids awarded.

Revenues

There are no projected Medi-Cal revenues, however, there will be in-kind contributions by TCHSA Public Health Division and TCHSA Drug and Alcohol Division for facilities, utilities, some supplies, etc.

County: Tehama County **PEI Project:** “YES” (Youth Empowerment Services) **Date:** 10/29/09

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

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

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

The Mental Health division of the Tehama County Health Services Agency requested that the Interagency Coordinating Council develop a subcommittee that would have the responsibility for the development of the MHSA Prevention and Early Intervention component. The Steering Committee reports to the Interagency Coordinating Council and also provides updates to and obtains input from the Mental Health Advisory Board. The MHSA Steering Committee is comprised of consumers (including an adolescent),

family members, and representatives from public and private agencies. The public and private agencies include: First 5 of Tehama County, Head Start, Department Of Education, Law Enforcement, NAMI, Public Health, Drug and Alcohol, Mental Health, Probation, Family Resource Centers, Northern Valley Catholic Social Services, Family Service Agency, and New Directions to Hope.

The MHSA Steering Committee utilized several methods to obtain stakeholder input. Online surveys were provided throughout the community, as well as stakeholder community meetings, and key informant interviews. Stakeholder community meetings were held in three locations in an attempt to provide the opportunity for input from all geographic areas. Meetings were held at the Family Resource Center in Corning with monolingual Spanish speaking mothers from the Latino community, the Vista Way Drop-In Center in Red Bluff, and Evergreen School in Cottonwood. Participants included consumers, family members, Mental Health staff, advisory board members, parents, community organization staff, NAMI, drug and alcohol services, etc. Participants were encouraged to provide verbal input and complete a written survey.

The online survey was provided through "Survey Monkey." Participants included community members, consumers, family members, service providers, Steering Committee members which include but are not limited to: Department Of Education, Department of Social Services, Probation, Mental Health, Public Health, Law Enforcement, Drug & Alcohol and community based organizations. The survey was followed by one-on-one key informant interviews consisting of a school psychologist, speech and occupational therapist, school administrators, school nurses and teachers. Meetings were held with mental health consumers, parents and community agencies.

The MHSA Steering Committee also reviewed the Healthy Kids Survey for youth at Tehama County Schools in the 5th, 7th, 9th and 11th grades. Feeling safe at or outside of school, depression and suicide were three of the areas addressed in the survey that related to our priority populations. The survey was done in 2004, 2006 and 2008. Data regarding feeling safe at or outside of school for 5th graders in 2008 indicated that 11% never feel safe away from home, and 18% only feel safe some of the time. When asked, "During the past 12 months, did you ever feel so sad and hopeless almost every day for two weeks or more that you stopped doing some usual activities?" the data is as follows:

	Feelings of Sadness	No Feelings of Sadness
7 th grade 2004	23%	77%
9 th grade 2004	29%	71%
11 th grade 2004	32%	68%
7 th grade 2006	24%	76%
9 th grade 2006	31%	69%
11 th grade 2006	32%	68%
7 th grade 2008	30%	70%
9 th grade 2008	35%	65%
11 th grade 2008	34%	66%

Clearly, the risk for depression/suicide increases with age, but also, the percentage of youth experiencing depression has increased over the five-year time span of the survey. This information helped to clarify the need for a suicide risk/depression reduction program for Tehama County youth, which ultimately led to the development of the YES component. This survey also looked at resiliency factors, including external and internal assets. External assets included caring relationships, high expectations, meaningful participation in activities (in school and at home), personal school connectedness, and pro-social peers. Internal assets included empathy, problem solving, and goals/aspirations. In the 5th grade survey, the scores were broken down into High, Moderate and Low levels of assets. For overall external assets, 65% were high, 35% were moderate, and 0% were low. 75% were in the moderate range for meaningful participation (67% at school, and 78% in the home), 20% were in the moderate range for having caring relationships at home. In the internal assets category, empathy was rated 37% in the high range, 57% in the moderate range, and 6% in the low range, problem solving was rated 33% in the high range, 59% in the moderate range, and 8% in the low range, Goals/Aspirations was rated 82% in the high range, 17% in the moderate range, and 0% in the low range. These scores could be interpreted in a variety of ways, but one conclusion could be that the high goals/aspirations scores indicate a high degree of hope in the youth, and therefore, with intervention to build the other weaker areas, overall resiliency could be increased. Looking at the resiliency components of this survey, as well as other research done as part of the planning process, led the Steering Committee to discuss the importance of resiliency in prevention and early intervention services, which then led to the inclusion of resiliency scales in each PEI Component.

Results from the surveys, key informant interviews and stakeholder meetings were analyzed to determine the age group and focus areas of greatest concern to the community. The results are summarized below:

PEI Priority Populations	Targeted Age Group- Top Priority per Survey
Disparities in Access to Mental Health Services	51%- Children and Youth
Psycho-Social Impact of Trauma	<u>70.7%- Children and Youth</u>
At-Risk Children, Youth & Young Adult Populations	68.1%- Children and Youth
Stigma and Discrimination	51.2% Transition Age Youth
Suicide Risk	<u>70.1%- Transition Age Youth</u>
Underserved Cultural Populations	40.7% Transition Age Youth

The MHSA Steering Committee evaluated these results, and then voted on the primary age group to focus the Prevention and Early Intervention project. Children age 6-11 were the primary target age group, with 12-18 as the secondary target age group. The Steering Committee also chose the priority population focus areas were the psycho-social impact of trauma and suicide risk. Once these target areas and age groups were identified, evidence-based programs with a focus on these areas of concern were researched and presented to the Steering Committee for review and discussion. If an evidence based program had not been found to be relevant or successful with other ethnic groups, primarily focusing on the Latino community, then it was not considered as an option.

