

Mental Health Services Act Prevention and Early Intervention Component Plan



**Ventura County Behavioral Health Department
Mental Health Services
October 22, 2009**

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

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MENTAL HEALTH SERVICES ACT (MHSA)
PREVENTION AND EARLY INTERVENTION COMPONENT
OF THE THREE-YEAR
PROGRAM AND EXPENDITURE PLAN
Fiscal Years 2007-08 and 2008-09

County Name: Ventura

Date: August 4, 2009

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

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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 Meloney Roy
County Mental Health Director

8.4.09
Date

Executed at Ventura, California

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EXECUTIVE SUMMARY

Introduction

Prevention and Early Intervention (PEI) is one of five program components for funding under the Mental Health Services Act (MHSA). Through the MHSA initiative, Counties are now responsible to ensure the participation of the community in the assessment, planning and implementation of programs which will serve the mental health needs of their community.

Ventura County Behavioral Health in collaboration with the PEI Planning Committee has worked over the past year to ensure that the voice of our community has been heard. The commitment of the Planning Committee has been to elicit and share information and resources to discover our community shared vision for Prevention and Early Intervention programs.

MHSA - Background

The Mental Health Services Act was passed by California voters as Proposition 63, effective January 2005. The Act imposes a 1% tax on annual adjusted income over \$1,000,000. MHSA was designed to create a comprehensive approach to the development of community-based mental health services and supports to reduce the adverse impact from untreated serious mental illness in adults and severe emotional disturbance in children and youth. Programs are to be designed in direct relationship with the cultural, ethnic and community needs as identified through an intensive and extensive community assessment process and should focus access toward those individuals and communities that have traditionally been un- or significantly underserved by the mental health system.

MHSA has also provided the opportunity to develop programs and supports which promote concepts of wellness and recovery for adults and older adults and resilience for children/youth and their families. This opportunity has shifted the manner and attitude toward mental illness to one of hope and recovery. In this light, the Prevention and Early Intervention component of MHSA provides the opportunity to create and expand supports to the community *prior* to a mental health diagnosis.

Prevention and Early Intervention

Prevention and Early Intervention is designed to bring mental health awareness into the lives of the community through educational initiatives and community dialogue. PEI builds the capacity for providing mental health early intervention services by facilitating access at the earliest possible signs of mental health problems. These opportunities are made possible by implementing services at sites throughout the community where people go for other activities, such as schools, health clinics and community organizations. By providing this level of access and education, “mental health becomes part of wellness for individuals and the community, reducing the potential for stigma and discrimination....” (*Calif. Dept. of Mental Health*)

The **Prevention** element of PEI includes programs and services which are designed to help prevent the development of serious emotional or behavioral disorders and mental illness. **Universal Prevention** is used to target an entire community of individuals who do not

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necessarily have a higher risk of mental health need. **Selective Prevention** includes strategies and interventions targeted to individuals or selected groups who have a set of risk factors for the potential to develop a mental illness.

Early Intervention is directed toward individuals and families for whom a short-duration (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services; or to prevent a mental health problem from getting worse.

State Department of Mental Health (DMH) developed a framework for the planning and implementation of PEI programs. Included in this framework is the requirement that 51% of PEI funding be allocated to programs targeting children and transitional age youth. Additionally, five Key Community Mental Health Needs and six Priority Populations were identified for inclusion in projects:

Community Mental Health Needs	Priority Populations
Disparities in Access to Mental Health	Underserved Cultural Populations
Psycho-Social Impact of Trauma	Individuals Experiencing Onset of Serious Psychiatric Illness
At Risk Children, Youth and Young Adults	Children/Youth in Stressed Families
Stigma and Discrimination	Trauma Exposed
Suicide Risk	Children/Youth at Risk of School Failure
	Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

Utilizing this framework for our county PEI Planning, the strategies adopted by the Committee were based on an approach to assessment which included these Community Mental Health Needs and Priority Populations in the outreach activities and discussions held. The Planning Committee determined that utilizing this framework, identifying geographic areas within the county for assessment, and utilizing the data collected to drive the decision and recommendation process this Plan would ensure inclusiveness, balance and a commitment to expanding access to mental health preventative and early intervention supports, as well as provide a bridge to higher level services for those in need. Table 1 provides a summary of our proposed PEI Projects and corresponding interventions.

Development and Role of Planning Committee:

The development of the Planning Committee was achieved through outreach efforts aimed at creating a balanced body of individuals reflecting representation across the required as well as recommended planning sectors as identified in the guidelines by DMH. With the selection of each member was the commitment to actively engage and represent their broader constituency. The members were responsible for ensuring that the outreach within their representative area was comprehensive and that opportunity for participation by the community was facilitated at each level of planning.

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Additionally, the Planning Committee was responsible for reviewing community feedback, participating in focus groups, community forums and community gatherings and utilizing the data and survey findings and reports to assist in making sound and informed decisions regarding selection of priority populations, needs, targeted outcomes and project design. The Department retained the expertise of EvalCorp for data gathering and community facilitation and CiMH for its expertise on Evidence Based Practices and other models which could be recommended to address the community needs priorities. These contractors worked closely with the Committee in planning, data gathering and providing the review and interpretation of the information received during the outreach efforts.

Overview of Planning Process

The planning process was extensive, reached deep into the community, and involved regionally specific events and outreach to ensure the representation and participation of underserved cultural groups. The priorities expressed by community members throughout the regions and across the ethnic/cultural groups were largely similar. These priorities were related to the adverse effects of poverty on children and families and the barriers associated with stigma about mental health (across the life span). Moreover, there was community agreement that the negative effects of poverty and stigma are exacerbated by racial prejudice and culturally specific beliefs about mental illness and treatment.

As a result, consensus developed around prioritizing the needs of children at-risk of school failure and individuals who have experienced trauma or the early signs of a serious mental illness. There was a clear understanding that strategies to reduce stigma and engage underserved and isolated populations (i.e. migrant workers, Mixteco, Asian Pacific Islanders) were needed.

As the planning process unfolded, the Planning Committee decided that its strategy would be to adopt a regional approach that would: build on existing Ventura County Initiatives; correspond to established regional projects such as Ventura County's First Five Neighborhoods for Learning (NfLs); be more responsive to the unique needs of the high-risk, communities; and finally, allow funding to be targeted towards the most needy communities at a level that would allow for meaningful change. The Committee was clear in its intent that with a declining PEI planning estimate, its desire was to strategically support the most needy communities as opposed to providing a minimal level of funding to every community count-wide.

Based on directive of the Planning Committee, the quantitative data concerning community needs was used to identify those communities in which PEI programs would first be implemented.

Identification of Priority Populations and Proposed PEI Projects

The planning process utilized the State defined priority populations and community mental health need guidelines as the basis for information gathering and decision making.

The community priorities and desired outcomes became clearly defined through the focus groups and key informant interviews. For example, in the Community Wide Focus Group findings, the five most frequently mentioned needs/impacts were:

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1. negative social, emotional and behavioral outcomes that result from unmet needs,
2. increase in the number of struggling and dysfunctional families,
3. rise in the number of children and families who experience isolation, depression and are at-risk of suicide,
4. lack of services and impediments to service access, and
5. evidence of an increase in exacerbated mental health issues, due to needs not being addressed in a timely manner.

The Community Focus Group findings drove the selection of Priorities (listed below) and the following target outcomes:

1. improved family functioning and school performance;
2. reduction in problem and criminal behavior in children/youth,
3. improved early recognition of trauma, depression and psychosis,
4. improved system responsiveness to early help seeking behavior, and
5. reduction in impairment from trauma, depression and psychosis.

Priority #1

Stressed families who were living in or near poverty and/or isolated by circumstances or cultural issues: A primary outcome of the community needs assessment was community concern about children exhibiting behavior problems at increasingly younger ages, increasing school failure and criminal behavior. These issues were attributed to limited parenting and social support for families and lacking pro-social skills in children/youth. The selected Projects (Parenting and School Based services) are directly responsive to these community priorities. Triple P is a multilevel parenting program that can be provided in the home or in other community settings such as churches or resource centers. School-based services include the Strengthening Families Program, which is designed to increase parenting and child skills, increase family cohesiveness and develop social support networks. Schools were selected because of their universal accessibility to children and families and the potential for stigma reduction when services are provided in such a community, non-clinical, setting.

Priority #2

Included individuals across the life span who have experienced trauma: The needs assessment indicated that community members expressed concern about the high level of trauma experienced by children and adults, particularly those living in or near poverty. It was also noted that this trauma is often unrecognized or untreated, in part due to stigma and cultural barriers. This was identified as a particular problem among minority youth, who often end up in the penal system rather than supported with mental health services. The selected programs, Primary Care Services and School Based services, are designed to address trauma by making relevant intervention models available in non-stigmatizing settings.

Priority #3

Individuals experiencing early signs of mental illness such as depression or psychosis: These individuals often do not seek services due to stigma, cultural barriers and lack of awareness, and in turn may be at elevated suicide risk. The selected programs,

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Primary Care Services and Early Signs of Psychosis Intervention, are specifically tailored to include a universal and selective prevention component designed to overcome stigma and cultural barriers and subsequently to provide identification, assessment and treatment.

It is important to note that the Ventura PEI plan organizes programs by setting (school, primary care) and by focus population (parents, individuals experiencing early psychosis, older adults). The Community Coalitions will integrate the various interventions, so that within each region, services are implemented in a manner that is responsive to the socioeconomic, cultural and linguistic factors that make each region unique. Therefore, the Community Coalitions will ensure that the needs of targeted communities are addressed in a comprehensive and coordinated manner. This is based on the understanding that the adverse effects of poverty, stigma and prejudice are intertwined with trauma, response to the early signs of mental illness, and the impact on the behavior of children in stressed families.

The Community Coalitions project has been intentionally designed to be fluid. It involves tailored education and outreach specific to unique demographics of the selected high-risk communities and is intended to overcome stigma and cultural barriers. The Community Coalitions will be involved in education and outreach around parenting, social isolation, mental health stigma, and help seeking. The content will vary to suit the cultural and demographic characteristics of families and individuals in each target community. The coalitions will also be responsible for implementing the universal prevention components of several interventions in a manner that is tailored to the characteristics of each region.

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TABLE 1: RECOMMENDED PEI PROJECTS AND INTERVENTION MODELS

PEI Projects	Intervention Models	Target Population
<p>Community coalitions</p> <ul style="list-style-type: none"> - Funds allocated to time-limited projects that advance county strategic plans - Tailored to community needs - Increase engagement, education, awareness - Reduce stigma - Increase collaboration and coordination 	<p>Examples of coalition activities:</p> <ul style="list-style-type: none"> - Promotores programs - Faith-based clergy council activities - Anti-stigma education campaigns specific to other PEI initiatives 	<p>All Ages:</p> <ul style="list-style-type: none"> - Children (0 – 17 y.o.) - Transitional Age Youth (18-24 y.o.) - Adults (25 – 59 y.o.) - Older Adults (60+ y.o.)
<p>Primary care services</p> <ul style="list-style-type: none"> - Services available at primary care clinics - Intervention that address depression, trauma, and child behavior problems 	<ul style="list-style-type: none"> - Depression Treatment Quality Improvement (DTQI) - Trauma Focused Cognitive Behavior Therapy - Prolonged Exposure Therapy for PTSD - Improving Mood Promoting Access to Collaborative Treatment (IMPACT) 	<p>All Ages:</p> <ul style="list-style-type: none"> - Children (0 – 17 y.o.) - Transitional Age Youth (18-24 y.o.) - Adults (25 – 59 y.o.) - Older Adults (60+ y.o.)
<p>School-based services</p> <ul style="list-style-type: none"> - Services available on school sites - Interventions that address disruptive behavior, depression, trauma 	<ul style="list-style-type: none"> - Strengthening Families Program - Depression Treatment Quality Improvement (DTQI) - Trauma Focused Cognitive Behavior Therapy 	<p>Children in elementary and high schools</p>
<p>Parenting</p> <ul style="list-style-type: none"> - Brief and full parenting interventions - Available in home, schools, primary care and community based settings - Universal public education campaign 	<ul style="list-style-type: none"> - Triple P Parenting 	<p>Children and their families</p>
<p>Early signs of psychosis intervention</p> <ul style="list-style-type: none"> - Education and awareness campaign - Early identification and treatment 	<ul style="list-style-type: none"> - Early Detection and Intervention for the Prevention of Psychosis (EDIPP) 	<p>Transitional Age Youth (ages 16 – 25 y.o.)</p>

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PEI Planning Committee

The Department thanks each and every member of this Planning Body for their insight, expertise and willingness to reach into our community and hear the voice of those we serve. The commitment, dedication and shared vision of the Planning Committee ensured an inclusive and expansive PEI Plan to support the mental health well-being of our community.

<u>NAME</u>	<u>ORGANIZATION</u>	<u>NAME</u>	<u>ORGANIZATION</u>
Alatorre, Tony	Clinicas del Camino Real	Hicks, Daniel	VCBH - ADP
Anderson, Cleo	St. Paul Baptist Church	Lopez, Arsenio	MICOP
Arner-Costello, Fran	VCOE-SELPA	Marquez-O'Neill, Barbara	Oxnard Community Action
Bartels, Bill	City of Fillmore	Mellick, Irene	Older Adults/Senior Concerns
Bates, Karyn	MHB – Consumer	Mendoza, Joe	Migrant Education
Bennett, Kris	AspiraNet	Mohorko, Edgar	Clergy Council
Bhavnani, Ratan	NAMI	Pentis, Gary	VC Sheriff
Brooking, Gane	MHB Older Adult Comm.	Pringle, Pete	VCBH – Youth & Family
Brudnicki, Cathy	VC Homeless Coalition	Ramirez, Jubal	TAY / Pacific Clinics
Campos-Juarez, Lucrecia	Clinicas del Camino Real	Reyes, Guadalupe	Oxnard School District
Casey, Diana	HCA Ambulatory Care	Roach, Pam	Mental Health Board
Chan, Patty	VC Public Health	Samples, Mary	VCOE
Collins, Mary Ellen	United Parents	Sternad, Erik	Interface Children and Family Services
Compton, George	Veteran's Services	Tatangelo, MA, Sue	Camarillo Health Care District
Contini, Patty	VCOE	Torres, Charlotte	First 5 Ventura County
Cortez, Patricia	El Centrito de la Colonia	Varela, Mark	VC Probation
Cotterell, Sherrienne	Rio School District	Vasquez, Armando	Keys Academy
Creadick, Debra	VC Human Services Agency		
Flores, Rogelio	Consul de Mexico - Oxnard		
Flores, Sonja	House Farmworkers		
Gertson, Linda	VCBH Adults - Manager		
Gomez, Jennifer	TAY Tunnel		
Gonzales, Laura	Coalition to End Family Violence		
Gray, Sonna	MHSA Liaison, Family Member		
Grothe, Pamela	Human Services Agency		
Gutierrez, Yvonne	El Concilio Board of Directors		
Handel, Deanna	First 5 Ventura County		

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FORM 2

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

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

Oversight for the community program planning process was provided by MHSA Coordinator Susan Kelly, who served as PEI Coordinator. She previously led the community program planning processes for Community Services and Supports, Workforce, Education and Training and Capital Facilities/Information Technology.

Ventura County Behavioral Health (VCBH) established a PEI Planning Committee, comprised of 44 stakeholders who represented all required PEI sectors and geographic areas of the County, including public and private providers across multiple disciplines, representatives from faith-based and underserved populations, and consumers and their family members. Each agency, organization, advocacy and community group self-identified its representative, who would best provide the 'voice' of their constituency. As gaps were identified in Planning Committee representation, both VCBH staff and Planning Committee members conducted outreach to identify participants to fill those gaps.

The Planning Committee was organized to provide direction and oversight to the planning process, including synthesis of the community input to determine priority populations, needs, outcomes and intervention models. Moreover, the Committee members agreed to actively, throughout the planning process, seek out and represent the views of the larger communities of which they were a part to assure a comprehensive, representative planning process. The PEI Planning Committee met every month from August 2008 through May 2009. Early on in the planning process, the Committee determined that dividing the county into regional areas for stakeholder outreach and assessment would provide the most informed and in-depth opportunity for stakeholder participation. Another goal of this structure was to better refine the needs and articulate the differences, though sometimes subtle, between regions. From this regional breakdown, each member of the Committee self-selected a regional workgroup to participate in the outreach component of our planning.

This design facilitated a cascading outreach effort, such that with each new contact and engagement of a community, we enhanced participation and received recommendations and feedback from constituencies who had never before been involved with the public mental health system at any level. This strategy worked well for us, and was later the source of several favorable comments during a public Mental Health Board Meeting. As the months progressed, we continually expanded our

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outreach, contacts and engagement efforts to promote an ever richer and more diverse representation from each region of our county.

The Planning Committee, working with VCBH, was very active and responsible, and was instrumental in every level of the plan development. Each decision, at each level, was based consensus of the Committee informed by the needs assessment process. Specific Committee tasks included:

- creating the design of the planning process;
- providing overall guidance and feedback throughout the planning process;
- selecting the ‘key indicators’ to be used in the quantitative data analysis;
- ensuring that all required priority populations and sectors were represented in the needs assessment and strategy development components;
- identifying and soliciting participants for the key informant interviews, focus groups and community forums;
- reviewing and synthesizing the results of the community needs assessment - county-wide and regional - to determine priority populations and mental health needs;
- review potential practices and strategies to address the populations and needs identified;
- providing strategy recommendations to the County; and
- identifying and selecting the priority populations, needs, target outcomes, and the corresponding programs and projects.

In summary, the PEI Planning Committee, along with many other stakeholders (e.g., those participating in Key Individual Interviews, Focus Groups, and Community Forums) played a strong and critical role in the planning process: making recommendations for participation in the community assessment data collection initiatives; responding to focus group and interview questions designed to elicit community-level needs, barriers to access, and recommended PEI strategies; reviewing and evaluating findings from the qualitative and quantitative components of the data collection and community assessment process; recommending and voting on PEI programs and strategies; and ensuring that the process adhered to California Department of Mental Health requirements.

b. Coordination and management of the Community Program Planning Process

Working under the oversight of the PEI Coordinator, VCBH retained consultants with relevant expertise and experience who have collaborated in the development, coordination and management of the planning process.

Dr. Gabino Aguirre, who has extensive local experience with community capacity building and collaborative work in underserved communities, was responsible for ensuring that the planning process included the participation of the widest possible array of stakeholders. His particular emphasis was on managing stakeholder participation in the planning process by ensuring the involvement of grassroots organizations who traditionally have not been involved in mental health planning

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processes and whose constituents have been unserved or underserved by the mental health system.