Presentations were given by the following organizations: “Girls Inc./Boys Council,” “Nurturing Parent,” “Triple P,” “Suzy’s Law,” “First 5,” “FAST,” “Search Institute: Forty Developmental Assets.” Packets of research and information were provided to Steering Committee members for reference about other evidence-based programs being considered. Members suggested possible evidence-based programs, and a small subcommittee completed a thorough review of all programs suggested. Summaries of these reviews were then presented to the Steering Committee for review, discussion, and ranking of importance. Areas that were assessed/evaluated included costs (ongoing consumables, staffing, program costs, sustainability), evidence based rating, flexibility, portability, adaptability (including flexibility in delivery

site), evaluation rating, parent/family friendly involvement component, proven effectiveness across ethnicity groups, and whether program targets identified age group and target area of need. If a program was not proven to be effective with the Latino population, it was not considered to be appropriate. As a result of the ranking process, the top eight programs were: Girls Inc/Boys Council, Nurturing Parent Programs, Second Step, Real Life Heroes, Seeking Safety, TeenScreen, Trauma Focused Cognitive Behavioral Therapy, and Triple P.

This list of eight programs was then reduced to five possible evidence-based programs for implementation. Seeking Safety was eliminated for this project as there is limited evidence-based research about the effectiveness for the targeted age group. Second Step was eliminated due to the time requirement for school personnel to implement. Girls Inc/Boys Council was eliminated as it is not currently accepted as an evidence-based program with the SAMHSA registry and there was not sufficient research to show that it is effective across ethnic groups. Of the remaining five, there were two parenting programs, two early intervention programs that address the impact of trauma, and one program that provides screening for suicide risk and other mental health issues. The Steering Committee voted to develop a three-pronged approach to address the areas that were identified through the stakeholder process. This approach included a parenting component to focus on the prevention and treatment of child abuse/neglect, an early intervention treatment program to address the impact of trauma, and a standardized screening tool and stigma reduction program targeting adolescents at risk for suicide and other mental health issues.

Further evaluation of the possible programs was completed, and TeenScreen was chosen as the screening tool for suicide risk and other mental health issues. This was the only program that specifically targeted this population group, and the area of concern. It was a program that could be very flexible, and used in a variety of settings. It could be utilized as a self-screen via the computer, an educational screening tool in school or other settings, or part of a formal clinical screen. It could be easily utilized in a drop in center, youth group setting, etc. In addition, it was decided that expansion of the teen hotline and public education campaigns would be incorporated into this component. Please see the other project summaries for descriptions of the other components.

Therefore, through this process a consensus was reached to choose the programs that best meet the needs identified by the Steering Committee – trauma, suicide risk, and the age range of 6-18. In addition, the MHSA Steering Committee felt strongly that resiliency was an area that was important to focus on in any program developed. It was the consensus of the group that all three of these programs could help to build resiliency in our youth, which also increases positive outcomes for youth and their families.

Resiliency can be described as the ability to bounce back, and/or the ability to face, overcome and be strengthened or transformed by the adversities of life. Resiliency comes from children having people that they trust, structures and boundaries for their safety, good role models, encouragement to do things on their own, and access to health, education and social services. A child is more likely to be resilient if he/she has good self-esteem, is able to do kind things for others, has empathy for others, takes responsibility for what he/she does, has hope, faith and trust, can communicate, solve problems, manage their feelings and impulses, understand how other people are feeling, and develop and keep trusting relationships. Our goal was to develop programs that will build this resiliency.

3. PEI Project Description: The YES (Youth Empowerment Services) Program (utilizing the Columbia University TeenScreen Program instrument) identifies middle school- and high school-aged youth in need of mental health services due to risk for suicide and undetected mental illness. The program's main objective is to assist in the early identification of problems that might not otherwise come to the attention of professionals. TeenScreen can be implemented in schools, clinics, doctors' offices, juvenile justice settings, shelters, or any other youth-serving setting. Typically, all youth in the target age group(s) at a setting are invited to participate, with participation being totally voluntary.

In Tehama County, we propose to offer TeenScreen in all counseling offices in the community as well as drop in centers, youth groups, cultural groups, educational settings and the juvenile justice center (voluntary basis). All clinical providers will be offered training and the use of the instrument. Our goal is to have a standardized screening instrument for all youth entering any type of mental health treatment. In addition, we plan to offer screenings in alternative settings to reach out to youth who are not comfortable or willing to come to the traditional counseling office. Such settings would include faith-based organizations and community settings. In addition, we propose to include a stigma reduction public education campaign, as well as expansion of our current teen crisis outreach. This includes expanding our current hotline, availability of online educational resources, and peer presentations in a variety of settings. This would include the use of peer counselors, peer-based advertising of the hotline, and other resources.

Following is an estimated timeline for implementation of the program:

<i>Activity</i>	<i>Time from Initiation of the Program</i>
Assign/hire staff	2 months
Outreach to the community, including development of an adolescent planning group, including consumers from a variety of ethnic groups	2-3 months

Secure sites for services based on geographical isolation or other needs	2-3 months
RFP out to the community	RFP out to the community
Purchase materials	2-3 months
Develop public relations plan with the adolescent planning group	
Develop evaluation process, using consumers and family members, as well as representatives from ethnic groups	3-4 months
Train staff regarding the screening tool	2-3 months
Begin outreach and screening	3 months
Evaluation	ongoing

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	
TeenScreen	Individuals: Families:	Individuals: Families: 100	6
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: Families:	Individuals: Families: 100	6

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

Linkage to ongoing mental health treatment when needed will be an integral component of the YES Program. Therapists will be fully trained regarding resources in the community and the referral process. As it becomes apparent

that there are needs for referral, we will utilize our existing multi-agency referral process. TeenScreen providers will also utilize the existing multi-agency treatment team process to facilitate comprehensive treatment planning as needed. Possible referral sources include: Educational community, youth pastors, CHDP – primary care physicians, Greenville Rancheria clinics, Family Resource Center, special education, Head Start, substance abuse treatment, Friday Night Live, Boys Council/Girls Inc, Mental Health and community based mental health providers.

6. Collaboration and System Enhancements

Tehama County is committed to full collaboration and has existing venues for assuring that county agencies and community partners are able to effectively collaborate. Groups that currently exist that embrace this philosophy and help to assure that collaboration occurs include the Tehama County Health Partnership, Multi-Agency Treatment team (MATT), Advisory Boards (Mental Health, Public Health, Drug and Alcohol), NAMI, First 5, Head Start, Department Of Education SELPA, School Attendance Review Board, Interagency Coordinating Council, Child Abuse Council, Latino Outreach, Family Resource Centers through Northern Valley Catholic Social Services, Nomlaki Tribe Of Paskenta Indians, Healthy Native Communities Partnership, etc. Members of these various groups include county agencies, organizational providers, tribal organizations, consumer and family member groups, law enforcement and private hospital staff.

As part of the ongoing MHSA planning and implementation process, we have established goals regarding increasing/enhancing collaboration. These include: 1) successfully implementing full collaboration with the Native American Community, 2) increasing partnerships with adolescent consumers, including branching out to the other two local high schools, and middle schools, 3) implementing full collaboration with the faith based community, 4) increasing collaboration with the Latino community, and 6) increasing collaboration with consumers and family members.

The YES component will enhance existing systems, as the focus is to provide education, identify youth at risk, and connect them to available services earlier. In addition, YES will utilize alternative sites for the program to reduce stigma about seeking assistance. Utilizing TeenScreen will standardize treatment throughout the county for youth. Also, YES will enhance consumer involvement, specifically youth, with a strong participation in all levels of the education campaign. Our hope is that by turning the advertisement and education components over to the youth in our community, our existing teen hotline will be revitalized and stigma will be significantly reduced.

Inservice trainings will be offered to all interested teachers and other groups to assist in understanding the program, and who is appropriate to refer. In addition, presentations will be done in the community to a variety of

community service organizations to provide education, and to encourage the organizations to get involved.

7. Intended Outcomes

Individual Outcomes: Youth mental health needs will be assessed using the Columbia TeenScreen that includes items relating to depression, suicidal ideation and attempts, anxiety, substance use, and other health issues. Individual outcomes include increased access to mental health services for youth at risk, increased resiliency in the clients served. The effectiveness of this project will be measured by the number of youth screened, number of youth accessing ongoing services, and number of youth accessing the hotline. A pre- and post- resiliency scale will be given to those youth entering ongoing treatment.

System Outcomes: Improves access to isolated areas and provides services to the underserved populations. Improves collaboration with existing community partners and expands system to include new partners including faith-based and ministerial organizations. Increased involvement of youth in this project and other youth-based organizations such as Friday Night Live and Mentoring.

Program Outcomes: Increase youth involvement, increase access to evidence-based screening tools, enhance standardization of treatment modalities by adding sites and trained professionals able to implement the evidence-based intervention program, and expand services to geographically isolated areas.

Evaluation methods available: Evaluation will include surveys completed by youth, as well as resiliency scales for youth receiving ongoing treatment. These instruments will be utilized pre treatment, during treatment and post treatment. We will be adding a resiliency scale to this project, as well as the other components of our PEI program. Our plan is to continue to follow our youth after they have completed the program, including ongoing brief surveys on status to help us evaluate the long-term impact of this prevention strategy.

What will be different as a result of the PEI project: Increase public awareness and acceptance of adolescent mental health issues and services available in the community. Increase numbers of youth served, expand services to unserved areas and increase use of the teen hotline. Implement use of the standardized screening tool by community partners. Our ultimate goal is to reduce stigma, increase access to youth services, increase resiliency and overall functioning in our youth, and decrease the likelihood of ongoing mental health issues.

8. Coordination with Other MHSA Components

Currently in our MHSA CSS program, we provide outreach in the community to assist community members in accessing mental health services. This PEI project will be able to coordinate with our existing outreach staff. In addition, as part of our CSS Access Work Plan, we provide groups in schools; and as at risk youth are identified, referrals can be made for a TeenScreen. In addition, as we provide groups in schools, we can provide education about this project, and engage youth in participating in YES.