VCBH also contracted with EvalCorp, an established applied research and consulting firm, to lead the community-based assessment initiative. Staff from EvalCorp Research & Consulting designed the community-based needs assessment strategy in collaboration with VCBH and the Planning Committee, and led the data collection and analysis activities, which were the underpinning of the community planning process. EvalCorp was primarily responsible for gathering and organizing data and community input to inform and support decision-making by the community planning participants. EvalCorp has experience with PEI data collection, analysis and report development in other counties, as well as extensive knowledge and understanding of the unique needs and existing resources/strengths of Ventura County, through their years of conducting community assessment and evaluation activities for VCBH's Alcohol and Drug Programs – Prevention Services, and First 5 Ventura County.

Finally, VCBH contracted with the California Institute for Mental Health (CIMH) who was primarily responsible for providing information about evidence-based and promising prevention and early intervention models, to inform and support decision-making by the community planning participants. Once priority populations, needs, outcome and intervention models were selected, CIMH also provided recommendations on the design of the proposed PEI projects—i.e. tips on how to structure programs, so that they had the greatest likelihood of being well-implemented and sustained over time.

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

In addition to this planning team, three full-time Community Service Coordinators (CSCs) were assigned to provide community outreach efforts to engage diverse and distinct stakeholders in the planning process. All three CSCs are bi-lingual, which afforded the opportunity to enhance outreach efforts into Latino mono and bi-lingual communities identified as unserved or significantly underserved. The CSCs' primary responsibility was to develop strong relationships within the community - most specifically those areas which were identified by the Planning Committee as unserved, provide information and education on the opportunities PEI offers, and to recruit individuals to participate in geographic area workgroups, focus groups, key individual interviews and community forums. The CSC's were given ideas, input and suggestions based on PEI Planning Committee recommendations for new membership. Additionally, an analysis of the Committee was undertaken by EvalCorp to ensure that there was broad representation across Priority Populations and Sectors by its members. The CSC's worked in coordination with Dr. Aguirre, a leader in the Latino community whose strong personal and professional ties provided the Department significant new opportunities for outreach, connection and understanding of the Latino community's priority needs. What is most exciting is that these outreach efforts have created and fostered new relationships with the Latino community,

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creating a strong foundation upon which we will be able to build our future outreach, prevention and early intervention efforts .

Outreach Structure and Strategy:

The outreach and engagement efforts focused on 4 primary activities that were key to our community needs assessment process:

- Key Individual Interviews
- Focus Groups
- Community Forums
- Small group meetings, presentations, conferences, community events

The Planning Committee felt strongly that the needs assessment and planning process should be organized regionally, in recognition of the diverse cultural, demographic and resource characteristics of different areas of the county. Therefore, the committee divided the county into five 'areas,' each with common characteristics:

1. Santa Clara Valley
2. Ventura/Ojai
3. Oxnard/Camarillo
4. Conejo Valley
5. Moorpark/Simi Valley

Members of the Planning Committee were divided into five Area Teams, based on the five geographic areas of the county. The purpose of each team was to help focus team member's expertise into a defined area, and to help coordinate and suggest participants for the Key Individual Interviews, Focus Groups and Community Forums, which were conducted to engage additional community stakeholders in the planning process at each level. Additionally, Planning Committee members were assigned the responsibility of coordinating county-wide focus groups for specific populations. This was done by their level of connectedness within a certain community, or an expertise in the topic-specific area.

Key Individual Interviews were one method utilized for gathering qualitative data from stakeholders. Twenty-five Key Individual Interviews were conducted, with five interviews in each of the five geographic regions of the county. Interviewees in each region were representative of the PEI priority populations, mental health needs, age groups, and community sectors. The Planning Committee assisted with these interviews by identifying individuals, organizations, advocacy groups and other stakeholders who would be able to provide the 'larger view' of their community strengths, challenges and assets. From these individual participants, additional recommendations for stakeholder involvement were received, again illustrating the interwoven nature of the planning process. Our list of interested stakeholders continued to grow, become more diverse and representative of the community.

The interviews gathered important information on:

1. Community mental health needs and impacts of unmet needs
2. Community strengths/protective factors
3. Prioritization of PEI mental health needs, age groups, and priority populations
4. Existing/needed prevention and early intervention services

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5. Recommended strategies for effective PEI service delivery
6. Access/service barriers
7. Strategies to increase access to services in the community
8. Recommended strategies for outreach, education, and awareness

From the Key Individual Interviews, which provided the ‘birds’ eye view’ of each region, the next step was to begin to ‘drill down’ to individual stakeholders within the community who have the experience to speak more specifically to the everyday challenges. This included consumers, family members, veterans, teachers, counselors, faith-based practitioners, stakeholders who are interested in preventative initiatives and many, many others. As with the Key Individual Interviews, individuals who participated in these focus groups were identified in several ways: Planning Committee members were able to make recommendations from their area of interest and expertise; Key Individual Interview participants made recommendations for Focus Groups; consumers on the Planning Committee and Mental Health Board assisted in coordinating focus groups and informational meetings; Client Network, NAMI and United Parents coordinated participation and made recommendations for participation; and representation from the largest African American Church in the County convened participants for focus group participation. Additionally, the Department regularly sent invitations, information and educational brochures inviting participation throughout the community. These were sent in both English and Spanish.

A total of 24 focus groups were conducted throughout the county. 11 of these were Area-based Focus Groups (two per region, with the exception of Oxnard, which had three). To ensure inclusion across sectors, and to include community members who had an interest in participating at this level across various sectors (i.e., Education, Mental Health, Health, Law Enforcement, etc.), all of those individuals who had been recommended, or who expressed interest were invited to participate in the Area Focus Groups. Additionally, EvalCorp facilitated 13 Countywide Groups comprised of participants from unserved/underserved communities. Across the 24 focus groups, three were conducted in Spanish and 212 individuals participated overall. Food was provided at all the focus groups, and stipends were provided to consumers, family members and others. Information gleaned from the focus groups included:

1. Primary community mental health needs
2. Existing prevention and early intervention services/resources
3. Recommended PEI strategies/services to address community mental health needs
4. Community strengths/protective factors
5. Prioritization of PEI mental health needs, age groups, and priority populations,
6. Barriers to accessing services
7. Recommendations for informing communities about PEI

A comprehensive analysis and evaluation of the needs assessment data produced from the Key Individual Interviews and Focus Groups was undertaken and presented to the Planning Committee. EvalCorp also conducted an extensive data review and analysis of the county, based on multiple key indicators for each of the six Priority Populations and two of the Mental Health Needs identified by the state. A total of

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forty-six quantitative data indicators were analyzed by Area and city, whenever possible, and presented in the Data Indicator Report. The Planning Committee was instrumental in identifying the data indicators to be utilized which would be used to assist in the identification of the Priority Populations and Community Mental Health needs as outlined in the Guidelines. The Committee also participated in the identification of already existing data reports from which some of this information could be extracted. EvalCorp was then tasked with compiling this and developing surveys which would provide the additional information necessary to complete this process. This information proved to be a critical complement to qualitative information gathered through interviews and focus groups, demonstrating trends over time in unmet mental health needs and helping to establish community-level priorities.

The Planning Committee Area Teams served an additional purpose, which included making PEI program recommendations based on that particular Area's strengths and needs. This was a 4-part process in which the Planning Committee developed the PEI projects tied to community needs and priorities.

1. EvalCorp facilitated five Area Team Data Review Meetings to review with the team and clarify the findings from the Data Indicator Report, Key Individual Interviews, Area Focus Groups, and Countywide Focus Groups. CiMH also participated in each of the Area Team Data Review Meetings for the purposes of clarifying relationships between priorities, needs and prevention and early intervention programs.
2. CiMH and VCBH facilitated meetings with the Planning Committee to discuss evidenced based and promising practices and how they can be utilized to address Prevention and Early Intervention needs.
3. CiMH facilitated a process whereby the committee selected programs and specific prevention and early intervention models that would best address the needs and priorities of each geographic area, as well as countywide needs and priorities, based upon the findings of the needs assessment. The programs identified were grounded in the data analyses produced by EvalCorp and the results of the Area Team Data Review Meetings, and were responsive to priorities and needs of the community.
4. The Committee developed the proposed PEI projects, with facilitation by CiMH. Through this process, the Committee established goals and determined the relative priority of populations and mental health needs identified in the needs assessment. It took into account the costs of the available interventions and the expected decline in upcoming years of PEI planning estimates. There was lively discussion among the committee about the number as well as the breadth and intensity of the various interventions. The resulting proposed PEI projects were recommended by the Planning Committee as most reflective of the priorities identified in the planning process and as most able to provide the greatest measurable impact in the County.

The final component of community outreach consisted of three community forums which were held across the county after extensive outreach by staff and Area Teams. The outreach included the distribution of multi-lingual flyers, coordination with community- and faith-based organizations, and personal invitations. For the PEI

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Planning Committee the purpose of the forum was threefold: to inform the community at large of the process and outcomes of the PEI Planning Process; to solicit feedback; and finally to celebrate the progress to date. To facilitate the highest level of participation and to accommodate working families, a light dinner was served before each of the forums. Participants were provided information about the recommended programs, and then given the opportunity to express their viewpoints, as well as complete a survey to inform the county of specific recommendations for delivery of PEI services.

Rich information was gathered in the surveys and this will be used to inform the location, times of service operation and the outreach efforts necessary to ensure success of these PEI projects. Feedback from the forums was very favorable, with participants expressing agreement with the PEI projects.

Through these county-wide forums, the community at large was afforded the opportunity to be fully informed and to celebrate what has truly been the most comprehensive planning process for any initiative associated with mental health in Ventura County's history.

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

a. Included representatives of unserved and/or underserved populations and family members of unserved/underserved populations

The stakeholder outreach process took several approaches to ensure participation in community planning. Our bi-lingual CSC staff focused outreach efforts on a grassroots approach to engagement. This included phone calls, drop-in visits to community sites, visiting parks and malls to reach individuals and offer information, brochures and the opportunity to participate in forums, focus groups, attend meetings or complete surveys. The following table lists most of the activities that were more formally scheduled as a component of these community efforts. These efforts of outreach resulted in a growing participation in the planning process and the development of projects and timelines for implementation. It has also added to community anticipation of services and supports being available in the near future for access. Events that were specifically designed to increase broad community participation and input are highlighted.

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Table 2: Participation/Presentations/Trainings for PEI

Date	Event	Purpose	Participants
May 16, 2008	MIMHM PEI Kick-Off Conference "Beginning The Dialogue"	Introduce the community to PEI Opportunities	450 Community Members
July 28 & 29 2008	CiMH Regional Roundtable-PEI	Training Opportunity for Interested Planning Committee Participation	10 Community Partners
Aug 2008	Presentation Office of Education Title IV Representatives - Prevention	Introduce and receive input on PEI Priorities	30
Aug. 4, 2008	PEI Planning Review Workgroup	Convene preliminary Planning Group	20
August 15	MHOAC Overview and Stakeholder Planning Workgroup	Introduction of PEI Guidelines & Planning to Committee	30
January 2009	Oxnard Faith Based Coalition -	Presentation on PEI & Receive Feedback	125
May 2009	MIMHM PEI - Suicide Prevention -	Community Outreach Conference on Suicide & PEI Planning & Opportunities	475 Community Members
Nov 5, 2008	Meeting with immigrant attorneys group	Intro PEI & outreach to immigrant population	10 participants
Nov 6, 2008	Met with Santa Paula SD representatives	Strategize on outreach opportunities via schools	6 participants
Nov 12, 2008	Presentation to Big Brothers Big Sisters community event	Presentation/Info on MHSA and PEI	approximately 600 in audience, primarily non-English speaking parents
Nov 13, 2008	Santa Paula Weed and Seed Advisory Board	Outreach regarding PEI and juvenile justice youth diversion	25 participants
Nov 15, 2008	Parent-School Conference	information and outreach	85 parents, educators and community members
Nov 20, 2008	Farmworker housing group	information and outreach	8 participants
Nov 21, 2008	Met with representatives from El Concilio	discussed community outreach re MHSA-PEI	10 participants
Nov 25, 2008	Interface Children Family Services	information on PEI and value of 2-1-1 program	3 participants
Dec 11, 2008	Presentation to SELPA	PowerPoint presentation on MHSA and PEI	12 participants
Dec 12, 2008	Hispanic Mentorship Council	discussed PEI and their youth mentoring program	8 participants
Dec 15, 2008	Poder Popular Leadership Council	Community issues related to school and youth violence	18 participants
Dec 16, 2008	Clinicas del Camino Real	Discussed PEI outreach with Clinicas staff	12 participants
Dec 18, 2008	Cultural Competence Committee	PEI and importance of building capacity in county agencies	9 participants
Dec 19, 2008	Family Resource Center (SP)	community outreach and information	7 participants
Jan 2, 2009	Inlakech Cultural Center	PEI and relation to outreach using the arts	5 participants
Jan 7, 2009	Clinicas community education/outreach workers	outreach and coordination of services	4 participants

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Jan 8, 2009	County-wide Migrant Education Meeting	PowerPoint info on MHSA-PEI	28 participants
Jan 13, 2009	High School counselors (Oxnard UHSD)	PEI efforts/opportunities in local high schools	12 participants
Jan 15, 2009	House Farmworkers Area Group	Outreach to farmworkers and agricultural community	7 participants
Jan 21, 2009	Schools Conference meeting	infusion of PEI into education conference	7 participants
Jan 24, 2009	Community schools meeting	PEI info and outreach	48 participants
Feb 4, 2009	Fillmore and Santa Paula outreach	PEI and Conference info to general community	approximately 50 individual and agency contacts
Feb 7, 2009	Parent-Schools Conference	Sponsored by VCBH, theme was wellness and MHSA-PEI efforts	approximately 100 participants
Feb 11, 2009	Teen Health Workshop	Shared info on PEI planning/youth outreach	16 participants
Feb 12, 2009	County Schools Nurses Group	PowerPoint presentation on PEI and Mental Health	12 participants
Feb 18, 2009	Meeting with ADP staff	discussion community coalitions and "request for proposals" process	4 participants
Feb 23, 2009	Meeting with QI-QM staff	Capacity issues and WET and PEI	3 participants
Feb 24, 2009	Area 4 Community Team meeting	Information, discussion and coordination	12 participants
Feb 25, 2009	Area Community Team meetings (Areas 1 and 5)	Information, discussion and coordination	8 + 5 participants
Feb 25, 2009	Homeless Task Force meeting	provided PEI info and discussed issues of homelessness	15 participants
Feb 25, 2009	Latino Town Hall Reception	Intro of VCBH staff and MHSA-PEI programs	29 participants
Feb 26, 2009	VC Alternative Educators Council	Truancy, juvenile justice diversion of high-risk students & PEI	9 participants
Feb 26, 2009	Area 2 Community Team meeting	Information, discussion and coordination	12 participants
Mar 2, 2009	Big Brothers Big Sisters	PEI planning, upcoming activities and mentoring efforts	5 participants
Mar 4, 2009	El Centrito de la Colonia	outreach to farm worker /immigrant community	6 participants
Mar 6, 2009	NAMI Recognition Dinner Presentation	PEI and MHSA efforts and advocacy	approximately 175 participants
Mar 10, 2009	CIMH meetings (Areas 2 and 4)	Provided info on evidence-based practices	5 + 7
Mar 11, 2009	Carpe Diem Youth Conference	VCBH sponsored youth event	approximately 75 participants
Mar 12, 2009	Latino Behavioral Health Institute	Discussed Latino Access Issues re: mental health services	7 participants
Mar 17, 2009	CIMH meetings (Areas 1 and 5)	Provided info on evidence-based practices	4 + 5 participants
Mar 18, 2009	Area Community Focus Groups (Area 4 and Area 1 (Span and Eng))	Data gathering effort in both English and Spanish	9 + 8 + 7 participants
Mar 19, 2009	Area 3 Community Focus Group	Data gathering effort	9 participants
Mar 25, 2009	Farm worker Housing Task Force	PEI information and presentation by CSCs	15 participants
Mar 26, 2009	Ministerial Association	Info on PEI and coming community forums	7 participants

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Mar 26, 2009	Community leadership Committee	Discussion of youth and employment needs	18 participants
Mar 30, 2009	Keys Academy	PEI planning info and community outreach	4 participants
May 7, 2009	May Is Mental Health Month-PEI Conference	Suicide: Risk, Recovery, Prevention	450 Community Stakeholders

The second approach to stakeholder outreach and participation was to utilize facilitators with relevant expertise concerning data/evaluation management and process facilitation to achieve broad, extensive and inclusive needs assessment. This component of our Planning Process was conducted by EvalCorp.

EvalCorp developed a series of intricate matrixes for the Key Individual Interviews, Area Focus Groups, and Countywide Focus Groups to validate broad representation across age groups, sectors, and geographical areas.

At each planning stage we were very successful at facilitating a process of engaging consumers and family members, as well as representatives from un and underserved populations across the county. Examples include:

1. **County Wide Focus Groups** specific to the following underserved populations
 - i. African Americans
 - ii. Ambulatory Care/Health
 - iii. Consumers of Mental Health Services
 - iv. Deaf and Hard of Hearing – conducted utilizing ASL translators
 - v. Developmental Disabilities
 - vi. Education (Pre-K, 0-5 through Elementary School)
 - vii. Education (Middle School through College)
 - viii. Faith-based Community
 - ix. Immigrants/Farm workers – conducted in Spanish
 - x. Juvenile Justice/Probation
 - xi. Older Adults
 - xii. Transition-Age Youth (TAY)
 - xiii. Veterans

2. **Consumer and family member participation** on the Planning Committee and Area Teams, including representatives from the Client (Peer) Network, NAMI, and transition-age youth.

3. **Planning committee** representatives from the following underserved populations and/or services
 - i. Homeless
 - ii. Older adults
 - iii. Faith-based community
 - iv. Indigent farm workers
 - v. Veteran’s Services
 - vi. Ventura County Office of Education - Migrant Students division
 - vii. African American community

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- b. Provided opportunities to participate for individuals reflecting the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, race/ethnicity and language.**

The Planning Committee organized the planning outreach process geographically in recognition of the unique needs and strengths of the various regions. It was anticipated that by focusing regionally, we would ultimately gain a more intimate, subtle and realistic view of the challenges and strengths of each area. Not only did the Planning Committee have a clear understanding of the regional needs of our county, but this approach also ensured that the community voice spoke *for itself, about itself*. We have also forged new - and lasting - community relationships with individuals and groups with whom we have not connected in the past. This success was most evident in the Latino community. A focus on outreach and engagement activities within the predominately Latino areas of our community identified as un- and significantly underserved began. Much of the historical minimal access to services has been due to the stigma associated with seeking mental health support. It was agreed by those involved in the community planning that PEI funded programs could provide an opportunity to shift this disparity in service access by identifying strategies and projects specifically designed to reduce stigma. Gabino Aguirre, as part of our PEI team, was key to this successful outreach. Dr. Aguirre has been a leadership voice for the Latino community in our county for several decades. Ensuring diverse representation from multiple organizations, grassroots alliances and individual stakeholders' on the Planning Committee, provided an additional avenue to ensure broad and diverse Latino community participation.