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

County Name: Tehama Date: 10/29/09
 PEI Project Name: YES (Youth Empowerment Services)
 Provider Name (if known): Unknown
 Intended Provider Category: Mental Health Provider
 Proposed Total Number of Individuals to be served: FY 09-10 100 FY 10-11 200
 Total Number of Individuals currently being served: FY 09-10 0 FY 10-11
 Total Number of Individuals to be served through PEI Expansion: FY 09-10 N/A FY 10-11
 Months of Operation: FY 09-10 6 months FY 10-11 12 months

Client Family	Proposed Expenses and Revenues	Total Program/PEI Project Budget		
		FY 09-10	FY 10-11	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
	Consumer Support Worker- .5 FTE	6,372	12,744	\$19,116
	Licensed Clinician - .20 FTE	6,192	12,384	18,576
	Health Educator- .15FTE	3,906	7,812	11,718
	TAY stipends	2,000	6,500	8,500
	LCS .1 FTE	3,960	7,920	11,880
	b. Benefits and Taxes @ 45 %	10,094	18,387	\$28,481
	c. Total Personnel Expenditures	\$32,524	\$65,747	\$98,271.00
2. Operating Expenditures				
	a. Facility Cost	\$0	\$0	\$0
	b. Other Operating Expenses	\$2,011	\$4,518	\$6,529
	c. Total Operating Expenses	\$2,011	\$4,518	\$6,529
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
	Organizational Providers- training for and implementation of TeenScreen with all age appropriate consumers, including administrative costs- RFP	\$7,500	\$2,000	\$9,500
	Non-profit providers offering teen drop in centers	\$2,000	\$8,000	\$10,000
	a. Total Subcontracts	\$9,500	\$10,000	\$19,500
	4. Total Proposed PEI Project Budget	\$44,035	\$80,265	\$124,300
B. Revenues (list/itemize by fund source)				
	EPSDT Medi-Cal	\$10,000	\$30,000	\$0
	MHSA CSS Funds	\$3,000	\$10,000	\$0
		\$0	\$0	\$0
	1. Total Revenue	\$13,000	\$40,000	\$53,000
	5. Total Funding Requested for PEI Project	\$57,035	\$120,265	\$177,300
	6. Total In-Kind Contributions	\$0	\$0	\$0

Budget Narrative
PEI Component
YES

Initial costs for FY 2009-2010 will utilize all of FY 2007-2008 PEI funds, and some of FY 2008-2009 funds. Ongoing costs in FY 2010-2011 will utilize FY 2008-2009 funds. The plan is to request FY 2009-2010 funds during the FY 2010-2011 MHSA Update to carry the PEI activities through FY 2011-2012.

Staffing and Line Item

Consumer Support Worker .5 FTE. This position will primarily oversee the development of the public education campaign and adolescent support programs. This position will be held by someone from the transition age youth group, if at all possible. The person in this position will engage the TAY community, building a group of adolescents and young adults willing to actively participate in this program by reducing stigma and increasing access to therapeutic interventions.

Marriage Family Therapist/Licensed Clinical Social Worker .20 FTE. This individual will provide screening with the use of the TeenScreen instrument in a variety of settings throughout the community and also provide ongoing treatment as needed.

Health Educator .15 FTE. This position will facilitate the development of the TeenScreen network of providers and alternative sites to provide the service. They will also assist with the public education campaign as needed.

Licensed Clinical Supervisor .10 FTE. This position will oversee the activities of this component and do outreach into the therapeutic community to help with the establishment of the therapeutic network, development of contracts, etc.

Stipends for transition age youth. Utilizing our current stipend process, these monies will be used to stipend transition age youth that participate in the public education campaign and a variety of peer support activities.

Non Recurring Costs

Office Needs. Basic office supplies will be provided so that the staff can complete assigned tasks.

Training. Staff assigned to this component will receive training during FY 2009-2010 regarding this program, outreach methods, needs assessment methods, and evaluation methods.

Ongoing program resources. This program requires minimal ongoing purchase of consumable program materials for the TeenScreen program, as well as the costs of the public education campaign.

Approach used to estimate and source documents

Salaries and benefits are based on current actual salaries and benefits. Training and resource materials are based on information from the Youth Empowerment Services.

Revenues

Estimated Medi-Cal FFP revenues are based on an approximation of consumers that are eligible for Medi-Cal who will engage in and receive treatment.

County: Tehama County

PEI Project Name: TF-CBT

Date: 10/29/09

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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Disparities in Access to Mental Health Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Psycho-Social Impact of Trauma	<input type="checkbox"/>	<input type="checkbox"/>		
3. At-Risk Children, Youth and Young Adult Populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Stigma and Discrimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Suicide Risk				

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

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

The Mental Health division of the Tehama County Health Services Agency requested that the Interagency Coordinating Council develop a subcommittee that would have the responsibility for the development of the MHSA Prevention and Early Intervention component. The Steering Committee reports to the Interagency Coordinating Council and also provides updates to and obtains input from the Mental Health Advisory Board. The MHSA Steering Committee is comprised of consumers (including an adolescent), family members, and representatives from public and private agencies. The public and private agencies include: First 5 of Tehama County, Head Start, Department Of Education, Law Enforcement, National Alliance for the Mentally ill, Public Health, Drug and Alcohol, Mental Health, Probation, Family

Resource Centers, Northern Valley Catholic Social Services, Family Service Agency, and New Directions to Hope.

The MHSA Steering Committee utilized several methods to obtain stakeholder input. Online surveys were provided throughout the community, as well as stakeholder community meetings and key informant interviews. Stakeholder community meetings were held in three locations in an attempt to provide the opportunity for input from all geographic areas. Meetings were held with monolingual Spanish speaking mothers from the Latino community at the Family Resource Center in Corning, Vista Way Drop-In Center in Red Bluff, and Evergreen School in Cottonwood. Participants included consumers, family members, mental health staff, advisory board members, parents, community organization staff, NAMI, drug and alcohol services, etc. Participants were encouraged to provide verbal input, and complete a written survey.

The online survey was provided through “Survey Monkey.” Participants included community members, consumers, family members, service providers, Steering Committee members which include but are not limited to: Department of Education, Department of Social Services, Probation, Mental Health, Public Health, Law Enforcement, Drug & Alcohol and community based organizations. The survey was followed by one-on-one key informant interviews consisting of a school psychologist, speech and occupational therapist, school administrators, school nurses and teachers. Meetings were held with mental health consumers, parents and community agencies.

The MHSA Steering Committee also reviewed the Healthy Kids Survey for youth at Tehama County Schools in the 5th, 7th, 9th and 11th grade. Feeling safe at or outside of school, depression and suicide were three of the areas addressed in the survey that related to our priority populations. The survey was done in 2004, 2006 and 2008. Data regarding feeling safe at or outside of school for 5th graders in 2008 indicated that 11% never feel safe away from home, and 18% only feel safe some of the time. When asked, “During the past 12 months, did you ever feel so sad and hopeless almost every day for two weeks or more that you stopped doing some usual activities?” the data is as follows:

	Feelings of Sadness	No Feelings of Sadness
7 th grade 2004	23%	77%
9 th grade 2004	29%	71%
11 th grade 2004	32%	68%
7 th grade 2006	24%	76%

9 th grade 2006	31%	69%
11 th grade 2006	32%	68%
7 th grade 2008	30%	70%
9 th grade 2008	35%	65%
11 th grade 2008	34%	66%

Clearly, the risk for depression/suicide increases with age, but also, the percentage of youth experiencing depression has increased over the five-year time span of the survey. This information helped to clarify the need for a suicide risk/depression reduction program for Tehama County youth, which ultimately led to the development of the YES component. This survey also looked at resiliency factors, including external and internal assets. External assets included caring relationships, high expectations, meaningful participation in activities (in school, and home), personal school connectedness, and pro-social peers. Internal assets included empathy, problem solving, and goals/aspirations. In the 5th grade survey, the scores were broken down into High, Moderate and Low levels of assets. For overall external assets, 65% were high, 35% were moderate, and 0% were low. 75% were in the moderate range for meaningful participation (67% at school, and 78% in the home), 20% were in the moderate range for having caring relationships at home. In the internal assets category, empathy was rated 37% in the high range, 57% in the moderate range, and 6% in the low range, problem solving was rated 33% in the high range, 59% in the moderate range, and 8% in the low range, Goals/Aspirations was rated 82% in the high range, 17% in the moderate range, and 0% in the low range. These scores could be interpreted in a variety of ways, but one conclusion could be that the high goals/aspirations scores indicate a high degree of hope in the youth, and therefore, with intervention to build the other weaker areas, overall resiliency could be increased. Looking at the resiliency components of this survey, as well as other research done as part of the planning process, led the Steering Committee to discuss the importance of resiliency in prevention and early intervention services, which then led to the inclusion of resiliency scales in each PEI Component.

Results from the surveys, key informant interviews and stakeholder meetings were analyzed to determine the age group and focus areas of greatest concern to the community. The results are summarized below:

PEI Priority Populations	Targeted Age Group- Top Priority per Survey
Disparities in Access to Mental Health Services	51%- Children and Youth
Psycho-Social Impact of Trauma	<u>70.7%- Children and Youth</u>
At-Risk Children, Youth and Young Adult Populations	68.1%- Children and Youth
Stigma and Discrimination	51.2% Transition Age Youth
Suicide Risk	<u>70.1%- Transition Age Youth</u>
Underserved Cultural Populations	40.7% Transition Age Youth

The MHSA Steering Committee evaluated these results, and then voted on the primary age group on which to focus the Prevention and Early Intervention project. Children age 6-11 were the primary target age group, with 12-18 as the secondary target age group. The Steering Committee also chose the priority population focus areas of the psycho-social impact of trauma and suicide risk. Once these target areas and age groups were identified, evidence-based programs with a focus on these areas of concern were researched and presented to the Steering Committee for review and discussion. If an evidence based program had not been found to be relevant or successful with other ethnic groups, primarily focusing on the Latino community, then it was not considered as an option.

Presentations were given by the following organizations: “Girls Inc./Boys Council,” “Nurturing Parent,” “Triple P,” “Suzy’s Law,” “First 5,” “FAST,” “Search Institute: Forty Developmental Assets.” Packets of research and information were provided to Steering Committee members for reference about other evidence-based programs being considered. Members suggested possible evidence-based programs, and a small subcommittee completed a thorough review of all programs suggested. Areas that were assessed/evaluated included costs (ongoing consumables, staffing, program costs, sustainability), evidence based rating, flexibility, portability, adaptability (including flexibility in delivery site), evaluation rating, parent/family friendly involvement component, proven effectiveness across ethnicity groups, and whether program targets identified age group and target area of need. If a program was not proven to be effective with the Latino population, it was not considered to be appropriate. Summaries of these reviews were then presented to the Steering Committee for review, discussion, and ranking of importance. As a result of the ranking process, the top eight programs were: Girls Inc/Boys Council, Nurturing Parent Programs, Second Step, Real Life

Heroes, Seeking Safety, TeenScreen, Trauma Focused Cognitive Behavioral Therapy, and Triple P.

This list of eight programs was then reduced to five possible evidence-based programs for implementation. Seeking Safety was eliminated for this project as there is limited evidence-based research about the effectiveness for the targeted age group. Second Step was eliminated due to the time requirement for school personnel to implement. Girls Inc/Boys Council was eliminated as it is not currently accepted as an evidence-based program with the SAMHSA registry and there was not sufficient research to show that it is effective across ethnic groups. Of the remaining five, there were two parenting programs, two early intervention programs that address the impact of trauma, and one program that provides screening for suicide risk and other mental health issues. The Steering Committee voted to develop a three-pronged approach to address the areas that were identified through the stakeholder process. This approach included a parenting component to focus on the prevention and treatment of child abuse/neglect, an early intervention treatment program to address the impact of trauma, and a standardized screening tool and stigma reduction program targeting adolescents at risk for suicide and other mental health issues.