Below is a subset of outreach and engagement efforts that focused on the Latino/Spanish-speaking community. These efforts included outreach to the migrant farm worker community, the Mixteco community and to migrant education. These include meetings and presentations with agencies that serve this sector of the County as well as face-to-face contacts with Latino parents and other residents of barrios, low-income and Spanish-Speaking areas of communities.

November 2008

- Meeting with Big Brothers/Big Sisters Latino Mentorship Project (N=9)
- Santa Paula Weed and Seed (crime prevention and community development in 12th Street Barrio area of Santa Paula (N=12)
- Parent-Schools Conference at Barbara Webster School (N=148)
- Latino Access Committee (N=11)
- Farm worker Housing Group (N=22)

December 2008

- Outreach to minority community for interview phase (N=42 calls)
- Presentation to CAVC, poverty-focused services agency (N=13)
- Presentation to SELPA (special education teachers/administrators, some of whom are Latinos (N=10)
- Presentation to Poder Popular, Latino grassroots activist organization (N=27)

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January 2009

- Inlakech Cultural Center (N=14)
- Migrant education (elementary and high school) meetings (N=43)
- Housing Coalition (N=14)
- Santa Clara Valley community meeting (N=27)
- Outreach for county-wide Spanish-language focus groups (N=54 calls)

February 2009

- Outreach for schools conference targeting Spanish-speaking parents (80 contacts)
- MHSA sponsored parent-schools conference at Isbell School, including PEI survey and presentations (N=148)
- Presentation to Cultural Competence Committee (N=13)
- Santa Paula (city is 72% Latino) Homeless Task Force presentation (N=22)
- Outreach and/or info/presentations to El Centrito, Keys Academy, El Concilio del Condado de Ventura, Clinicas del Camino Real, Latino Town Hall, Poder Popular, CAUSE, Latino Peace Officers Association, One Step a-la-Vez, Mexican-American Bar Association, LUCHA, Incorporated and other Latino/Latino-serving organizations (N=150-175)

March 2009

- Follow-up outreach for focus group participation with special emphasis on Spanish-speaking and general Latino community (N=85 calls)
- Presentation to Ministerial Association with churches serving majority Latino congregations (N=11)

April 2009

- Santa Paula Education Committee meeting (N=17)
- Fillmore community group meeting (N=14)
- Oxnard Community Coalition (N=25)
- Thousand Oaks Parents Group meeting (N=19)
- Outreach for community forums with focus on Latinos (N=50 calls)
- Clergy/Faith Coalition meeting (N=100)

May 2009

- Schools Conference at Santa Paula High School (N=112)
- General outreach to all community sectors for community forums

June 2009

- Latino Town Hall community meeting (N=17)
- MICOP/Las Islas community meeting (N=150)

An area of challenge for our planning and outreach efforts was in the engagement of the Asian Pacific Islander (API) community. Our outreach and engagement to the API community to date has included contact with the National Asian Pacific Bar Association, discussion with the Filipino-American Club in Oxnard, requests to non-profit organizations in the community for referrals to API volunteers working with them, as well as contact with several Asian Pacific faith-based communities throughout the county. Our efforts with this outreach resulted in participation on Focus Groups - in

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Area 2 (Ventura) and 5 (Moorpark/Simi Valley) and participation in Key Individual Interviews. It was expressed that the challenges faced in engaging this community are often due to specific topics which are shrouded in stigma - including mental illness. We have received commitments from individuals within the Asian Pacific Islander community that as we move forward in the implementation phase of PEI, they will assist us in strategically identifying ways to engage the API community. Understanding that the Asian Pacific Islander population in Ventura County is 5% and growing, we will continue our efforts as we move forward. These engagement efforts have been identified as a seed issue for the Community Coalitions. The opportunity for this engagement is most specifically identified in Project 1 - Community Coalitions. As described in the next section of this Plan, Community Coalitions are intended to bring communities together to support PEI projects and initiatives at the community-specific level. This 'grassroots' approach to PEI Project implementation ensures integration of culturally competent practices and meaningful outreach to those who the Coalition represents. This may occur in multiple formats - through funding a county-wide community coalition specific to the Asian Pacific Islander community, engaging API communities in region-specific initiatives, as well as through the hiring of consultants to assist in the strategic implementation of PEI projects within the various cultures represented within the Asian Pacific Islander community.

Continued Opportunities for Planning Participation:

EvalCorp conducted an extensive analysis of census data based on the 5 geographic regions, which was then distributed and explained to Planning Committee members so that the analysis could serve as a basis for future decisions. As such, the quantitative and qualitative data collection was divided by the five geographic regions of the county. Outreach efforts by the Planning Committee ensued to identify representatives with expertise in each region who participated in Key Individual Interviews and the 24 focus groups.

As described above, participants representing the community stakeholder driven nature of the planning process and deliberate effort to reach the diverse communities of the county continued throughout the process. Beginning with the Planning Committee, each stage depended on "stakeholders identifying stakeholders" that represented the diverse demographic characteristics of the county, the required sectors and those who had a variety of perspectives, from administrator to social worker to consumer, manager to service provider, teacher to student, parent to caretaker.

For the county-wide focus groups, a Planning Committee member, who was also a stakeholder representing the particular focus group category, (e.g., consumers, deaf & hard of hearing, veterans, developmentally disabled, etc.) served as liaison for each focus group. The liaison recruited participants for that focus group, ensuring that each participant could represent the particular underserved population targeted by the group. As with the county-wide focus groups, the Planning Committee Area Teams were responsible for identifying the area focus group participants and for ensuring that all required sectors and age groups were represented.

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Much thought was put into the overall process of data collection to ensure that there was representation across age, ethnic, gender, and language groups. For example, three of the focus groups were conducted in Spanish, the county's largest threshold language. Additionally, forms, brochures and outreach materials used in the community planning and assessment process also were available in Spanish.

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

As indicated above, there were consumer and family members represented throughout the planning process, with seats on the Planning Committee and participation in the focus groups and community forums. Outreach was done through our Mental Health Board, Client Network, peer-run wellness and recovery centers, and by having the Planning Committee members conduct additional outreach.

Specifically, the Planning Committee included two family member representatives, the current president of NAMI in Ventura County and the MHSA family member liaison. The planning committee's consumer representatives included one individual who is also on the Mental Health Board and serves as Secretary of the local Client Network. The other consumer representative is a transitional age youth (TAY) and peer employee at the TAY Wellness and Recovery Center. Each of these representatives brought a long history of advocacy on behalf of consumers and family members in the county.

County-level focus groups were held specifically for adult and another for TAY consumers. The Planning Committee's Adult Consumer representative and the head of the TAY Wellness and Recovery Center served as focus group liaisons for the respective groups. In identifying participants, they conducted outreach through the Client Network, the peer-run wellness and recovery centers, VCBH clinics, other community mental health programs and through the Mental Health Board.

Participation by consumers and family was also included in other focus groups not specific to consumer issues.

Finally, as indicated above, the Planning Committee Area Teams were responsible to reach out to and identify participants for the area focus groups. The Area Teams ensured that there was family member representation in each focus group.

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

a. Participation of stakeholders as defined in Title 9, California Code of Regulations (CCR), Chapter 14, Article 2, Section 3200.270, including, but not limited to:

- **Individuals with serious mental illness and/or serious emotional disturbance and/or their families**
- **Providers of mental health and/or related services such as physical health care and/or social services**
- **Educators and/or representatives of education**
- **Representatives of law enforcement**
- **Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families**

The Planning Committee and Area Teams, Key Individual Interviewees, and Focus Group participants were comprised of stakeholders from and across all of the required priority sectors. Detailed matrices were developed to monitor and track participation of these stakeholders throughout each aspect of the planning process and for each data collection strategy (see Tables 3, 4 and 5 below). Particular attention and outreach occurred to ensure participation in every aspect of the planning process by individuals who represented diverse interests. Examples of participants from the categories listed above include:

- Consumer and family member participation as described in Question 2a
- County and private providers from mental health, probation, child welfare, ambulatory health care, public health, and other social services
- Professional (regional, district, and school administration, teachers, nurses) and other representatives from education, including preschool, elementary, middle and high school, and from the community colleges
- Sheriff's department and probation representatives

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TABLE 3: Age Groups, Sectors, and Geographic Regions Represented by Interviewees

KEY INDIVIDUAL INTERVIEWS																					
INTERVIEWEES	Total Participants	AGE GROUPS					SECTOR REPRESENTATION										GEOGRAPHIC AREA				
		Prenatal - 5	Child	TAY	Adult	Older Adult	Underserved Cultural Pops.	Education	SMI & their Family	MHS Provider	Health	Social Services	Law Enforcement	Comm Fam Resource Cnrs	Employment	Media	1	2	3	4	5
1	KIIs - Area 1	5	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
2	KIIs - Area 2	5	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
3	KIIs - Area 3	5	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
4	KIIs - Area 4	5	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
5	KIIs - Area 5	5	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

TABLE 4: Age Groups, Sectors, and Geographic Regions Represented by Countywide Focus Group Participants

COUNTYWIDE FOCUS GROUPS																					
GROUP NAME	Total Participants	AGE GROUPS					SECTOR REPRESENTATION										GEOGRAPHIC AREA				
		Prenatal - 5	Child	TAY	Adult	Older Adult	Underserved Cult. Pop.	Education	SMI & their Families	MHS Provider	Health	Social Services	Law Enforcement	Comm Family Resource Cnrs	Employment	Media	1	2	3	4	5
1	African-American	7		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
2	Ambulatory Care/Health	8	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
3	ARC/Developmental Disabilities	11	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
4	Consumers of MH Services	8	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
5	Deaf and Hard of Hearing	10			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
6	Education (Pre-K and Elementary)	11	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
7	Education (9th - College)	9	X	X	X			X	X	X	X			X			X	X	X	X	
8	Faith Communities	9	X	X	X	X	X	X	X				X	X	X			X	X	X	
9	Immigrants/Farmworkers	8	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	
10	Juvenile Probation	9		X	X			X						X				X	X	X	
11	Older Adults	9			X	X	X	X			X	X	X					X	X	X	
12	Veterans	7	X	X	X	X	X	X			X	X						X	X	X	
13	Transition Age Youth	12	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

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**TABLE 5: Age Groups, Sectors, and Geographic Regions Represented
by Area-based Focus Group Participants**

AREA BASED FOCUS GROUPS																					
GROUP NAME	Total Participants	AGE GROUPS					SECTOR REPRESENTATION										GEOGRAPHIC AREA				
		Prenatal - 5	Child	TAY	Adult	Older Adult	Underserved Cult. Pop.	Education	SMI & their Families	MHS Provider	Health	Social Services	Law Enforcement	Comm Family Resource Ctrs	Employment	Media	1	2	3	4	5
1 Area 1, Focus Group 1	7	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X				
2 Area 1, Focus Group 2	6	X	X	X	X	X	X	X			X	X	X	X		X					
3 Area 2, Focus Group 1	8	X	X	X	X	X	X	X		X	X	X		X				X			
4 Area 2, Focus Group 2	8	X	X	X	X	X	X	X	X	X	X	X	X	X		X		X			
5 Area 3, Focus Group 1	10	X	X	X	X	X	X	X	X	X	X	X	X						X		
6 Area 3, Focus Group 2	10	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X			X		
7 Area 3, Focus Group 3	9	X	X	X	X	X	X	X	X	X		X	X						X		
8 Area 4, Focus Group 1	7	X	X	X	X	X	X	X	X	X	X	X		X					X		
9 Area 4, Focus Group 2	10	X	X	X	X	X	X	X			X	X	X	X	X		X			X	
10 Area 5, Focus Group 1	10	X	X	X	X	X	X		X	X	X	X	X	X	X					X	
11 Area 5, Focus Group 2	9	X	X	X	X	X	X	X		X		X		X						X	

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

Education for stakeholders occurred continually throughout the PEI Planning Process with the goal of supporting the planning and to facilitate informed decision-making. Staff and stakeholders received training throughout the PEI planning process. At the start of the planning process, 10 Early Planning Committee members attended the Statewide PEI Conference in Universal City. This included representation from law enforcement, education, probation, NAMI, United Parents and Client Network. This was an opportunity to gain an in-depth understanding of PEI goals and requirements as well as learn how other counties were conducting their planning processes. Also early in the planning process, a group of seven individuals, consisting of staff, consultants, and planning committee members, spent a full day with San Bernardino County MHSA staff and outside consultants. They had the opportunity to learn in-depth how San Bernardino approached its planning process. Within a month of this event, we scheduled MHSA to provide a face-to-face day long seminar for those involved in the process to provide training on MHSA, PEI and how the role of the MHSA. By this time, most of the Planning Committee was formed and all participated in this training. It was from these two experiences that the Planning Committee began to design the planning process structure. Additionally, representatives from the planning committee took a ‘road trip’ to San Bernardino to learn about that county’s planning process - how it was designed and moved forward.

The Planning Committee was provided with extensive orientation and training on PEI principles, goals, and requirements. This training was done by VCBH, EvalCorp, and

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CiMH, which also provided training to staff, the Planning Committee members, and the Area Teams on PEI models and Evidence-Based Practices.

As the Committee moved beyond designing the stakeholder outreach process additional trainings were scheduled. These were offered to provide additional guidance as new components of planning and decision making developed. A training on Evidence Based and Promising Practices – what that means and why consider them – supported the program selection process. This training was conducted by CiMH and provided a broad spectrum of the possibilities of evidenced based and promising practices as well as including specific examples of practices which could address the Prevention and Early Intervention needs of our community. CiMH provided examples of linking community based priorities with specific practices. Training and overview on how to read and interpret data was provided throughout the process by EvalCorp as the Planning Committee began to receive and review information.

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

a. The lessons learned from the CSS process and how these were applied in the PEI process.

There are two key areas in which the PEI planning process has evolved from the CSS process, building further on lessons learned:

1. Strong Emphasis on a Data Driven Process and Reliance on Effective and Community Relevant Practices

From the beginning, the planning process for the PEI plan has been founded on the idea that data should drive our needs assessment and decision making. VCBH has put an extensive amount of energy, resources, and emphasis on the collection of comprehensive needs assessment data to ensure an accurate, detailed, and complete picture of the prevention and early intervention needs and resources in our community. In this way, PEI programs have been developed based upon the needs and priorities as clarified by the needs assessment process.

Moreover, the needs assessment process has been enhanced by providing more training and support to stakeholders with the goal of increasing their informed participation. Training activities included, among other things, core information about prevention and early intervention programs and evidence based practices.

2. Broad and Diverse Stakeholder Participation

From the outset, the planning process has been stakeholder driven, with VCBH as facilitators of the process. There was significantly more diversity across stakeholders in the PEI planning process as compared to the CSS process. This was led by a heterogeneous planning committee, which was instrumental in soliciting participation by an even wider array of diverse community stakeholders. In addition to the required

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priority populations, VCBH was successful in securing participation representing various underserved populations, such as the immigrant farm worker and Mixteco communities, veterans, the homeless, and community advocates.

- b. Measures of success that outreach efforts produced an inclusive and effective community program planning process with participation by individuals who are part of the PEI priority populations, including Transition Age Youth.**

As indicated above, extensive analysis was done to track and ensure that participation and representation occurred across all priority populations. This included both representatives of and experts on the various priority populations, as well as individuals who are part of the priority populations. One of the countywide focus groups was specifically for and attended by transition-age youth. The matrixes developed for the Key Individual Interviews, Area Focus Groups, and Countywide Focus Groups certified there was broad representation across age groups, sectors, and geographical areas (see Section 3a). To ensure effective planning, continual feedback and evaluations were collected from all stakeholders throughout the process including the Planning Committee, Area Team members, Key Individual Interviewees, focus group participants, and community forum attendees. Based on this feedback, at least 98% of participants were satisfied or very satisfied with the process. Additionally, participant data/information profiles were obtained and analyzed throughout the process to validate equitable and representative participation in the process.

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

- a. The date of the public hearing:**

The Public Hearing occurred July 20, 2009 just prior to the regularly scheduled Mental Health Board meeting. This Public Hearing took place after a 30-day posting of the Plan, from June 16, 2009 through July 16, 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.**

After review and recommendation by the Mental Health Board during their June general meeting, the plan was posted on the VCBH page of the Ventura County website. Hard copies were made available upon request. Notification of the posting was announced to all MHSA stakeholders electronically. Additionally, notice of the hearing was widely circulated among all participants, interested community members, community-based organizations, and other community and government partners/agencies.

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

Summary of Public Comment and Hearing Process:

The Department posted the plan on its website for public review and additionally notified approximately 1,050 individuals and organizations of the posting.

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The Department received a total of 3 public comments during the 30-day review and 6 additional comments (some of which were also provided in writing) at the Public Hearing. Copies of the written comments are attached in Appendix V for review. Six of the Public Comments reflected community appreciation for the inclusive and thorough planning process which unfolded over the last year. Noting the breadth and depth of outreach efforts, each of these individuals, representing First 5, schools, primary care medical clinics, faith based councils and Community Action Coalitions, praised the inclusiveness of the community planning process. It was noted that a broad, diverse group of stakeholders, including representatives from groups that had been historically unserved or underserved by the mental health system, were actively included in the Plan development. Several comments expressed that the PEI Plan will provide the opportunity for collaboration and community partnerships in implementing universal prevention strategies. There was also support for some of the specific strategies included in the Plan, such as Triple P Parenting, that will be implemented in schools and at primary health care sites, to increase access and decrease stigma for those seeking assistance. The Special Education Local Plan Area representative noted disappointment that “Response to Intervention” (RTI) was not funded.

One written comment opined that the plan does not address the relationship between racism and mental health issues. Another writer indicated his disagreement with the Department’s use of the Institute of Medicine (IOM) model for prevention and stated that there was insufficient emphasis on universal prevention.

A representative of the Department explained at the hearing that the State’s directive was to use IOM framework in the development of the plan. Additionally, it was noted that Ventura County’s distribution of universal and selective prevention as well as early intervention approaches is consistent with the results of the needs assessment and the community planning process, and it is similar to the distribution employed by other counties. In giving consideration to the public comments, the Mental Health Board thanked the community for its efforts in this exhaustive planning process. Although not all projects and recommendations can be included in project funding, the commitment to hear each voice and to assure inclusivity was reiterated.

After listening to and considering all comments presented, the Mental Health Board voted unanimously to recommend the Board of Supervisors review and approve the Plan to move forward to State DMH for review and approval. On August 4, 2009, the Plan was approved by the Board of Supervisors for submission to the State for its review and approval.

Department Response to Substantive Comments:

As noted in the Guidelines and in accordance with statutory and regulatory requirements, any substantive comments raised at the public hearing should include county mental health program’s response. Two such comments were received and are included in the appendix of this document for review.

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These two public comments focus primarily on research outcomes, center on the primary themes of "maximizing community program planning from key cultural/racial specific individual community experts..." and the need to "ensure community oriented programs". Both the Department and Ventura County MHSA stakeholders would agree with these themes and feel confident that the Ventura County PEI plan approved by the Mental Health Board, Ventura County Board of Supervisors and submitted to the Oversight and Accountability Commission for approval reflects those foundational principals.

Ventura County's Prevention and Early Intervention Stakeholder process distinguished itself by outstanding outreach efforts that brought together the largest, most geographically and culturally diverse community of stakeholders achieved thus far. Many of the individuals involved in this process were people who had never before been involved in mental health policy and planning, many of them key informants representing large, culturally diverse constituencies. Many of these individuals and their constituencies are now committed partners and will be integral to the formation of the Community Coalitions, local advocates for Prevention and Early Intervention who will support the universal strategies of our programs and be instrumental in the development of regional initiatives to further the vision of preventative outreach in our community.

In order to assure unbiased data collection and expert analysis for Ventura County's Prevention and Early Intervention needs assessment, we engaged the assistance of EvalCorp, who had successfully completed similar work for Los Angeles County. Similarly, the California Institute of Mental Health provided its expertise in assisting the stakeholders in choosing evidenced based prevention and early intervention strategies. What has grown from the PEI stakeholder process is a plan that responds to local need, with proven practice. In fact, The World Health Organization, referenced in one public comment, in an article entitled, "Prevention is better than cure" specifically mentions Triple-P as a prevention strategy to address child maltreatment, closely associated with mental illness. Triple-P is one of the Prevention Strategies adopted in Ventura County's plan.

In one of the public comments, there was a reference to the Children's Outreach and Engagement Project, funded under Community Services and Supports. In a review of the first couple years' implementation of that project, there was general consensus, including support from key informants in the underserved communities of our county, that the project was not achieving the vision and goals outlined in the plan. Lessons learned necessitated a revamping of the project from a model which utilized a centralized oversight organization to one that supported more inclusiveness and the engagement of individuals and their constituencies who would realize a more broad impact on the identified communities targeted.

We are proud to note that these Outreach and Engagement projects are now managed at the local level in all three identified un- and under served regions. In the Oxnard plains area, our community partner is St. Paul's Baptist Church. St. Paul's represents a community that is not only multi-ethnic, but is also the largest African

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American community in the county. St. Paul's has positive/working relationships with other churches and organizations in the Oxnard Plains, including the other largest African American church. Additionally, it has a vibrant infrastructure, upon which to build, which includes a community pre-school and recreational center for youth. For the Santa Paula Project, our partner is Our Lady of Guadalupe Church, which represents the largest un- and under served Latino community in the area. Our Lady of Guadalupe has a close working relationship with its sister church in Santa Paula, both committed to inclusiveness and serving that community. And lastly, in Fillmore our partner is the local Boys and Girls Club who continues to work on creative outreach efforts with the local high school.

d. The estimated number of participants:

As mentioned above, approximately 1,050 emails were sent out notifying the community of the 30 day posting of the plan and of the public hearing. Aside from 15 Behavioral Health Department staff, there were approximately 20 community members, and 10 MHB members in attendance at the public hearing. Seven individuals made comments during the hearing. Several provided written comments as well, which are included as part of the Plan.

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County: Ventura

PEI Project Name: Community Coalitions

Date: June 2009

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	X	X	X	X
2. Psycho-Social Impact of Trauma				
3. At-Risk Children, Youth and Young Adult Populations				
4. Stigma and Discrimination	X	X	X	X
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				
2. Individuals Experiencing Onset of Serious Psychiatric Illness				
3. Children and Youth in Stressed Families				
4. Children and Youth at Risk for School Failure				
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement				
6. Underserved Cultural Populations	X	X	X	X

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Summary of Project 1: Community Coalitions

Community Coalitions have been designed to provide regionally based outreach and education and to complement and support the continuum of universal, selected and early intervention strategies in a community. Reflecting the approach adopted for the community wide planning process, regionally based outreach, initiatives, universal education and community participation will be at the heart of these local Coalitions. Viewed as “Circles of Care” each Coalition will be comprised of stakeholders who reside in, and are connected to, the community they represent. Members of the Coalitions will include service providers of the other PEI Projects, non-profit organizations within the community, advocacy organizations, agencies providing services to the community, family members and consumers. The Coalitions become a ‘mirror’ reflecting the cultural, ethnic/racial and linguistic make-up of the community which they serve.

There are two specific and interlinked goals identified for these Coalitions. The first is to develop regionally specific outreach and engagement efforts designed to reduce stigma and increase access to services for populations that, through the planning process, were identified as most in need in that particular region. This includes receiving training on the universal strategies embedded in the Projects - and then using this information to educate and outreach within their community to ensure service access, provide educational materials and, with their community connectedness, reduce the stigma that often prevents individuals and families from receiving the supports they need. Coalitions will be responsible for ensuring development of culturally and linguistically appropriate outreach and educational materials as well as for promoting engagement of diverse cultural and ethnic communities. The Coalitions will also work with each Project to identify where within the community services would best be located, again with the goal of increasing access and reducing stigma. For instance, the Children’s Outreach and Engagement Projects which are providing targeted, culturally specific outreach and engagement efforts in Fillmore (Latino) Santa Paula (Latino) and Oxnard (African American/Latino), will be integrated with and complement the work of the community coalitions in those areas. Coalitions in other regions of the county will target other underserved ethnic minority groups, such as the Asian Pacific Islander community.

Interwoven with these targeted, regional engagement and stigma reduction efforts, will be implementation by the Community Coalitions of the universal prevention component of several of the PEI projects. Three interventions included in the projects described later in the Plan include a universal prevention component - Triple P Parenting Level 1, Early Detection and Intervention for the Prevention of Psychosis (EDIPP) and Improving Mood Promoting Access to Collaborative Treatment (IMPACT). The coalitions will be responsible for developing localized strategies to implement these universal prevention models, including the dissemination of educational materials associated with each model. These culturally and community specific strategies will be interlinked with the broader outreach and stigma reduction efforts described above. An example of this model would be the Triple P Project. Not only will the Coalition provide ‘Level 1’ Universal support for this Project, but they will also work within the Coalition to make recommendations of appropriate locations for the parent and child groups. So although the Triple P Project is identified as ‘school based’ and ‘primary care’ based, referrals may be generated from other sources and services may be offered at

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other locations (such as churches or community centers), if the community feels that service delivery in those location will facilitate the best access.

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

The recommended PEI Project, Community Coalitions, is the result of a community-based needs assessment effort spearheaded by VCBH in collaboration with a 44 member PEI Planning Committee, representative of all PEI sectors and the County. The community-based needs assessment involved stakeholders at multiple levels who were identified to participate in the process based on their geographic representation, and representation within the following MHSA categories: age group, community sector, priority populations, and key PEI community mental health needs. The needs assessment was designed to collect both quantitative and qualitative data from various community sources as well from community stakeholders to inform the identification of PEI Projects. Quantitative data included existing data from multiple sources on key indicators representative of the MHSA defined priority populations. Qualitative data included direct input from community stakeholders in the form of 1) key individual interviews; 2) focus groups (area-based and countywide groups with specific populations); 3) Area Work Group data review meetings; and, 4) community forums. Please refer to Form #2 for specific details about the needs assessment program planning process.

The focus of this section will be twofold. First to describe the role stakeholders played at multiple levels in the selection of the Community Coalitions PEI Project; and, second to show how the quantitative and qualitative data collection strategies, analysis, and review process directly informed the selection of the Community Coalitions PEI Project as well as recommended interventions to be implemented as part of the Project.

Stakeholder Input

A countywide grass roots outreach effort was conducted to invite stakeholders to participate in the multilevel PEI Planning process. The 44 member PEI Planning Committee guided the overall planning process and formed area-based Work Groups responsible for reviewing the quantitative and qualitative data collected through the needs assessment and using the corresponding findings to recommend the Community Coalitions PEI Project and related evidence-based intervention models.

To reach the point at which Work Groups were able to review and use data to make PEI project recommendations, other stakeholder input was gathered through a systematic data collection process. Key individual interviews were conducted across the County with 25 stakeholders who were not only identified to participate in the process based on specific demographic and MHSA categories, but also were knowledgeable about a specific community, issue, or problem related to mental health prevention and early intervention. These individuals were asked to provide input on community and mental health needs, age group priorities and priority populations, existing and needed PEI services, and recommendations for providing effective PEI services.

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Focus groups were conducted at two levels: 1) By geographic area of the County (at least two in each area); and, 2) Countywide representing 13 distinct populations: African Americans, Ambulatory Care professionals, Consumers, Deaf and hard of hearing, Developmental disabilities, Pre-K and elementary school students, High school and college students, Faith-based community members, Immigrants and farm workers, Juvenile probation, Older adults, Transitional-age youth, and Veterans. The purpose of the focus groups was to conduct in-depth discussions with different community leaders, gatekeepers and other community members. Participants were selected because they were knowledgeable about their constituency and had insight into community mental health needs and strategies for PEI.

The PEI Planning Committee members also provided input on the types of key data indicators that would supplement, add to, and validate the qualitative findings from the key individual interviews and focus groups. Data were compiled on 46 primary indicators representing and categorized by the priority populations. Examples relevant to Community Coalitions will be provided in the *Data Analysis and Review* section. A complete presentation of the key indicator data compiled can be found in the Key Indicator Data Report in Appendix I.

Once the key indicators and the findings from the key individual interviews and focus groups were compiled, the five PEI Planning Committee Area Work Groups were convened and provided with copies of the Area-based reports along with a presentation of key findings across all three data collection strategies. (Interview and focus group reports are located in Appendix II.) Work groups were asked to react to and comment on the findings presented, as well as asked to use the findings to identify needed PEI services. The needed PEI services identified by each of the five Area Work Groups were compiled and an additional meeting was held with all five Area Work Groups present to review and comment upon the PEI Projects summarized in this report.

One additional level of stakeholder input was sought from community members throughout the County who had not had an opportunity to participate in the PEI Planning Committee, Area Work Groups, key individual interviews, or focus groups. Three Community Forums were held in one of each of three regions: East County, West County, and Santa Clara Valley. These forums were designed to share findings, present the recommended PEI Projects that emerged from the process and obtain additional comments and suggestions on the recommended PEI Projects and their corresponding interventions.

The Community Coalitions Project is one of five PEI Projects recommended as a result of input from stakeholders at multiple levels. The next section describes the community mental health needs, priority populations, and barriers reported by stakeholders that guided the Project selection and recommended interventions.

Data Analysis, Review, and Implications

Based upon findings across the three data collection strategies—key indicators, key individual interviews, and focus groups, Community Coalitions emerged as a vital project to provide several of the most highly recommended and needed PEI services. As shown

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in Table 2, education and outreach to increase awareness of mental health issues and services was the number one most recommended PEI strategy in interviews and countywide focus groups, and the third most recommended strategy in area focus groups. Other highly recommended strategies that the Community Coalitions PEI Project address include services that increase access and collaboration, coordination, and communication amongst mental health providers, law enforcement, schools, social services, community organizations, and faith-based organizations.

**Table 6
Most Frequently Recommended PEI Services**

Key Individual Interviews	Countywide Focus Groups	Area Focus Groups
1. Education, Awareness, and Outreach	1. Education, Awareness, and Outreach	1. Services that Increase Access
2. Services that Increase Access	2. Service Provider Workforce Development and Training	2. School-based Services
3. School-based Services	3. Services that Increase Access	3. Education, Awareness, and Outreach
4. Parent/Family Education and Training	4. Collaborations, Coordination, and Communication	4. Collaborations, Coordination, and Communication
5. Culturally Competent Providers	5. School-based Services	5. Services for Parents and/or Families
6. Service Provider Workforce Development and Training	6. Parent Education and Training	6. Service Provider Workforce Development and Training

These prevention and early intervention services were recommended by stakeholders in order to meet the top prioritized mental health needs, priority populations, and age groups in the County. Key indicator data and interview and focus group discussions regarding the mental health needs in the five geographic regions of Ventura pointed to a significant concern for underserved cultural populations, disparities in access to mental health services, and stigma and discrimination across all age groups.

Underserved cultural populations were highly prioritized for both prevention and early intervention services by participants in interviews and focus groups (see Table 3). Stakeholders frequently commented that it was critical to address underserved cultural populations as they were predominant across the County and most unaware of, or unwilling to access mental health services for cultural reasons. Accordingly, stakeholders also viewed disparities in access to mental health services and stigma and discrimination as top mental health needs, particularly for marginalized populations in the County such as Latino/Hispanic families, immigrants, and farm workers.

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**Table 7
Top Priority Populations**

Key Individual Interviews	Countywide Focus Groups	Area Focus Groups
1. Children and Youth in Stressed Families	1. Children and Youth in Stressed Families	1. Children and Youth in Stressed Families
2. Underserved Cultural Populations	2. Underserved Cultural Populations	2. Children At-risk for School Failure
3. Individuals Experiencing the Onset of Serious Psychiatric Illness	3. Children At-risk for School Failure	3. Underserved Cultural Populations
4. Children At-risk for School Failure	4. Trauma-exposed	4. Children and Youth At-risk of or Experiencing Juvenile Justice Involvement
5. Children and Youth At-risk of or Experiencing Juvenile Justice Involvement	5. Individuals Experiencing the Onset of Serious Psychiatric Illness	5. Trauma-exposed
6. Trauma-exposed	6. Children and Youth At-risk of or Experiencing Juvenile Justice Involvement	6. Individuals Experiencing the Onset of Serious Psychiatric Illness

Key indicator data show that Latinos/Hispanics are by far the largest racial/ethnic minority group in Ventura County, comprising 33% of the total population. However, in some areas of the County, Latinos/Hispanics make up as much as 70% of the population. Similarly, 26% of the countywide population primarily speaks Spanish in their homes, with the number of primarily Spanish-speakers rising to 55% in some areas of the County. In addition, there are a substantial number of residents who are migrant workers/farm workers and not included in the above-mentioned Census 2000 figures. Although it is difficult to estimate the size of the migrant population due to its nature, the number of youth in schools classified as migrant students can shed some light. In the 2007-2008 academic years, there were approximately 11,000 migrant students in the County. Furthermore, one quarter of the students in one area of the County was migrant students.

Another racial/ethnic group which is growing is the Asian Pacific Islander (API) community, making up 5% of the population in the county. In Oxnard, this group makes up 8% of the population, with 7% in Camarillo and Port Hueneme and 6% in the east county cities of Simi Valley, Moorpark, Thousand Oaks and Westlake Village (Appendix I, page 4). Also, 4% of county residents speak an API language, with the highest percentages in Oxnard, Camarillo and Port Hueneme (6%, 5% and 5%, respectively). Ensuring that PEI implementation is culturally and linguistically appropriate to the API community will be a responsibility of the Department.

According to stakeholders in interviews and focus groups, these underserved cultural populations are highly in need of prevention and early intervention services. It was reported that negative mental health outcomes, such as depression and substance abuse, are more pervasive in marginalized populations due to the disparities in access to mental health services and the cultural stigma associated with mental health treatment.

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During interviews and focus group, stakeholders overwhelmingly pointed out the limited access to mental health services across the County, citing the following barriers to accessing services: lack of services available (particularly bilingual and bicultural services), stigma and discrimination, lack of awareness of mental health issues and services, and lack of communication, coordination and collaboration amongst providers. Stakeholders discussed the challenges many Latino/Hispanic and Mixteco community members faced acknowledging and understanding mental health issues. In addition, when they do wish to seek mental health services, Latino/Hispanic and Mixteco populations are often unaware of services available, encounter language barriers, and have difficulties navigating the system.

As indicated above, the language spoken by mental health providers may limit access and contribute to stigma as those who try to access services and are not able to find a provider in their language may feel stigmatized and discriminated against. Only 21% of the managed health care providers who contract with Ventura County Behavioral Health speak a language other than English. According to the Ventura County's Workforce Education and Training (WET) estimate, more Spanish-speaking mental health work force members are needed across the county. In 2008, it was estimated that 74 additional direct service personnel proficient in Spanish were needed to fill the 35% gap in need. Stakeholders suggested partnerships and collaborations with community organizations to help address language barriers, provide information about PEI services in native languages, coordinate referrals, and facilitate participation in prevention and early intervention services with underserved cultural populations, as well as the community at large.

In addition to language barriers, the cultural stigma associated with mental health and the lack of awareness about mental health issues and services are noteworthy considerations for underserved cultural populations. Stakeholders emphasized that many Latino/Hispanic community members would not seek services due to the shame associated with mental illness in their culture, lack of understanding of what mental health is, and fear and distrust of other individuals/organizations outside of their culture.

To overcome these barriers and meet the needs of underserved cultural populations, stakeholders recommended culturally and linguistically sensitive outreach and education to increase awareness of mental health overall, as well as awareness of mental health services and resources in the community. They emphasized the need for outreach to engage and meet community members in their "comfort zone" such as in schools, homes, churches, and community organizations. In addition, they suggested partnerships with community and faith-based organizations because outreach and education provided by trusted community leaders and entities would be most effective for underserved cultural populations.

Overall, the Community Collaborations PEI Project was considered best suited to address stigma and discrimination and disparities in access to services, particularly for underserved cultural populations, due to its ability to:

- Be tailored to specific community needs and resources in each area of the County;

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- Engage community members in locations and ways that are comfortable and non-threatening to community members;
- Provide culturally and linguistically appropriate outreach to help overcome the stigma and discrimination associated with mental health;
- Educate community members about mental health through positive, non-stigmatizing materials and mediums; and
- Increase awareness of existing mental health services and resources;
- Facilitate participation in prevention activities; and,
- Increase access to early intervention services through coordinated referral procedures.

Using the findings from stakeholder input, the PEI Planning Committee Area Work Groups were able to identify the Community Coalitions PEI Project as an appropriate and needed approach to addressing the mental health needs of children, transition-age youth, adults and older adults. Similarly, the mental health needs that emerged from the findings directly implied the need for interventions that increase engagement and outreach, overcome stigma, coordinate referrals, and increase education and awareness about risk and protective factors, as well as services. It is of particular importance that Community Coalitions are tailored to community needs. Therefore, selected interventions may include Promotores, faith-based clergy council activities, and/or screening and referral activities dependent upon the needs and resources indicative of each area of the County.