Further evaluation of the possible programs was completed and it was determined that Trauma Focused Cognitive Behavioral Therapy was the most appropriate for the Early Intervention component as there are therapists within the community who are trained, it specifically focuses on trauma, has been found to be effective with the Latino, African American and White population groups, and there is an outcome measurement process. In addition, this program is being implemented in Corning High School through a grant called Project Hope. It was hoped that by utilizing the same component, this would increase consistency and stability of therapeutic components throughout the county. Students often move between school districts, and this would help to facilitate continuity of care. Please see the other project summaries for descriptions of the other components.

Therefore, through this process, a consensus was reached to choose the programs that best meet the needs identified by the Steering Committee – trauma (Nurturing Parent Programs as prevention and TF-CBT as early intervention), suicide risk (TeenScreen), and the targeted age range of 6-18. In addition, the MHSAs Steering Committee felt strongly that resiliency was an area that was important to focus on in any program developed. It was the consensus of the group that all three of these programs could help to build resiliency in our youth, which also increases positive outcomes for youth and their families. Resiliency can be described as the ability to bounce back, and/or the ability to face, overcome and be strengthened or transformed by the adversities of life. Resiliency comes from children having people that they trust, structures and boundaries for their safety, good role models,

encouragement to do things on their own, and access to health, education and social services. A child is more likely to be resilient if he/she has good self-esteem, is able to do kind things for others, has empathy for others, takes responsibility for what he/she does, has hope, faith and trust, can communicate, solve problems, manage their feelings and impulses, understand how other people are feeling, and develop and keep trusting relationships. Our goal was to develop programs that will build this resiliency.

3. PEI Project Description:

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. The model has been adapted for use with children who have a wide array of traumatic experiences, including domestic violence, traumatic loss, and the often multiple psychological traumas experienced by children prior to foster care placement. The treatment model is designed to be delivered by trained therapists who initially provide parallel individual sessions with children and their parents (or guardians), with conjoint parent-child sessions increasingly incorporated over the course of treatment. The acronym PRACTICE reflects the components of the treatment model: Psychoeducation and parenting skills, Relaxation skills, Affect expression and regulation skills, Cognitive coping skills and processing, Trauma narrative, In vivo exposure (when needed), Conjoint parent-child sessions, and Enhancing safety and future development. This early intervention model includes a component on identifying and screening children for trauma exposure and PTSD symptoms, and the focus is on helping children, youth, and parents overcome the negative effects of traumatic life events. It has been found to significantly reduce behaviors related to risk factors and reduces PTSD symptoms, depression and anxiety.

As part of Tehama County's PEI project, TF-CBT will be utilized throughout the county, by trained therapists, in a variety of settings. A current organizational provider has trained therapists in this model and they are going to be providing the service in their offices. In addition, a grant was recently awarded to the Department of Education that includes this treatment modality, specifically at one high school. Our plan is to expand these services to other isolated geographical areas and other settings appropriate to meet the need of our community. These other settings could include the juvenile justice detention facility for those youth and families interested in voluntarily participating in this program. It would not be considered a mandatory program and would target those youth that are just entering the system as a possible intervention that could disrupt the cycle of ongoing legal difficulties and behavioral issues. Many youth in the juvenile detention center have experienced trauma and this trauma is directly impacting their behavior. Therefore, it is hoped that this program could also have a positive impact in

the reduction of juvenile justice involvement, although this is not a primary focus.

Following is an estimated timeline for implementation of the program:

Activity	Time from Initiation of the Program
Assign/hire staff	2 months
RFP out to the community	
Outreach to the community, including development of identified sites for implementation, utilizing consumer and family member input from a variety of ethnic groups	2-3 months
Secure sites for services based on geographical isolation or other needs	2-3 months
Purchase materials	2-3 months
Develop evaluation process, using consumers and family members, as well as representatives from ethnic groups	3-4 months
Train staff regarding the screening tool	2-3 months
Begin outreach and screening	3 months
Evaluation	ongoing

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	
TF-CBT	Individuals: Families:	Individuals: Families: 20-25	6
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: Families:	Individuals: Families: 20-25	6

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

Linkage to Mental Health and other providers in the community for further treatment when needed will be an integral component of the TF-CBT program. Therapists will be fully trained regarding resources in the community and the referral process. As it becomes apparent that there are needs for referral, we will utilize our existing multi-agency referral process. TF-CBT providers will also utilize the existing multi-agency treatment team process to facilitate comprehensive treatment planning as needed. Possible referral sources include: CHDP – primary care physicians, Greenville Rancheria clinics, dental referrals, Family Resource Center, special education, Head Start, First 5, substance abuse treatment, Friday Night Live, Boys Council/Girls Inc, Mental Health and community based mental health providers.

6. Collaboration and System Enhancements

Tehama County is committed to full collaboration, and has existing venues for assuring that county agencies and community partners are able to effectively collaborate. Groups that currently exist that embrace this philosophy and help to assure that collaboration occurs include the Tehama County Health Partnership, Multi-Agency Treatment team (MATT), Advisory Boards (Mental Health, Public Health, Drug and Alcohol), NAMI, First 5, Head Start, Department Of Education SELPA, School Attendance Review Board, Interagency Coordinating Council, Child Abuse Council, Latino Outreach, Family Resource Centers through Northern Valley Catholic Social Services, Nomlaki Tribe Of Paskenta Indians and Healthy Native Communities Partnership. Members of these various groups include county agencies, organizational providers, tribal organizations, consumer and family member groups, law enforcement and private hospital staff.