3. PEI Project Description:

Community Coalitions

The Community Coalitions program is primarily responsive to the overwhelming priority, as identified by the community planning process, to increase awareness and education about the need for, and availability of, respectful and effective mental health prevention and early intervention services. Moreover, that education and outreach be provided in a manner that is sensitive to the needs of Ventura County's ethnically/culturally diverse communities and reduces stigma and access barriers.

This project is intended to consist of 4-6 "grassroots" coalitions each of which will be funded to provide education and outreach specific to the needs for their local community. These coalitions will consist of local collaborative groups (for example, local faith and civic organizations, schools, social service and mental health agencies, law enforcement) that are committed and prepared to develop educational materials and execute a range of outreach activities to (1) inform their local community about mental health issues, (2) reduce stigma, (3) facilitate participation in universal and selective prevention activities, (4) increase access to early intervention services, and (5) coordinate referral activities.

Community coalitions will function as a foundation for the other 4 proposed PEI projects, and each coalition will be expected to promote the five goals listed above. All coalition activities are universal and selective prevention in nature. Moreover, the coalitions, among other things, will all be expected to incorporate and make use of universal prevention educational materials that are a part of three specific intervention models associated with several of the

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other projects (Triple P Parenting Level 1, Early Detection and Intervention for the Prevention of Psychosis, Improving Mood Promoting Access to Collaborative Treatment) discussed in greater length under the relevant PEI projects.

PEI resources will be used primarily as “seed” funding to support and enhance the work of the community coalitions, with the expectations that the coalitions will expand and sustain their education and outreach work through coordination with other local initiatives and volunteerism.

Additionally, in order to advance coordinated referrals, the Children’s Outreach and Engagement Project (Work plan 3) will be transferred from Community Services and Supports to PEI - Project Plan 1, Community Coalitions. This CSS project currently provides the outreach and education activities within specific un- and underserved communities that is in keeping with the goals of both PEI and this recommended Community Coalition project. As this CSS project evolved, it became apparent that the activities and individuals served fell into the categories of selective prevention and early identification of children at risk for key mental health indicators. In this way, increased integration of services and supports is achieved.

Similar to the Children’s Outreach and Engagement Projects, Community Coalitions will be funded to support other specific un/underserved populations, to ensure PEI project implementation in a manner that addresses the unique needs and ensures participation of traditionally un/under served groups. Coalitions specific to the Asian Pacific Islander (API), Deaf and Hard of Hearing (DHH) and Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) communities are examples. The goal of the these coalitions will be to work with the regional coalitions to ensure design of culturally and linguistically appropriate materials and strategies to effectively implement the various PEI projects within each group. While established as stand alone coalitions, these cultural specific coalitions will also ensure representation and participation of their constituency at the regional community coalition level, in order to promote integration of culturally specific approaches to PEI implementation.

For example, at each of the community forums, “Staff who speak other languages” was cited as one of the most important factors for families in making a decision about using PEI services. At the Santa Paula forum, as expected, Spanish was the most frequent language cited (63%), but a significant need was also expressed for staff who speak Mixteco (19%), Vietnamese (19%), American Sign Language (13%), Cantonese (6%) and Tagalog (6%) (Appendix IV, page 10). There were similar results at the other two forums, in Simi Valley and Oxnard. Culturally specific coalitions will play a critical role in ensuring the recruitment and hiring of Project staff that reflect the different language and cultural needs of the various communities targeted for PEI implementation.

Per direction provided by the PEI Planning Committee, community coalitions will be selected from within targeted communities, based on a combination of need (as indicated by a significant gap between mental health needs in the community and access to/use of mental health services) and the readiness of the collaborative (as indicated by the strength of collaborative development and linkage to the target community) to successfully carryout and sustain the education and outreach activities.

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The geographical boundaries for communities, under this initiative, will correspond to the Neighborhoods for Learning. Neighborhoods for Learning is a countywide initiative, spearheaded by First 5 Ventura County, involving parents, schools, early childhood educators, and service providers working together to offer a web of support for young children and families designed by and for each community (see www.first5ventura.org/parents-caregivers/neighborhoods-for-learning). The county is divided into eleven Neighborhoods for Learning that is inclusive of all regions of the county. Each Neighborhood for Learning's geographical boundaries conforms to the boundaries of a school district or group of districts. The Neighborhoods for Learning were developed after extensive community planning and involve a web of health, dental, mental health and early childhood education services, coordinated through regional resource centers.

VCBH will fund Community Coalitions based on a competitive bidding process. This is consistent with direction given by the PEI Planning Committee, based on their appreciation that the PEI resources are limited, and that the intent be that those coalitions that are selected have sufficient funding to be effective.

Successful respondents will need to meet the following conditions: (1) Partner with Neighborhoods for Learning, and other local civic and faith organizations, school districts, city municipalities, service providers and county agencies to ensure responsiveness, ownership, and sustainability. (2) Develop plans specific to the needs of un- and underserved ethnic and cultural populations specific to their communities. (3) Include participation and direction from local community leaders who are members of the targeted underserved communities. (4) Demonstrate clear strategies for carrying out education and outreach activities. (5) Demonstrate viable strategies for sustainability.

Other than incorporating educational materials associated with the three intervention models noted above, coalitions will be encouraged to develop strategies that are uniquely suited to their respective communities, for example, a Promotores program or similar model for reaching out to underserved populations. These strategies will be documented and their impacts, in terms of increased access to use of selective prevention and early intervention services, will be monitored.

Although each coalition will develop educational materials and carry out a range of outreach activities, the nature of those activities is not being prescribed in advance; rather creativity is being encouraged so that coalitions can be highly responsive to their respective communities, with direction being provided by local leaders representing underserved ethnic groups. Priority groups include migrant farm workers, first generation immigrants from Mexico, and Mixteco populations. However, key milestones for all coalitions are as follows:

- A process for requesting and selecting coalitions will be established
- 4-6 community coalitions will be selected and funded based on criteria described above
- Community coalitions will develop educational information including, but not limited to, material associated with the 3 specified universal prevention models (Triple P, EDIPP, IMPACT)

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- Outreach activities will be implemented, specific to each community coalition, and may include community events/fairs, training (for teachers, primary care centers, resources centers), media campaign (newsletters, newspaper articles, television and radio spots), and so forth
- Outreach activities will be documented by VCBH along with impact on access to and use of selective prevention and early intervention services, as established under PEI Projects 2-5.

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	
Community Coalitions	Individuals: 5,000 Families: 2,500	Individuals: Families:	12
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 5,000 Families: 2,500	Individuals: Families:	12

**Community Coalition activities are entirely universal and selective prevention in nature. The number of individuals and families who will be exposed to educational materials and outreach activities is expected to be quite high. The proposed numbers are based on the conservative assumption that 10 individuals will be affected by the coalitions work for every individual who receives an early intervention under one of the four projects.*

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

The Community Coalitions will serve as the foundation for the other 4 PEI projects, and dovetail with the Neighborhoods for Learning, and the larger mental health and social services system, encompassing both formal and informal services and supports. Coalitions will be expected to increase help seeking on the part of individuals and families, and reduce access barriers, such that access to and use of both formal and informal services and supports will be enhanced.

The nature of the linkages between each of the coalitions and the larger service system will vary in accordance with constituents of each coalition and the needs and resources of their community. However, in every case, formal referral structures will be in place to ensure that individuals in need of treatment level services will have access to the full range of opportunities under the VCBH Mental Health Plan and Full Service Partnership programs. This will largely be accomplished through the work of the Children’s Outreach and Engagement Project and VCBH’s newly established STAR program that is responsible for

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coordinating, streamlining and facilitating countywide triage, assessment, referral and linkage to ensure that all VCBH resources are optimally managed.

6. Collaboration and System Enhancements

Community Coalitions will, in every case, build upon and enhance existing, local community collaborative structures, including but not limited to the Neighborhoods for Learning. All coalitions will be expected to develop strategies to sustain and expand education and outreach activities through coordination with related initiatives (current and future) and through the resources of their collaborative partners and volunteerism.

7. Intended Outcomes

Community coalitions are expected to engage local communities, through collaborative efforts, to embrace mental health promotion, as a local community responsibility, and in turn to engage in strategic education and outreach activities that reduce stigma, and increase protective factors, help seeking and access to formal and informal services and supports. Specific intended outcomes include:

- Inform their local community about mental health issues
- Reduce stigma and other barriers to seeking and receiving services and supports
- Facilitate participation in universal and selective prevention activities
- Increase access to early intervention services
- Coordinate referral activities

8. Coordination with Other MHSA Components

Formal referral structures will be in place to ensure that individuals in need of treatment level services will have access to Full Service Partnership programs when appropriate.

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PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: **Ventura** Date: June 9, 2009
 PEI Project Name: **1. Community Coalitions**
 Provider Name (if known): **Various (See Below)**
 Intended Provider Category: **Ethnic or Cultural Organization**
 Proposed Total Number of Individuals to be served: FY 09-10 5000
 Total Number of Individuals currently being served: FY 09-10 _____
 Total Number of Individuals to be served through PEI Expansion: FY 09-10 5000
 Months of Operation: FY 09-10 12

Proposed Expenses and Revenues		Total Program/PEI Project Budget		
		FY 09-10		Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages	TBD	\$44,079	\$0	\$44,079
		\$0	\$0	\$0
b. Benefits and Taxes @	44%	\$19,615	\$0	\$19,615
c. Total Personnel Expenditures		\$63,694	\$0	\$63,694
2. Operating Expenditures				
a. Facility Cost	8%	\$5,096	\$0	\$5,096
b. Other Operating Expenses	49%	\$31,210	\$0	\$31,210
c. Total Operating Expenses		\$36,306	\$0	\$36,306
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
a-1	Children's Outreach & Engagement	\$150,000	\$0	\$150,000
a-2	Education, Awareness & Collaboration	\$350,000	\$0	\$350,000
a-2	Training	\$22,000	\$0	\$22,000
a. Total Subcontracts		\$522,000	\$0	\$522,000
4. Total Proposed PEI Project Budget		\$622,000	\$0	\$622,000
B. Revenues (list/itemize by fund source)				
			\$0	\$0
1. Total Revenue		\$0	\$0	\$0
5. Total Funding Requested for PEI Project		\$622,000	\$0	\$622,000
6. Total In-Kind Contributions		\$0	\$0	\$0

FORM NO. 4 (cont)

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CONTRACTOR (a-1)

1) Boys & Girls Club	\$50,000
2) Guadalupe Church	\$50,000
3) St. Paul Baptist Church	<u>\$50,000</u>
	<u>\$150,000</u>

CONTRACTOR (a-2)

1) TBD	<u>\$350,000</u>
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CONTRACTOR (a-3)

1) TBD	<u>\$22,000</u>
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**BUDGET NARRATIVE
PEI Project #1 – Community Coalitions**

ESTIMATED PERSONNEL

Costs for salaries and wages amount to **\$63,694**. This includes:

a. Behavioral Health Clinician - .62 FTE at \$44,079

This position would serve on the county's Screening, Triage, Assessment and Referral (STAR) program, which acts as the portal of entry for individuals entering the traditional VCBH service delivery system, and would provide STAR services to those individuals referred to PEI programs.

b. Employee Benefits

Benefits and Taxes. Benefits are estimated at **\$19,615** and include FICA, health and dental coverage, SDI, workers compensation insurance, state and federal payroll taxes.

OPERATING EXPENSES

Total Operating Expenses amount to **\$36,306**:

a. Facility Cost. \$5,096

b. Other Operating Expenses. Other operating expenses are estimated at **\$31,210** and include costs for office supplies, program supplies, equipment, travel/mileage, and computers/printers for staff. These Operating Expenditures include non-recurring, start up expenses. Once projects are fully implemented, we expect the operating expenditures percentage to be reduced from 49% to 34% or less.

SUBCONTRACTS/PROFESSIONAL SERVICES

a. Children's Outreach and Engagement - \$150,000. This represents costs for contracts with community based organizations to provide outreach and engagement to children at risk of key mental health indicators in the un/under served regions of Santa Paula, Fillmore and Oxnard. This program is being moved to PEI from Community Services and Supports.

b. Education, Awareness and Collaboration - \$350,000. This represents contracts for community coalitions that will be responsible to provide outreach and engagement activities targeted to local communities in support of the other PEI projects. This includes responsibility for the universal prevention components of several projects, including Triple P Parenting Level 1, Early Detection and Intervention for the Prevention of Psychosis, Improving Mood Promoting Access to Collaborative Treatment.

c. Training - \$22,000. This includes funding for technical assistance and training of the community coalitions, including training in the implementation of the universal prevention components described above.

TOTAL FUNDING REQUESTED FOR PEI PROJECT - \$622,000. There are no other revenues.

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County: Ventura

PEI Project Name: Primary Care Services

Date: June 2009

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	X	X	X	X
2. Psycho-Social Impact of Trauma	X	X	X	X
3. At-Risk Children, Youth and Young Adult Populations				
4. Stigma and Discrimination	X	X	X	X
5. Suicide Risk		X	X	X

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

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

The recommended PEI Project, Primary Care Services, is the result of a community-based needs assessment effort spearheaded by the VCBH in collaboration with a 44 member PEI Planning Committee, representative of all PEI sectors and the County. The community-based needs assessment involved stakeholders at multiple levels who were identified to participate in the process based on their geographic representation, and representation within the following MHSA categories: age group, community sector, priority populations, and key PEI community mental health needs. The needs assessment was designed to collect both quantitative and qualitative data from various community sources as well from community stakeholders to inform the identification of PEI Projects. Quantitative data included existing data from multiple sources on key data indicators representative of the MHSA defined priority populations. Qualitative data included direct input from community stakeholders in the form of 1) key individual interviews; 2) focus groups (area-based and countywide groups with specific populations); 3) Area Work Group data review meetings; and, 4) community forums. Please refer to Form #2 for specific details about the needs assessment program planning process.

The focus of this section will be twofold. First to describe the role stakeholders played at multiple levels in the selection of the Primary Care Services PEI Project; and, second to show how the quantitative and qualitative data collection strategies, analysis, and review process directly informed the selection of the Primary Care Services PEI Project as well as the recommended interventions to be implemented as part of the Project.

Stakeholder Input

A countywide grass roots outreach effort was conducted to invite stakeholder participation in the PEI Planning process at multiple levels. The 44 member PEI Planning Committee guided the overall planning process and formed area-based Work Groups responsible for reviewing the quantitative and qualitative data collected through the needs assessment and use those findings to recommend the Primary Care Services PEI Project and select the evidence-based intervention models corresponding to community needs and populations.

To reach the point at which Work Groups were able to review and use data to make PEI project recommendations, other stakeholder input was gathered through a systematic data collection process. Key individual interviews were conducted across the County with 25 stakeholders who were not only identified to participate in the process based on specific demographic and MHSA categories, but also were knowledgeable about a specific community, issue, or problem related to mental health prevention and early intervention. These individuals were asked to provide input on community and mental health needs, age group priorities and priority populations, existing and needed PEI services, and recommendations for providing effective PEI services.

Focus groups were conducted at two levels: 1) By geographic area of the County (at least two in each area); and, 2) Countywide representing 13 distinct populations: African Americans, ambulatory care professionals, consumers, deaf and hard of hearing,

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developmental disabilities, pre-K and elementary school students, high school and college students, faith-based community members, immigrants and farm workers, juvenile probation, older adults, transitional-age youth, and veterans. The purpose of the focus groups was to conduct in-depth discussions with different community leaders, gatekeepers and other community members. Participants were selected because they were knowledgeable about their constituency and had insight into community mental health needs and strategies for PEI.

The PEI Planning Committee members also provided input on the types of key data indicators that would supplement, add to, and validate the qualitative findings from the key individual interviews and focus groups. Quantitative data were compiled on 46 primary indicators representing and categorized by the priority populations. Examples relevant to Primary Care Services will be provided in the *Data Analysis and Review* section. A complete presentation of the key indicator data compiled can be found in the Key Indicator Data Report in Appendix I.

Once the key indicators and the findings from the key individual interviews and focus groups were compiled, the five PEI Planning Committee Area Work Groups were convened and provided with copies of the Area-based reports along with a presentation of key findings across all three data collection strategies. (Interview and focus group reports are located in Appendix II.) Work groups were asked to react to and comment on the findings presented, as well as asked to use the findings to identify needed PEI services. The needed PEI services identified by each of the five Area Work Groups were compiled and an additional meeting was held with all five Area Work Groups present to review and comment upon the PEI Projects summarized in this report.

One additional level of stakeholder input was sought from community members throughout the County. Three Community Forums were held in one of each of three regions: East County, West County, and Santa Clara Valley. These forums were designed to share the needs assessment findings, present the recommended PEI Projects that emerged from the process, and obtain additional comments and suggestions on the recommended PEI Projects and their corresponding interventions.

The Primary Care Services PEI Project is one of five PEI Projects recommended as a result of input from stakeholders at multiple levels. The next section describes the community mental health needs, priority populations, and barriers reported by stakeholders that guided the Project selection and recommended interventions.

Data Analysis and Review

Based upon findings across the three data collection strategies—key indicators, key individual interviews, and focus groups—Primary Care Services emerged as a highly recommended project for Ventura County. Primary Care Services are a vital means of addressing the mental health needs and priority populations emphasized by community stakeholders. Key indicator data and interview and focus group discussions in the five geographic regions of Ventura County highlighted the need to reduce disparities in access to mental health services, stigma and discrimination, the psycho-social impact of trauma, and suicide risk, by making prevention and early intervention services available and

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accessible in non stigmatizing settings for all age groups, with an emphasis on underserved cultural populations, trauma-exposed individuals, and those experiencing the onset of serious psychiatric illness.

**Table 8
Prioritized Mental Health Needs**

Key Individual Interviews	Countywide Focus Groups	Area Focus Groups
1. At-risk Children, Youth, and Young Adult Populations	1. Disparities in Access to Mental Health Services	1. At-risk Children, Youth, and Young Adult Populations
2. Disparities in Access to Mental Health Services	2. At-risk Children, Youth, and Young Adult Populations	2. Disparities in Access to Mental Health Services
3. Stigma and Discrimination	3. Stigma and Discrimination	3. Psycho-social Impact of Trauma
4. Psycho-social Impact of Trauma	4. Psycho-social Impact of Trauma	4. Suicide Risk
5. Suicide Risk	5. Suicide Risk	5. Stigma and Discrimination

As shown in Table 4, the need to reduce disparities in access to mental health services, as well as stigma and discrimination consistently emerged as a top priority among interviewees and focus group participants. Specifically, stakeholders emphasized the dearth of services in Ventura County that address the mental health needs of all age groups. Furthermore, stakeholders noted that those services that do exist do not have the capacity to meet the high demand across the County, which leaves those in need of mental health services vulnerable to escalating and exacerbated mental health issues. According to interviewees and focus group participants, those particularly at-risk of exacerbated mental health issues are the underserved cultural populations.

As noted in Table 3 in the Community Coalitions section, underserved cultural populations were highly prioritized for both prevention and early intervention services across stakeholders in interviews and focus groups. Stakeholders also noted a high need to increase knowledge about mental health as a means of reducing stigma and increasing access. Among the underserved in general, there is a lack of understanding of what mental health is and what it means to be emotionally healthy, as well as an uneasiness and unwillingness to access services for cultural reasons. It was reported that this issue is acute among the Latino community, especially the Mixteco community and migrant farm workers. (Key indicator data presented in the Community Coalitions section show the estimated number of families represented by this particular group.) Other underserved cultural populations mentioned during interviews and focus group discussions included the deaf and hard of hearing community, African Americans, the developmentally disabled, and veterans.

As part of addressing the needs of the underserved cultural populations, key indicator data and interview and focus group discussions emphasized a high need for prevention and early intervention services that address trauma-exposure and suicide risk across age groups. Key indicator data show that almost one-third of Ventura County households are living at or below the 200 percent poverty level. According to interview and focus groups discussions, financial hardship and living in sub-standard conditions puts families at-risk of domestic and community violence, divorce (sometimes due to deportation), depression, and suicide, resulting in the need for services to address these mental health issues.

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Key indicator data also provide further evidence of trauma-exposure among children and older adults. In 2008, 8,139 child abuse referrals were made, with two areas of Ventura County representing 21 percent and 45 percent of those referrals. Furthermore, the percentage of children removed from their homes or in foster care ranged from 3 to 40 percent across the five geographic areas of Ventura County. As a consequence of these conditions, interviewees and focus group participants reported a rising number of children and youth who are acting out and displaying disruptive behaviors. It also was reported that children and youth are exhibiting the signs of depressed mood, showing evidence of self-harm such as cutting, and attempting suicide. These mental health concerns among children and youth also suggest the need to provide parents with the tools they need to address and manage associated issues that emerge among their children such as poor academic performance, troublesome behaviors, and inappropriate emotional responses.

With respect to older adults, among the reported cases of abuse perpetrated on older adults and adults in Ventura County in 2008, 41 and 24 percent of those cases represented two of the five County geographic areas. In focus group discussions, participants reported that older adults were particularly vulnerable to trauma from financial, physical, and emotional scams and abuse. Vulnerability to trauma was coupled with indicators of suicide risk such as feelings of isolation, loneliness, and depression.

Another aspect of Primary Care Services considered by stakeholders to be key to meeting the mental health needs and priority populations discussed above is collaboration, coordination, and communication between primary care and mental health providers. Stakeholders in interviews and focus groups pointed out that a closer working relationship between health and mental health providers would foster distribution of educational materials, targeted screenings and assessments, better patient tracking, comprehensive service plans, increased referrals and referral coordination, and coordinated medication management.

Given the findings discussed above, Primary Care Services was considered to be well-positioned to respond to disparities in access, stigma and discrimination, the psycho-social impact of trauma and suicide risk, and to meet these needs across age groups and underserved cultural populations, such as the Latino migrant workers, the deaf and hard of hearing, African Americans, individuals with disabilities, and veterans by:

- Serving as an easily accessible and non-stigmatizing service location for all age groups;
- Serving as a place where early detection of mental health issues can occur;
- Promoting continuity of care;
- Identifying and addressing trauma, depression, and problem behaviors before they lead to negative outcomes;
- Providing the ability to acquire treatment and medication for health and mental health concerns in one location;
- Increasing the level of collaboration, coordination, and communication between health and mental health providers; and,

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- Establishing the potential for multi-disciplinary teams that might include law enforcement, Child Protective Services, teachers, among others, in addition to the health and mental health providers.

Using the findings from stakeholder input the PEI Planning Committee Area Work Groups were able to identify the Primary Care Services PEI Project as an appropriate and needed approach to addressing the mental health needs of individuals across age groups. Similarly, the mental health needs that emerged from the findings directly call for interventions focusing on trauma, depression, and providing parents with the skills they need to address disruptive behavior among their children, all of which led to five recommended evidence-based interventions: Depression Treatment Quality Improvement (DTQI), Improving Mood Promoting Access to Collaborative Treatment (IMPACT, specifically designed for older adults), Trauma Focused Cognitive Behavior Therapy (TFCBT), Prolonged Exposure Therapy for PTSD, and Triple P Parenting (PPP). These interventions will be discussed in detail in the following sections.

3. PEI Project Description:

Primary Care Project

The Primary Care Project is specifically responsive to the priority, as identified by the community planning process, to make prevention and early intervention services, targeting individuals of all age groups, readily available and accessible in non-stigmatizing settings. In keeping with the areas of greatest need, this project will primarily support selective prevention and early intervention services targeting depression and trauma experienced across the age span, and secondarily support selective prevention services for children with disruptive behaviors.

Integration with primary care centers was prioritized, based on extensive feedback from participants in the community forums and key informant interviews, because it is viewed as less stigmatizing and more accessible, in particular for individuals and families who have recently emigrated from Mexico, which constitute a significant underserved population in the County. Providing selective prevention and early intervention services in primary care settings is one key strategy, in addition to the work of the community coalitions, to reduce stigma and disparities in access.

Primary Care services will be provided by two teams of practitioners (Psychiatric Social Worker IVs), composed of county and/or private organizational provider(s), dedicated to serving adults/older adults and TAY/children populations, respectively. These PEI Primary Care service teams will be trained in evidence-based intervention models (as described below) and assigned to county and community partner primary care clinics that predominately serve the health needs of low income adults, children and families, and that are located in communities with elevated levels of need.

In every case, the PEI Primary Care service teams will be fully integrated into the primary care clinics, and support a set of interrelated selective prevention and early intervention activities. These activities will be modeled after the Improving Mood, Promoting Access to

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Collaborative Treatment (IMPACT). This model, which targets depression in older adults, involves the use of educational materials, screening, assessment, and intervention. In the case of the IMPACT model, educational materials are designed to inform individuals about elder depression, reduce stigma and increase self-referrals. The IMPACT practitioners complete screenings, and when indicated assessment and intervention. Treatment services include an evidence-based cognitive-behavioral intervention for depression specifically designed for older adults coupled with coordinated medication treatment provided by the individual's primary care physician with consultation from the IMPACT practitioners and psychiatrist.

Using the same key elements, the Adult Primary Care Service Team will develop educational materials, and provide screening, assessment and treatment, for adults with depression, and adults and older adults with trauma. Coordination with primary care medical staff will occur as in the IMPACT model. The service team will be cross-trained in IMPACT (for older adult depression), Depression Treatment Quality Improvement—DTQI (for adult depression), and Prolonged Exposure for Therapy for PTSD (for adult and older adult trauma).

The Child Primary Care Service Team will provide educational materials, screening, assessment and coordinated treatment for depression and trauma. The service team will be cross-trained in DTQI (for adolescent depression) and Trauma Focused Cognitive Behavior Therapy—TF-CBT (for child trauma). The child service team will additionally be prepared to provide these services in school settings, in coordination with school staff (described further under the School-Based Project).

Finally, the service team and primary care medical staff will be trained in the use of a brief parenting intervention (Triple P Level 2 which is discussed further under the Parenting Project) targeting mild disruptive behavior concerns in children.

Each of the proposed intervention models is evidence-based, having demonstrated effectiveness in clinical research trials. Brief descriptions of the primary care intervention models are as follows:

Improving Mood, Promoting Access to Collaborative Treatment (IMPACT)

Improving Mood, Promoting Access to Collaborative Treatment (IMPACT)—A selective prevention and early treatment intervention for late-life depression including an educational campaign, screening/assessment, and treatment integrated into primary care settings. Key components include:

- Educational information on late-life depression
- Short assessment
- Behavioral activation therapy
- Antidepressant algorithm (provided by primary care physician with consultation from IMPACT team psychiatrist)
- Problem Solving Therapy (6-8 sessions in duration)

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Depression Treatment Quality Improvement (DTQI)

Depression Treatment Quality Improvement (DTQI)—An intervention model for depression in adolescents and adults that will be enhanced with IMPACT style educational materials and coordination with primary care medical staff. Key components of the DTQI model include:

- Evaluation—screening and assessment of depression and co-morbid conditions and problems
- Psychosocial Treatment—manualized cognitive behavior therapy using individual, group or family-based formats (12-20 sessions in duration)
- Environmental Risk and Protective Factors—adjustments to choice and implementation of treatment strategies based on risk and protective factors
- Symptom and Outcomes Monitoring—ongoing monitoring of symptoms/outcomes to inform treatment delivery
- Crisis Management—management of therapy threatening behaviors including suicidal behavior, cutting, drug and alcohol use, family crisis, removal from home, change in living situation, abuse and victimization
- Relapse Prevention and After Care—development and practice of relapse plans, and development for treatment after CBT is completed
- Coordination with Psychiatry—regular communication with treating psychiatrist, use of current research-based medication practices for treating depression in adolescents and adults

Prolonged Exposure Therapy for PTSD

Prolonged Exposure Therapy for PTSD—An intervention model for adults showing PTSD from single or multiple episode(s) of trauma that will be enhanced with IMPACT style educational materials and coordination with primary care medical staff. Key components of the model include:

- Individual therapy sessions (1-2 contacts per week totaling 8-15 sessions)
- Psycho-education, imaginal exposure and in vivo exposure.

Trauma Focused Cognitive Behavior Therapy (TF-CBT)

Trauma Focused Cognitive Behavior Therapy (TF-CBT)—An intervention model for children (ages 4-18) with difficulties related to traumatic events that will be enhanced with IMPACT style educational materials and coordination with primary care medical staff. Key components include:

- Weekly sessions (12-16 in duration) with child and caregiver individually and together
- Psycho-education
- Relaxation and stress management
- Emotional regulation
- Connecting thoughts-feelings and behaviors
- Gradual in vivo exposure
- Cognitive and affective processing of trauma experiences
- Personal safety and skills training.

The Adult Primary Care Service Team will be composed of 8 clinicians and consulting psychiatrist. The clinicians will be cross trained in IMPACT, DTQI and Prolonged Exposure Therapy for PTSD and be prepared to work with adults and older adults with

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depression and/or trauma. The clinicians will work in pairs. Each pair will be responsible for two primary care clinics. In total, PEI Primary Care Services for adults will be available in 8 primary care clinics.

The Child Primary Care Service Team will be composed of 2 clinicians and consulting psychiatrist. The clinicians will be cross trained in DTQI and TF-CBT and be prepared to work with children and transition age youth with depression and/or trauma. The child clinicians will work in coordination with the adult clinicians and be assigned to the same 8 primary care clinics. In addition, child clinicians will be available to provide these interventions, as needed, in coordination with school-based services (described below).

Selective prevention materials, including brochures, articles for newsletters, and video vignettes will all be available in the lobbies of the 8 primary care clinics. In addition, these materials will be incorporated into the work of the Community Coalitions. It is anticipated that the 8 adult clinicians will provide depression and trauma intervention to about 360 adults and older adults per year, and that the 6 child clinicians will provide depression and trauma intervention to 90 children and transition age youth per year in the primary care clinics (and another 180 children through school based programs).

Clinics will be selected based on level of the unmet need and readiness to support an integrated mental health teams.

Key milestones are as follows:

- Establishing primary care service teams and developing formal collaborative structures with primary care staff
- Developing and implementing educational materials
- Coordinating with Community Coalitions to enhance educational campaign
- Complete training in each of the intervention models for the adult/older adult and child/TAY service teams respectively
- Initiate intervention models

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4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
IMPACT	Individuals:1,200	Individuals:120	12
DTQI	Individuals:1,650	Individuals: 165	12
Prolonged Exposure Therapy for PTSD	Individuals:1,200	Individuals: 120	12
TF-CBT	Individuals:450	Individuals: 45	12
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 4,500	Individuals: 450	

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

Community members receiving PEI services under the Primary Care project will have access to the full array of services available through VCBH. Formal referral channels to the VCBH Mental Health Plan will be established. Moreover, through this project coordination with primary care health services will be greatly enhanced. Finally, the Primary Care service teams will be prepared to provide referrals to formal and/or informal services for mental health or other needed services as indicated.

6. Collaboration and System Enhancements

The Primary Care project is inherently collaborative, building upon and partnering with primary care clinics. In this way, PEI services will be easily accessible, linked with health care, and less stigmatizing. As previously noted, the educational campaign components of the project will be expanded through the work of the Community Coalitions.

VCBH will leverage Medi-Cal and EPSDT funding for Primary Care intervention services when appropriate, which is important for sustaining these activities.

7. Intended Outcomes

Primary Care services are expected to reduce stigma, and increase help seeking and access to early and proven intervention models for depression and trauma across the age span. Specific intended outcomes include:

- Increased access to early intervention services for depression and trauma (all ages_
- Increased interagency collaboration to meet the Prevention and Early Intervention needs of the community (all ages)
- Reduced severity of post traumatic symptoms (all ages)
- Reduced severity of depressive symptoms (transition age youth, adult, older adult)
- Reduced suicide attempts (transition age youth, adult, older adult)
- Improved level of functioning and quality of life (all ages)

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8. Coordination with Other MHSA Components

Formal referral structures will be in place to ensure that individuals in need of more extensive treatment level services will have access to Full Service Partnership programs when appropriate.

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PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name:	Ventura	Date:	<u>June 9, 2009</u>
PEI Project Name:	2. Primary Care Services		
Provider Name (if known):	Various (See Below)		
Intended Provider Category:	Primary Health Care		
Proposed Total Number of Individuals to be served:		FY 09-10	450
Total Number of Individuals currently being served:		FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:		FY 09-10	450
	Months of Operation:	FY 09-10	12

Proposed Expenses and Revenues		Total Program/PEI Project Budget		
		FY 09-10		Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
Psy Social Worker IV	10.00	\$714,630	\$0	\$714,630
BH Clinic Administrator III	.67	\$62,400	\$0	\$62,400
Office Assistant IV	.67	\$29,053	\$0	\$29,053
b. Benefits and Taxes @ 44%	44%	\$358,706	\$0	\$358,706
c. Total Personnel Expenditures	16.00	\$1,164,789	\$0	\$1,164,789
2. Operating Expenditures				
a. Facility Cost	8%	\$93,183	\$0	\$93,183
b. Other Operating Expenses	49%	\$570,747	\$0	\$570,747
c. Total Operating Expenses		\$663,930	\$0	\$663,930
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
Initial training of staff on treatment models		\$293,333	\$0	\$293,333
Ongoing training/support to ensure program fidelity		\$29,333	\$0	\$29,333
Contractor - Sr. Psychiatrist (667hrs @ \$130)		\$86,667	\$0	\$86,667
Medications		\$40,000	\$0	\$40,000
a. Total Subcontracts		\$449,333	\$0	\$449,333
4. Total Proposed PEI Project Budget		\$2,278,053	\$0	\$2,278,053
B. Revenues (list/itemize by fund source)				
Medi-Cal		\$530,624	\$0	\$530,624
1. Total Revenue	Medi-Cal	\$530,624	\$0	\$530,624
5. Total Funding Requested for PEI Project		\$1,747,429	\$0	\$1,747,429
6. Total In-Kind Contributions		\$0	\$0	\$0

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**BUDGET NARRATIVE
Project #2 – Primary Care Services**

ESTIMATED PERSONNEL

Costs for salaries and wages amount to **\$1,164,789**. This includes:

a. Psychiatric Social Worker IV – 10 FTEs at \$714,630

These positions will constitute county and/or contractor treatment teams that will provide screening, assessment and treatment for children and adults experiencing depression and a history of trauma, and for older adults with depression. The treatment teams will be based in and coordinate services with primary care health care providers.

b. Behavioral Health Clinic Administrator III - .67 FTE at \$62,400

This position will provide administrative and clinical oversight of the primary care treatment teams, oversee program fidelity and serve as liaison to the primary care health providers.

c. Office Assistant IV - .67 FTE at \$29,053

This position will provide administrative support to the primary care treatment teams and clinic administrator.

d. Employee Benefits

Benefits and Taxes. Benefits are estimated at \$358,706 and include FICA, health and dental coverage, SDI, workers compensation insurance, state and federal payroll taxes.

OPERATING EXPENSES

Total Operating Expenses amount to **\$663,930**

a. Facility Cost. \$93,183

b. Other Operating Expenses. Other operating expenses are estimated at **\$570,747** and include costs for office supplies, program supplies, equipment, travel/mileage, and computers/printers for staff. These Operating Expenditures include non-recurring, start up expenses. Once projects are fully implemented, we expect the operating expenditures percentage to be reduced from 49% to 34% or less.

SUBCONTRACTS/PROFESSIONAL SERVICES

a. Initial Training of Staff on Treatment Models - \$293,333. This represents costs for training by outside contractors of treatment staff in the five evidenced based practice interventions that will be utilized in this PEI project. Each staff will be trained on two to three interventions. Adult teams will be trained in Improving Mood, Promoting Access to Collaborative Treatment – IMPACT (for older adult depression), Depression Treatment Quality Improvement—DTQI (for adult depression), and Prolonged Exposure for Therapy for PTSD (for adult and older adult trauma). Children’s teams will be cross-trained in DTQI (for adolescent depression) and Trauma Focused Cognitive Behavior Therapy—TF-CBT (for child trauma). Training will be extended to additional county and community based providers in order to extend service capacity in the county beyond PEI funded services.

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- b. **Ongoing training/support to ensure program fidelity - \$29,333.** In order to ensure the integrity and fidelity of each evidence based practice, periodic staff training will be provided as well as support from the training entities.
- c. **Contracted senior psychiatrist - \$86,667.** This represents a contract with a psychiatrist(s) to provide 667 hours of psychiatric assessment and treatment for individuals served by the interventions in this PEI project.
- d. **Medications - \$40,000.** This represents the costs for short term psychiatric medications, for those individuals served through IMPACT and DTQI.

TOTAL PROPOSED PEI BUDGET

- a. The overall expenditure level for this project is **\$2,278,053**.
- b. Other revenues for this program are estimated at **\$530,624** in MediCal revenue.

TOTAL FUNDING REQUESTED FOR PEI PROJECT - \$1,747,429. The total funding requested is the difference between the total expenditures of **\$2,278,053** and **\$530,624** in Offsetting MediCal revenue.

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County: Ventura

PEI Project Name: School Based Services

Date: June 2009

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services 2. Psycho-Social Impact of Trauma 3. At-Risk Children, Youth and Young Adult Populations 4. Stigma and Discrimination 5. Suicide Risk	X	X		

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

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

The recommended PEI Project, School-based Services, is the result of a community-based needs assessment effort spearheaded by the VCBH in collaboration with a 44 member PEI Planning Committee, representative of all PEI sectors and the County. The community-based needs assessment involved stakeholders at multiple levels who were identified to participate in the process based on their geographic representation, and representation within the following MHSA categories: age group, community sector, priority populations, and key PEI community mental health needs. The needs assessment was designed to collect both quantitative and qualitative data from various community sources as well from community stakeholders to inform the identification of PEI Projects. Quantitative data included existing data from multiple sources on key data indicators representative of the MHSA defined priority populations. Qualitative data included direct input from community stakeholders in the form of 1) key individual interviews; 2) focus groups (area-based and countywide groups with specific populations); 3) Area Work Group data review meetings; and, 4) community forums. Please refer to Form #2 for specific details about the needs assessment program planning process.