As part of the ongoing MHSA planning and implementation process, we have established goals regarding increasing/enhancing collaboration. These include: 1) successfully implementing full collaboration with the Native American Community, 2) increasing partnerships with adolescent consumers, including branching out to the other two local high schools, and middle schools, 3) implementing full collaboration with the faith based community, 4) increasing collaboration with the Latino community, and 6) increasing collaboration with consumers and family members.

The TF-CBT component will enhance existing systems, as the focus is to expand services to isolated geographic areas and utilize alternative sites for the program to reduce stigma about seeking assistance. Utilizing this modality will also standardize treatment throughout the county for youth exposed to trauma.

Inservice trainings will be offered to all interested teachers and other groups to assist in understanding the program, and who is appropriate to refer. In addition, presentations will be done in the community to a variety of community service organizations to provide education, and to encourage the organizations to get involved.

7. Intended Outcomes

Individual Outcomes: Decrease of PTSD symptoms (re-experiencing the trauma, avoidance of trauma reminders and hyperarousal symptoms) for trauma-exposed youth as well as decreasing depressive symptoms and feelings of shame.

In addition, outcomes include an increase in pro-social behaviors (attendance at school, decrease in juvenile justice involvement) and resiliency for the youth.

System Outcomes: Improve access to isolated areas and provide services to the underserved populations. Improve collaboration with existing community partners and expand the current system to include new partners and new sites for intervention. Decrease the number of children requiring intensive intervention on a long-term basis.

Program Outcomes: Increase access to evidence-based early intervention programs, enhance standardization of treatment modalities by adding sites and trained professionals able to implement the evidence-based intervention program, and expand services to geographically isolated areas.

Evaluation methods available: TF-CBT utilizes several instruments to measure symptom reduction and behavior improvement. These tools are:

- 1.) Child Behavior Checklist--Parent Version, which is a descriptive rating measure used to assess both adaptive competencies and behavior problems. It includes areas of child activities and functioning related to family, social, and school behaviors.
- 2.) Weekly Behavior Report, which documents the frequency of 21 PTSD-like behaviors in sexually abused preschool children, such as re-experiencing symptoms (e.g., nightmares, sexualized behaviors), avoidance of trauma reminders, and hyperarousal symptoms (e.g., new fears, aggression).
- 3.) PTSD section of the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS-PL) will be used to measure symptoms of PTSD. The K-SADS-PL is a structured

diagnostic interview administered by therapists to the child and parent separately, with a consensus response obtained for each item as a summary score. The interview includes a selection of screening questions used to identify traumatic events that the child has experienced. Items assess behaviors related to re-experiencing symptoms, hyperarousal, and avoidance of the trauma.

- 4.) Child depression will be measured using the Child Depression Inventory, a 27-item self-report scale of depressive symptoms for children 7 to 17 years old. Children are asked to respond based on how they have been feeling over the past 2 weeks.
- 5.) Feelings of shame will be measured using the Shame Questionnaire, a self-report instrument for children ages 7 years and older used to measure feelings of shame related to sexual abuse.

These instruments will be utilized pre treatment, during treatment and post treatment. In addition, we will be adding a resiliency scale to this project, as well as the other components of our PEI program. Our plan is to continue to follow our families after they have completed the program, including ongoing brief surveys on status to help us evaluate the long-term impact of this prevention strategy.

What will be different as a result of the PEI project: Increased numbers of trauma exposed youth and their families receiving treatment, expansion of geographical areas with services available and increased collaboration. Our ultimate goal is to break the generational cycle of abuse, increase resiliency and overall functioning in our youth, and decrease the likelihood of ongoing mental health issues and juvenile justice issues.

8. Coordination with Other MHSA Components

Currently in our MHSA CSS program, we provide Seeking Safety intervention to members of the community in crisis that enter our crisis unit, as well as providing this intervention on an outpatient basis. As youth are identified through this program as having experienced trauma, referring to TF-CBT will be an effective and useful additional resource. In addition, as part of our CSS Access Work Plan, we provide groups in schools; and as trauma issues are identified, referrals can be made to the TF-CBT program. When the TF-CBT therapists are working with families and they identify issues that could be addressed through our existing CSS plan, referrals can be made.

**Form
No. 4**

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

County Name: Tehama Date: 10/29/09
 PEI Project Name: TF-CBT
 Provider Name (if known):
 Intended Provider Category: Mental Health Provider
 Proposed Total Number of Individuals to be served: FY 09-10 20-25 FY 10-11 100
 Total Number of Individuals currently being served: FY 09-10 0 FY 10-11 0
 Total Number of Individuals to be served through PEI Expansion: FY 09-10 0 FY 10-11 0
 Months of Operation: FY 09-10 6 FY 10-11 12

		Total Program/PEI Project Budget		
Proposed Expenses and Revenues		FY 09-11	FY 10-11	Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
	Clinician .4 FTE	8,256	24,768	\$33,024
				\$0
				\$0
b. Benefits and Taxes @ 45 %		3,715	11,146	\$14,861
c. Total Personnel Expenditures		\$11,971	\$35,914	\$47,885
2. Operating Expenditures				
a. Facility Cost				
		\$0	\$0	\$0
b. Other Operating Expenses				
		\$750	\$1,750	\$2,500
c. Total Operating Expenses		\$750	\$1,750	\$2,500
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
	Organizational Provider to provide treatment- RFP	\$4,000	\$11,000	\$14,000
	training	\$4,000	\$1,000	\$5,000
a. Total Subcontracts		\$8,000	\$12,000	\$19,000
4. Total Proposed PEI Project Budget		\$20,721	\$49,664	\$70,385
B. Revenues (list/itemize by fund source)				
	Medi-Cal- EPSDT	\$5,000	\$25,000	\$30,000
	Healthy Families	\$0	\$0	\$0
1. Total Revenue		\$0	\$0	\$0
5. Total Funding Requested for PEI Project		\$25,721	\$74,664	\$100,385
6. Total In-Kind Contributions		\$0	\$0	\$0

Budget Narrative
PEI Component # 3
Trauma Focused Cognitive Behavioral Therapy

Initial costs for FY 2009-2010 will utilize all of FY 2007-2008 PEI funds, and some of FY 2008-2009 funds. Ongoing costs in FY 2010-2011 will utilize FY 2008-2009 funds. The plan is to request FY 2009-2010 funds during the FY 2010-2011 MHSA Update to carry the PEI activities through FY 2011-2012.

Staffing and Line Item

Marriage Family Therapist/Licensed Clinical Social Worker .4 FTE. This position will receive training in TF-CBT, and provide ongoing treatment to identified youth and their families.

Non Recurring Costs

Office Needs. Basic office supplies will be provided so that the staff can complete assigned tasks.

Training. Staff assigned to this component will receive training during FY 2009-2010 regarding this program, outreach methods, needs assessment methods, and evaluation methods.

Program Materials. Initial purchase of program materials that can be repeatedly utilized.

Approach used to estimate and source documents

Salaries and benefits are based on current actual salaries and benefits. Training and resource materials are based on information from the Trauma Focused Cognitive Behavioral Therapy program.

Revenues

Estimated Medi-Cal FFP revenues are based on an approximation of consumers that are eligible for Medi-Cal who will engage in and receive treatment.

PEI Administrative Budget Worksheet

**Form
No.5**

County: Tehama

Date: 10/29/09

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2009-10	Budgeted Expenditure FY 2010-11	Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator		.25	9,906	19,812	\$29,718
* b. PEI Support Staff	.05	.15	7,400	14,800	\$22,200
c. Other Personnel (list all classifications)				0	\$0
MH Director		.05	2,274	4,548	\$6,822
Community Health Education Supervisor		.05	1,440	2,880	4,320
Health Educator		.05	1,302	2,604	\$3,906
				0	\$0
d. Employee Benefits			10,045	20,090	\$30,135
e. Total Personnel Expenditures			\$32,367	\$64,734	\$97,101
2. Operating Expenditures					
a. Facility Costs			\$0	\$0	\$0
b. Other Operating Expenditures			\$0	\$0	\$0
c. Total Operating Expenditures			\$0	\$0	\$0
3. County Allocated Administration					
a. Total County Administration Cost			\$3,100	\$16,000	\$19,100
4. Total PEI Funding Request for County Administration Budget			\$35,467	\$80,734	\$116,201
B. Revenue					
1. Total Revenue			\$0	\$0	\$0
C. Total Funding Requirements			\$0	\$0	\$0
D. Total In-Kind Contributions			\$0	\$0	\$0

**Budget Narrative
Administrative Budget
PEI**

Initial costs for FY 2009-2010 will utilize all of FY 2007-2008 PEI funds, and some of FY 2008-2009 funds. Ongoing costs in FY 2010-2011 will utilize FY 2008-2009 funds. The plan is to request FY 2009-2010 funds during the FY 2010-2011 MHSA Update to carry the PEI activities through FY 2011-2012.

Staffing and Line Item

Mental Health Services Act Coordinator/Licensed Clinical Supervisor .25 FTE.

This position includes oversight of all PEI components and ongoing MHSA Steering Committee activities, such as program evaluation.

Support Staff: This includes the cost of the administrative secretary and office assistants in providing support to all of the components of the plan.

Mental Health Director: .05 FTE. This position includes oversight of all components, contract development, MHSA Steering Committee activities, including program evaluation.

Community Health Education Supervisor .05 FTE. This position includes oversight of all education components, as well as program evaluation.

Health Educator, bilingual .05 FTE. This position includes outreach to the Latino community to assure participation in all components of the PEI plan, MHSA Steering Committee activities, and involvement in program evaluation.

A-87 costs. Standard requirement.

Non Recurring Costs

None.

Approach used to estimate and source documents

Salaries and benefits are based on current actual salaries and benefits.

Revenues

None.

PREVENTION AND EARLY INTERVENTION BUDGET SUMMARY

**Form
No. 6**

County:	Tehama
Date:	09/30/09

#	List each PEI Project	Fiscal Year			Funds Requested by Age Group			
		FY 09/10	FY 10/11	Total	*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
1	Nurturing Parent Programs	\$66,178	\$120,436	\$186,614	158,622	\$27,992	\$	\$
2	YES	\$44,035	\$80,265	\$124,300	\$24,860	\$99,440		
3	TF-CBT	\$20,721	\$49,664	\$70,385	\$63,347	\$7,038		
				\$0				
				\$0				
				\$0				
				\$0				
				\$0				
				\$0				
	Administration	\$35,467	\$80,734	\$116,201	\$84,827	31,374		
	Total PEI Funds Requested:	\$166,401	\$331,099	\$497,500	\$331,656	\$165,844	\$0	\$0

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