The focus of this section will be twofold. First to describe the role stakeholders played at multiple levels in the selection of the School-based Services PEI Project; and, second to show how the quantitative and qualitative data collection strategies, analysis, and review process directly informed the selection of the School-Based Services PEI Project as well as the recommended interventions to be implemented as part of the Project.

Stakeholder Input

A countywide grass roots outreach effort was conducted to invite stakeholder participation in the PEI Planning process at multiple levels. The 44 member PEI Planning Committee guided the overall planning process and formed area-based Work Groups responsible for reviewing the quantitative and qualitative data collected through the needs assessment and use those findings to recommend the School-based Services PEI Project and select the evidence-based intervention models corresponding to community needs and populations.

To reach the point at which Work Groups were able to review and use data to make PEI project recommendations, other stakeholder input was gathered through a systematic data collection process. Key individual interviews were conducted across the County with 25 stakeholders who were not only identified to participate in the process based on specific demographic and MHSA categories, but also were knowledgeable about a specific community, issue, or problem related to mental health prevention and early intervention. These individuals were asked to provide input on community and mental health needs, age group priorities and priority populations, existing and needed PEI services, and recommendations for providing effective PEI services.

Focus groups were conducted at two levels: 1) By geographic area of the County (at least two in each area); and, 2) Countywide representing 13 distinct populations: African Americans, Ambulatory Care professionals, Consumers, Deaf and hard of hearing, Developmental disabilities, Pre-K and elementary school students, High school and

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college students, Faith-based community members, Immigrants and farm workers, Juvenile probation, Older adults, Transitional-age youth, and Veterans. The purpose of the focus groups was to conduct in-depth discussions with different community leaders, gatekeepers and other community members. Participants were selected because they were knowledgeable about their constituency and had insight into community mental health needs and strategies for PEI.

The PEI Planning Committee members also provided input on the types of key data indicators that would supplement, add to, and validate the qualitative findings from the key individual interviews and focus groups. Quantitative data were compiled on 46 primary indicators representing and categorized by the priority populations. Examples relevant to School-based Services will be provided in the *Data Analysis and Review* section. A complete presentation of the key indicator data compiled can be found in the Key Indicator Data Report in Appendix I.

Once the key indicators and the findings from the key individual interviews and focus groups were compiled, the five PEI Planning Committee Area Work Groups were convened and provided with copies of the Area-based reports along with a presentation of key findings across all three data collection strategies. (Interview and focus group reports are located in Appendix II.) Work groups were asked to react to and comment on the findings presented, as well as asked to use the findings to identify needed PEI services. The needed PEI services identified by each of the five Area Work Groups were compiled and an additional meeting was held with all five Area Work Groups present to review and comment upon the PEI Projects summarized in this report.

One additional level of stakeholder input was sought from community members throughout the County. Three Community Forums were held in one of each of three regions: East County, West County, and Santa Clara Valley. These forums were designed to share the needs assessment findings, present the recommended PEI Projects that emerged from the process, and obtain additional comments and suggestions on the recommended PEI Projects and their corresponding interventions.

The School-based Services Project is one of five PEI Projects recommended as a result of input from stakeholders at multiple levels. The next section describes the community mental health needs, priority populations, and barriers reported by stakeholders that guided the Project selection and recommended interventions.

Data Analysis and Review

Based upon findings across the three data collection strategies—key indicators, key individual interviews, and focus groups—School-based Services emerged as a highly recommended project for Ventura County (see Table 2 in Community Coalitions section). School-based Services are a vital means of addressing the mental health needs and priority populations emphasized by community stakeholders. Key indicator data and interview and focus group discussions in the five geographic regions of Ventura County highlighted the need to reduce disparities in access to mental health services by making prevention and early intervention services available and accessible in non stigmatizing

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settings for children and transition-age youth in stressed families, at-risk of school failure and/or at-risk of juvenile justice involvement.

As shown in Table 4 in the Primary Care Services section, the need to reduce disparities in access to mental health services consistently emerged as a top mental health need among interviewees and focus group participants. Specifically, stakeholders emphasized the dearth of services to address the mental health needs of children and transition-age youth in Ventura County. Furthermore, stakeholders noted that those services that do exist do not have the capacity to meet the high demand across the County, which leaves those in need of mental health services vulnerable to escalating and exacerbated mental health issues. According to interviewees and focus group participants, age groups particularly at-risk of exacerbated mental health issues are children and transition-age youth. Stakeholders indicated that “The best prevention is that which comes earlier, especially among school-aged youth.”

Among children and transition-age youth, the two top priority populations identified as needing services were children and youth in stressed families and children at-risk of school failure (see Table 3 in the Community Coalitions section). In addition, children at-risk of juvenile justice involvement, while not among the top three prioritized populations, was considered by stakeholders to be a priority population highly interrelated with the other two; and, as such, would benefit highly from School-based services.

Key indicator data and interview and focus group discussions regarding the mental health needs of stressed families across the five geographic areas of Ventura County show that almost one-third of Ventura County households are living at or below the 200 percent poverty level. These data are corroborated by stakeholder input reporting that families are experiencing economic hardship and at-risk of living in overcrowded and undesirable conditions. In addition, stakeholder input also noted that families are not only stressed economically, but are being affected by substance abuse, violence within the home and in the community, divorce or separation (sometimes due to deportation), unaddressed mental health issues, and an inability to parent their own children. As a result, children and transition-age youth in these families are exhibiting a host of behavioral problems that are placing them at-risk of school failure and juvenile justice involvement. One stakeholder commented that, “We are now seeing mental health issues at a younger age than ever before.” Behavioral problems of children and transition-age youth reported by community stakeholders included: depressed mood; thoughts of self harm, such as eating disorders, cutting and/or suicide; poor academic performance and behaviors, such as skipping school, dropping out, and getting suspended or expelled; acting out and disrupting classroom and family life; gang and/or juvenile justice involvement; and, substance abuse.

Key indicator data provide additional supporting evidence that children and transition-age youth in stressed families, at-risk of school failure, and at-risk of juvenile justice involvement are in high need of prevention and early intervention services throughout the County. During the 1st half of the 2008-09 year, these data show that 34 percent of a total of 4,055 children seen for various serious mental illnesses were diagnosed as disruptive; another 18 percent were diagnosed with depression, and another 12 percent were

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diagnosed with anxiety. With respect to school behavior and performance, truancy rates in 2007-08 at elementary schools throughout the County ranged from 2 to 60 percent with 10 of 20 elementary schools reporting truancy rates 25 percent or higher. Among 10 high school districts across the five geographic areas of Ventura County, all but two showed a decline in graduation rate between 2004-05 and 2006-07 ranging between 0.3 and 5.9 percentage points. Finally, data indicators representing juvenile justice involvement show that the actual counts of weapons confiscated from students rose from 110 in 2007 to 125 in 2008, a 12 percent increase. While there are a large proportion of documented gang members in one portion of the Ventura County (over 1,500), other areas of Ventura County have between 50 and 1,000.

School-Based Services

Given the key indicator and interview and focus group findings School-based Services was considered a means of providing greater access to prevention and early intervention services for children and transition-age youth. In addition, schools are viewed by interviewees and focus group participants as well as by community members as an existing strength in the community; they represent “service provision in natural community settings.” Stakeholders also envisioned school-based services as an opportunity to develop collaborative relationships between school personnel and mental health providers. Overall, schools were considered well-positioned to address the needs of children in stressed families and at risk of school failure and juvenile justice involvement, by:

- Serving as an easily accessible and non-stigmatizing service location for both parents and children;
- Serving as a place where early detection can occur via universal screenings or teacher identification of early signs and symptoms;
- Interfacing collaboratively with school staff and sharing educational materials regarding mental health with school staff
- Offering interventions for children and TAY while simultaneously offering parents intervention services and parenting education; and,
- Identifying and addressing risk factors such as trauma, depression, and problem behaviors that can lead to poor academic outcomes.

Using the findings from stakeholder input and data indicators the PEI Planning Committee Area Work Groups were able to identify School-based Services as an appropriate and needed approach to addressing disparities in access to mental health services for children and transition-age youth in stressed families, at-risk of school failure, and at-risk of juvenile justice involvement. Similarly, the mental health needs that emerged from the findings directly implied the need for interventions focusing on trauma, depression, and behavior problems as well as providing parents with the skills they need to parent resulting in four recommended evidence-based interventions: Strengthening Families Program; Depression Treatment Quality Improvement (DTQI), Trauma Focused Cognitive Behavior Therapy (TFCBT), and Triple P Parenting (PPP).

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3. PEI Project Description:

School Based Services

The School Based Services Project is specifically responsive to the priority, as identified by the community planning process, to make prevention and early intervention services, targeting children/TAY in stressed families and at-risk of school failure and/or juvenile justice system involvement, readily available and accessible in non-stigmatizing settings. In keeping with the areas of greatest need, this project will primarily support selective prevention and early intervention services targeting risk factors associated with disruptive behavior problems, school failure, drug use, and juvenile crime.

In addition, interventions for depression and trauma experienced by children/TAY (as described under the Primary Care Services Project) will be available at school sites. Finally, the school based practitioners (Psychiatric Social Worker IVs) and school staff will be trained in the use of a brief parenting intervention (Triple P – Level 2 which is discussed further under the Parenting Project) targeting mild disruptive behavior concerns in children.

School Based services will be provided by practitioners (Psychiatric Social Worker IVs), composed of county and/or private organizational provider(s), dedicated to serving children/TAY populations showing (or at-risk of) disruptive behavior, school failure, and/or juvenile crime. These services will be provided on school sites and in close collaboration with school staff, and primarily consist of the evidence-based Strengthening Families Program—SFP (described below). Schools will be identified, from among those that are associated with a Neighborhood for Learning area that is also the target of a Community Coalition, and then based on an elevated level of unmet need and readiness to collaborate and sustain these PEI services.

Strengthening Families Program (SFP)

The Strengthening Families Program (SFP) is a selective prevention and early intervention evidence-based model, having demonstrated effectiveness in clinical research trials, improving school performance and behavior, and diverting youth from substance use and social behavior problems that contribute to risk of juvenile crime. The model is tailored to three age groups (3-5, 6-11 and 12-16 year olds) and is designed to teach child, parent and family skills through a series of child, parenting and family groups.

The intervention consists of fourteen 2-hour group sessions that focus on parent skills (enhancing parent-child bonding, managing anger and family conflict, fostering positive child involvement in family tasks, monitoring compliance and using appropriate consequences, and understanding risk factors for substance abuse), and child skills (communication skills, problem solving, feeling identification, anger management, and resisting peer influences to use substance).

Eight practitioners will be trained in the SFP. It is anticipated that they will work in pairs to conduct 48 SFP groups, serving a total of 350 children/TAY and their families, per year. These eight practitioners will work out of 16 schools (8 elementary, 4 junior and 4 senior high). These school-based practitioners will provide educational material and training for

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teachers and parents, participate in child study teams and student study teams to facilitate referrals and coordinate with families and schools. Finally, the school-based program will be coordinated with and supported by the responsible Community Coalition.

Depression and Trauma Intervention (DTQI)

In addition to use of the SFP, the child service teams (described under the Primary Care project) will be additionally assigned to provide depression and trauma intervention at school sites, for children and youth who are identified by school staff, caregivers, or the youth themselves so as to make these early interventions more accessible and less stigmatizing. As noted under the Primary Care Project, the team of 6 Child Primary Care clinicians will be assigned (1-day per week to each of the 14 school sites) to provide depression and trauma intervention services.

Key milestones are as follows:

- Establishing school based assignments and developing formal collaborative structures with school staff
- Sharing educational materials and formal referral structures (teacher, parent, child)
- Participating in child study teams and student study teams
- Completing training in the SFP model
- Initiating SFP services and arranging for school based depression and trauma services (as described under Primary Care project)

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	
Strengthening Families Program	Individuals:250 Families:250	Individuals: 100 Families: 100	12
DTQI	Individuals:	Individuals:90	12
TF-CBT	Individuals:	Individuals:90	12
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Individuals:250 Families: 250	Individuals: 380 Families:	

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

Community members receiving PEI services under the School Based project will have access to the full array of services available through VCBH. Formal referral channels to the VCBH Mental Health Plan will be established (through the Children’s Outreach and Engagement

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Project and VCBH's newly established STAR program). Moreover, through this project coordination with schools, and Neighborhood for Learning centers, will be greatly enhanced.

6. Collaboration and System Enhancements

The School Based project is inherently collaborative, building upon and partnering with schools. In this way, PEI services will be easily accessible, linked with school programs and related after school programs, and less stigmatizing. Schools will be providing space and support for SFP services. Moreover, the schools will develop formal referral structures building PEI services into the larger array of school supports for assisting at-risk children and families. Finally, VCBH will leverage Medi-Cal and EPSDT funding for the SFP intervention services when appropriate, which will be important for sustaining these activities.

7. Intended Outcomes

School Based services are expected to reduce stigma, increase help seeking and access to early and proven intervention models for stressed families and children at-risk for school failure and juvenile justice involvement. Specific intended outcomes include:

- Increased access to early intervention services for children showing (or at-risk of) disruptive behaviors, and their families
- Increased interagency collaboration between schools and PEI service providers
- Improved school performance
- Improve child behavior
- Improved family communication and cohesiveness
- Reduced school failure and juvenile justice involvement

8. Coordination with Other MHSA Components

Formal referral structures will be in place to ensure that individuals in need of more extensive treatment level services will have access to Full Service Partnership programs when appropriate.

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PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: **Ventura** Date: June 9, 2009
 PEI Project Name: **3. School Based Services**
 Provider Name (if known): **Various (See below)**
 Intended Provider Category: **Mental Health Treatment/Service Provider**
 Proposed Total Number of Individuals to be served: FY 09-10 530
 Total Number of Individuals currently being served: FY 09-10 0
 Total Number of Individuals to be served through PEI Expansion: FY 09-10 530
 Months of Operation: FY 09-10 12

Proposed Expenses and Revenues		Total Program/PEI Project Budget		
		FY 09-10		Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
Psy Social Worker IV	8.00	\$571,704	\$0	\$571,704
BH Clinic Administrator III	0.58	\$54,600	\$0	\$54,600
Office Assistant IV	0.58	\$25,422	\$0	\$25,422
b. Benefits and Taxes @ 44%	44%	\$290,017	\$0	\$290,017
c. Total Personnel Expenditures		9.17	\$941,743	\$0
2. Operating Expenditures				
a. Facility Cost	8%	\$75,339	\$0	\$75,339
b. Other Operating Expenses	49%	\$461,454	\$0	\$461,454
c. Total Operating Expenses		\$536,793	\$0	\$536,793
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
Initial training of staff on treatment models		\$186,667	\$0	\$186,667
Ongoing training/support to ensure program fidelity		\$25,667	\$0	\$25,667
Contractor - Sr. Psychiatrist (333hrs @ \$130)		\$43,333	\$0	\$43,333
Medications		\$20,000	\$0	\$20,000
a. Total Subcontracts		\$275,667	\$0	\$275,667
4. Total Proposed PEI Project Budget		\$1,754,203	\$0	\$1,754,203
B. Revenues (list/itemize by fund source)				
Medi-Cal		\$670,122	\$0	\$670,122
1. Total Revenue	Medi-Cal	\$670,122	\$0	\$670,122
5. Total Funding Requested for PEI Project		\$1,084,081	\$0	\$1,084,081
6. Total In-Kind Contributions		\$0	\$0	\$0

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**BUDGET NARRATIVE
Project #3 – School Based Services**

ESTIMATED PERSONNEL

Costs for salaries and wages amount to **\$941,743**. This includes:

- a. **Psychiatric Social Worker IV – 8 FTEs at \$571,704**
These positions will constitute county and/or contractor providers that will provide screening, assessment and treatment for children and transitional age youth showing (or at-risk of) disruptive behavior, school failure, and/or juvenile crime. Providers will be based in and coordinate services with schools and community based settings.
- b. **Behavioral Health Clinic Administrator III - .58 FTE at \$54,600**
This position will provide administrative and clinical oversight of the school based providers, oversee program fidelity and serve as liaison to schools and community.
- c. **Office Assistant IV - .58 FTE at \$25,422**
This position will provide administrative support to the school based providers and clinic administrator.
- d. **Employee Benefits**
Benefits and Taxes. Benefits are estimated at **\$290,017** and include FICA, health and dental coverage, SDI, workers compensation insurance, state and federal payroll taxes.

OPERATING EXPENSES

Total Operating Expenses amount to **\$536,793**

- a. Facility Cost. **\$75,339**
- b. Other Operating Expenses. Other operating expenses are estimated at **\$461,454** and include costs for office supplies, program supplies, equipment, travel/mileage, and computers/printers for staff. These Operating Expenditures include non-recurring, start up expenses. Once projects are fully implemented, we expect the operating expenditures percentage to be reduced from 49% to 34% or less.

SUBCONTRACTS/PROFESSIONAL SERVICES

- a. **Initial Training of Staff on Treatment Models - \$186,667.** This represents costs for training by outside contractors of treatment staff in the evidenced based practice interventions, the Strengthening Families program, which will be utilized in this PEI project. Treatment staff will also be cross- trained in DTQI (for adolescent depression) and Trauma Focused Cognitive Behavior Therapy—TF-CBT (for child trauma). Training will be extended to additional county and community based providers in order to extend service capacity in the county beyond PEI funded services
- b. **Ongoing training/support to ensure program fidelity - \$25,667.** In order to ensure the integrity and fidelity of each evidence based practice, periodic staff training will be provided as well as support from the training entities.

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- c. **Contracted senior psychiatrist - \$43,333.** This represents a contract with a psychiatrist(s) to provide 333 hours of psychiatric assessment and treatment for individuals served by the interventions in this PEI project.
- d. **Medications - \$20,000.** This represents the costs for short term psychiatric medications, for those individuals served through DTQI.

TOTAL PROPOSED PEI BUDGET

- a. The overall expenditure level for this project is **\$1,754,203.**
- b. Other revenues for this program are estimated at **\$670,122** in MediCal revenue.

TOTAL FUNDING REQUESTED FOR PEI PROJECT - \$1,084,081.

The total funding requested is the difference between the total expenditures of **\$1,754,203** and **\$670,122** in offsetting MediCal revenue.

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County: Ventura

PEI Project Name: Parenting

Date: June 2009

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	X			
2. Psycho-Social Impact of Trauma				
3. At-Risk Children, Youth and Young Adult Populations	X			
4. Stigma and Discrimination				
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
D. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals				
2. Individuals Experiencing Onset of Serious Psychiatric Illness				
3. Children and Youth in Stressed Families	X			
4. Children and Youth at Risk for School Failure	X			
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement				
6. Underserved Cultural Populations	X			

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

The recommended PEI Project, Parenting, is the result of a community-based needs assessment effort spearheaded by the Ventura County Behavioral Health Department in collaboration with a 44 member PEI Planning Committee, representative of all PEI sectors and the County. The community-based needs assessment involved stakeholders at multiple levels who were identified to participate in the process based on their geographic representation, and representation within the following MHSA categories: age group, community sector, priority populations, and key PEI community mental health needs. The needs assessment was designed to collect both quantitative and qualitative data from various community sources as well from community stakeholders to inform the identification of PEI Projects. Quantitative data included existing data from multiple sources on key data indicators representative of the MHSA defined priority populations. Qualitative data included direct input from community stakeholders in the form of 1) key individual interviews; 2) focus groups (area-based and countywide groups with specific populations); 3) Area Work Group data review meetings; and, 4) community forums. Please refer to Form #2 for specific details about the needs assessment program planning process.

The focus of this section will be twofold. First to describe the role stakeholders played at multiple levels in the selection of the Parenting PEI Project; and, second to show how the quantitative and qualitative data collection strategies, analysis, and review process directly informed the selection of the Parenting PEI Project as well as the recommended interventions to be implemented as part of the Project.

Stakeholder Input

A countywide grass roots outreach effort was conducted to invite stakeholder participation in the PEI Planning process at multiple levels. The 44 member PEI Planning Committee guided the overall planning process and formed area-based Work Groups responsible for reviewing the quantitative and qualitative data collected through the needs assessment and use those findings to recommend the Parenting PEI Project and select the evidence-based intervention models corresponding to community needs and populations.

To reach the point at which Work Groups were able to review and use data to make PEI project recommendations, other stakeholder input was gathered through a systematic data collection process. Key individual interviews were conducted across the County with 25 stakeholders who were not only identified to participate in the process based on specific demographic and MHSA categories, but also were knowledgeable about a specific community, issue, or problem related to mental health prevention and early intervention. These individuals were asked to provide input on community and mental health needs, age group priorities and priority populations, existing and needed PEI services, and recommendations for providing effective PEI services.

Focus groups were conducted at two levels: 1) By geographic area of the County (at least two in each area); and, 2) Countywide representing 13 distinct populations: African Americans, Ambulatory Care professionals, Consumers, Deaf and hard of hearing,

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Developmental disabilities, Pre-K and elementary school students, High school and college students, Faith-based community members, Immigrants and farm workers, Juvenile probation, Older adults, Transitional-age youth, and Veterans. The purpose of the focus groups was to conduct in-depth discussions with different community leaders, gatekeepers and other community members. Participants were selected because they were knowledgeable about their constituency and had insight into community mental health needs and strategies for PEI.

The PEI Planning Committee members also provided input on the types of key data indicators that would supplement, add to, and validate the qualitative findings from the key individual interviews and focus groups. Quantitative data were compiled on 46 primary indicators representing and categorized by the priority populations. Examples relevant to the Parenting Project will be provided in the *Data Analysis and Review* section. A complete presentation of the key indicator data compiled can be found in the Key Indicator Data Report in Appendix I.

Once the key indicators and the findings from the key individual interviews and focus groups were compiled, the five PEI Planning Committee Area Work Groups were convened and provided with copies of the Area-based reports along with a presentation of key findings across all three data collection strategies. (Interview and focus group reports are located in Appendix II.) Work groups were asked to react to and comment on the findings presented, as well as asked to use the findings to identify needed PEI services. The needed PEI services identified by each of the five Area Work Groups were compiled and an additional meeting was held with all five Area Work Groups present to review and comment upon the PEI Projects summarized in this report.

One additional level of stakeholder input was sought from community members throughout the County. Three Community Forums were held in one of each of three regions: East County, West County, and Santa Clara Valley. These forums were designed to share the needs assessment findings, present the recommended PEI Projects that emerged from the process, and obtain additional comments and suggestions on the recommended PEI Projects and their corresponding interventions.

The Parenting PEI Project is one of five PEI Projects recommended as a result of input from stakeholders at multiple levels. The next section describes the community mental health needs, priority populations, and barriers reported by stakeholders that guided the Project selection and recommended interventions.

Data Analysis, Review, and Implications

Analysis of input across the three data collection strategies—key indicators, key individual interviews, and focus groups—reveals how Parenting arose as one of the needed PEI projects. Key indicator data and interview and focus group discussions regarding the mental health needs in the five geographic regions of Ventura pointed to a significant concern for stressed families, and the impact those stressors have on parenting and outcomes in children and youth. Accordingly, parent/family education, training, and services was one of the top six recommended prevention and early intervention strategies by stakeholders as shown on Table 2 in the Community Coalitions section.

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Across interviews and focus groups, children and youth in stressed families, underserved cultural populations, and children at-risk of school failure were among the top three prioritized populations (see Table 3 in the Community Coalitions section). Similarly, disparities in access to services and at-risk children, youth, and young adult populations were the top two prioritized mental health needs in both interviews and focus groups (see Table 4 in the Primary Care Services section). While discussing the top priority populations and mental health needs, stakeholders emphasized that prevention and early intervention services for at-risk children and youth must include their parents and families in order to be effective. One stakeholder stated, “If the child needs help, so do the parents.”

Along with underserved cultural populations, families with single parents and both parents in the workforce were also cited as overwhelmed, stressed, and in need of parenting interventions. According to the 2000 Census, 15% of families are headed by single mothers and 53% of families have both parents in the workforce across the County. Input from stakeholders indicates that these numbers may have increased in the past nine years. They reported that many parents need to work multiple jobs, leaving insufficient time for involvement in their children’s lives; this was particularly pervasive among underserved cultural populations. Stakeholders discussed how immigration concerns, economic stressors, demanding work schedules, and the breakdown of family structures all contribute to the inability of many parents to supervise, communicate with, emotionally support, and effectively parent their children.

The lack of positive parenting skills described by stakeholders is made evident in indicator data on child abuse and foster care placements in Ventura County. In the 2007-08 fiscal year there were 8,139 child abuse referrals in the County, with 314 children removed from their homes. During that time, 605 children were placed in foster care as of December 2008. In both interviews and focus groups, stakeholders discussed the increased child neglect, child abuse, familial violence repeated over generations, and substance abuse in homes seen across the County, as well as the affect these parental behaviors had on children and youth.

When looking at the impact on children and youth in stressed families, stakeholders were overwhelmingly concerned about negative social, emotional, and behavioral outcomes. They reported children acting out as early as elementary school, lacking coping and communication skills, and exhibiting disruptive and violent behaviors. Parents were seen as unequipped to manage their children’s communicative and behavioral issues.

Being in stressed families also put children and youth at-risk of school failure. When there are tensions at home and their basic needs are not being met, children’s abilities to learn and get along with others are negatively affected. Stakeholders also cited increased school failure, suspensions and expulsions, and drop outs at earlier ages as a result of family stressors. Furthermore, stakeholders discussed increased alcohol and drug use, gang involvement, and criminal activity, all at earlier ages among children and youth. Key indicators support stakeholder input. Averaged across all school districts in the County,

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suspension and expulsion rates have steadily increased in the past 3 years, particularly suspensions and expulsions related to violence and/or alcohol and drug usage.

Accordingly, stakeholders prioritized prevention and early intervention services for youth and their parents and families. However, they were concerned that the stigma associated with mental health would hamper access to these services. In both interviews and focus groups, stakeholders reported that parents often refuse to follow through with referrals made for their children due to stigma. Some parents tend to deny and minimize their children's mental health issues, and/or prefer to deal with their children's issues within their familial and cultural support system instead of seeking assistance from others outside their culture, particularly in underserved populations. Therefore, stakeholders emphasized the need for an educational campaign targeted to parents in order to overcome stigma and encourage positive parenting and help seeking behaviors. They recommended that educational materials be provided in multiple languages to reach underserved populations in the County, especially Spanish-speaking and Mixteco communities.

In order to address the mental health needs of at-risk children and youth and the stigmas limiting access to mental health services, stakeholders identified a number of needed prevention and early intervention strategies. Parent education, training, and early intervention services emerged as one of the top strategies in interviews and focus groups. In addition, stakeholders emphasized that parenting education and supports should be provided in collaboration with other community organizations and services in non-stigmatizing locations such as schools, primary care settings, family resource centers, faith-based organizations and in home settings.

Overall, the Parenting PEI Project was considered well suited to address the impact of stressed families and reported lack of parenting skills placing children and youth at-risk. At the same time, this PEI Project is well positioned to raise parental awareness about mental health issues, reduce the stigma surrounding mental health, and increase access to mental health services for children and families. Specifically, this PEI Project has the ability to:

- Increase awareness of positive parenting strategies through a broad media campaign;
- Educate parents and families on various topics such as nutrition, life skills, coping skills, and parenting skills in non-stigmatizing locations such as churches, schools, local clinics, and resource centers at convenient days and times for working parents;
- Improve child behaviors and school performance;
- Improve child-parent communications and family cohesiveness;
- Train parents how to identify mental health issues, navigate the system, access services, and support children with mental health issues; and,
- Provide parenting training and other early intervention services for at-risk families in order to reduce child abuse and other negative outcomes.

Using the findings from stakeholder input the PEI Planning Committee Area Work Groups were able to identify the Parenting PEI Project as an appropriate and needed approach to addressing the mental health needs of children and their parents and families. Similarly, the mental health needs that emerged from the findings directly implied the need for parenting

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education and interventions available in homes, schools, primary care, and community-based settings, as well as a universal public education campaign. These findings led to the two recommended evidence-based interventions: Strengthening Families Program (incorporated in the School Based Project) and Triple P Parenting (PPP).

3. PEI Project Description:

Parenting Project

The Parenting Project is specifically responsive to the priority, as identified by the community planning process, to support a broad multilevel prevention and parenting intervention targeting children in stressed families and at-risk of school failure. This project primarily involves implementation of the Triple P Parenting model, targeting communities showing elevated child risk factors, with a special focus on underserved populations.

The Triple P Parenting model is ideally suited to advance Ventura County's interest in providing parenting supports and preventing child behavior problems and school failure. This model has been subject to random clinical trials and found to be effective in improving parenting, child behavior and parent-child interactions, and decreasing child maltreatment and child behavior problems.

Triple P Parenting

Specifically, Triple P Parenting is a multi-level, parenting and family support strategy that aims to prevent severe behavioral, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents. This tiered multi-level strategy recognizes that parents have differing needs and desires regarding the type, intensity and mode of assistance they may require, as such it is designed to reduce stigma and overcome access barriers, particularly for underserved populations.

The Triple P system is designed to maximize efficiency, contain costs and ensure the program has wide reach in the community. The program targets five different developmental periods from infancy to adolescence. Within each developmental period the reach of the intervention can vary from being very broad (targeting an entire population) to quite narrow (targeting only high-risk children). The model consists of five levels as follows:

- **Level 1**—is a universal prevention parent information strategy, provides parents with access to information about parenting through a coordinated media and promotional campaign using print and electronic media. This level of intervention aims to increase community awareness of parenting resources, to encourage parents to participate in programs, and to create a sense of optimism by depicting solutions to common behavioral and developmental concerns. This component will be coordinated with all Community Coalitions and have a countywide reach. Materials will be developed in English and Spanish, including special design elements specific to Spanish speaking families, migrant farm workers, and Mixteco families.
- **Level 2**—is a brief, 1 or 2-session primary health care intervention providing anticipatory developmental guidance to parents of children with mild behavior difficulties, with the aid of user-friendly parenting tip sheets and videotapes that demonstrate specific parenting strategies.

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- **Level 3**—is a 4-session primary care intervention, targeting children with mild to moderate behavior difficulties and includes active skills training for parents. Training and materials will be provided for primary care clinics and schools sites that are involved in the other PEI projects for both levels 2 and 3. In addition, the Neighborhood for Learning resource centers will be invited to provide Level 2/3 services.
- **Level 4**—is an intensive 8 to 10-session individual, group or self-help parenting program for parents of children with more severe behavior difficulties.
- **Level 5**—is an enhanced behavioral family intervention program for families where parenting difficulties are complicated by other sources of family distress (e.g. relationship conflict, parental depression or high levels of stress). Levels 4 and 5 can be provided in-home, reducing access barriers for underserved populations.

Level 1 (universal prevention education campaign including—flyers, newsletters, newspaper articles, radio and televisions spots, and bus placards) will be supported in coordination with Community Coalitions (as previously described). Moreover, Level 2/3 (brief intervention) will be provided by primary care and school staff (as noted in the Primary Care and School Based projects). In addition, staff from the Neighborhood for Learning resource centers, and child care programs will be provided Level 2/3 training and materials so that these selective prevention activities can be readily available in multiple settings through the targeted communities.

Finally, a team of 4 full-time practitioners (Psychiatric Social Worker IVs), from county and private organizational providers, will be trained in the use of Levels 4 and 5 (full early intervention parenting curriculum) that can be provided individually (in-home) or in a group format (in schools, churches, community organizations).

Level 2/3 and Level 4/5 activities will be primarily available in the communities supported by the primary care and/or school based services projects. It is anticipated that about 24,000 families will be influenced by a Triple P Level 1 public marketing message, and that 750 families will participate in a Level 2/3 selective prevention activity (in a primary care or school site), and that 240 families will participate in a Level 4/5 parenting early intervention (in home).

Key milestones are as follows:

- Establishing Triple P intervention teams and collaboration with primary care centers, schools, and resource centers around use of Level 2/3
- Completing Triple P training (Levels 2-5)
- Initiating Triple P Level 2-5 activities
- Developing and implementing Level 1 educational materials

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4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Triple P Parenting	Families:24,000	Families: 240	12
TOTAL PEI PROJECT ESTIMATED <i>UNDUPLICATED</i> COUNT OF INDIVIDUALS TO BE SERVED	Families: 24,000	Families: 240	

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

Through this project coordination with primary care health services, school sites, and Neighborhoods for Learning will all be enhanced. Moreover, formal referral channels to the VCBH Mental Health Plan will be established.

6. Collaboration and System Enhancements

The Parenting project (though the Triple P Parenting model) builds upon and enhances community efforts to provide parenting supports. Level 1 is a multifaceted public media campaign that will be assisted by the Community Coalitions project and community volunteerism.

Level 2/3 involves coordination and collaboration among a host of formal and informal systems including primary care centers, schools, resources centers, and others as interested, who together provide brief parenting guidance and facilitate referral to other needed services when indicated. PEI will fund the Level 2/3 training and materials, but the collaborating agencies will provide their staff (as in kind support) when they make use of the Level 2/3 activities for parents. Finally, VCBH will leverage Medi-Cal and EPSDT funding for the Triple P Level 4/5 services when appropriate, which will be important for sustaining these activities.

7. Intended Outcomes

Parenting (Triple P Parenting) activities are expected to reduce stigma, increase help seeking and access to early and proven parenting supports for stressed families and children at-risk for school failure. Specific intended outcomes include:

- Positive parenting media campaign
- Increased access to parenting supports for children with behavior problems
- Increased interagency collaboration between primary care clinics, schools, resource centers, and Triple P providers
- Improved child behavior
- Improved family communication and cohesiveness

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- Improved school performance
- Reduced child maltreatment and school failure

8. Coordination with Other MHSA Components

Formal referral structures will be in place to ensure that individuals in need of more extensive treatment level services will have access to Full Service Partnership programs when appropriate.

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PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: **Ventura** Date: June 9, 2009
 PEI Project Name: **4. Parenting**
 Provider Name (if known): **Various (See Below)**
 Intended Provider Category: **Mental Health Treatment/Service Provider**
 Proposed Total Number of Individuals to be served: FY 09-10 240
 Total Number of Individuals currently being served: FY 09-10 0
 Total Number of Individuals to be served through PEI Expansion: FY 09-10 240
 Months of Operation: FY 09-10 12

Proposed Expenses and Revenues		Total Program/PEI Project Budget		
		FY 09-10		Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
Psy Social Worker IV	2.00	\$142,926	\$0	\$142,926
MHA - Unlicensed	2.00	\$95,308	\$0	\$95,308
BH Clinic Administrator III	0.25	\$23,400	\$0	\$23,400
Office Assistant IV	0.25	\$10,895	\$0	\$10,895
b. Benefits and Taxes @ 44%	44%	\$121,275	\$0	\$121,275
c. Total Personnel Expenditures	4.50	\$393,804	\$0	\$393,804
2. Operating Expenditures				
a. Facility Cost	8%	\$31,504	\$0	\$31,504
b. Other Operating Expenses	49%	\$192,964	\$0	\$192,964
c. Total Operating Expenses		\$224,468	\$0	\$224,468
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
Initial training of staff on treatment models		\$80,000	\$0	\$80,000
Ongoing training/support to ensure program fidelity		\$11,000	\$0	\$11,000
a. Total Subcontracts		\$91,000	\$0	\$91,000
4. Total Proposed PEI Project Budget		\$709,272	\$0	\$709,272
B. Revenues (list/itemize by fund source)				
1. Total Revenue	Medi-Cal	\$269,013	\$0	\$269,013
	Medi-Cal	\$269,013	\$0	\$269,013
5. Total Funding Requested for PEI Project		\$440,259	\$0	\$440,259
6. Total In-Kind Contributions		\$0	\$0	\$0

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**BUDGET NARRATIVE
Project #4 – Parenting**

ESTIMATED PERSONNEL

Costs for salaries and wages amount to **\$393,804**. This includes:

- a. **Psychiatric Social Worker IV – 2 FTEs at \$142,926**
Mental Health Associate, Unlicensed – 2 FTEs at \$95,308
These positions will constitute county and/or contractor providers that will individual and group treatment for children with behavior problems and at risk of school failure and their families through the Triple P Parenting program, Levels 4 and 5. Providers will be based in and coordinate services with schools and community based settings.
- b. **Behavioral Health Clinic Administrator III - .25 FTE at \$23,400**
This position will provide administrative and clinical oversight of the Triple P providers, oversee program fidelity and serve as liaison to schools and community based organizations.
- c. **Office Assistant IV - .58 FTE at \$10,895**
This position will provide administrative support to the Triple P providers and clinic administrator.
- d. **Employee Benefits**
Benefits and Taxes. Benefits are estimated at **\$121,275** and include FICA, health and dental coverage, SDI, workers compensation insurance, state and federal payroll taxes.

OPERATING EXPENSES

Total Operating Expenses amount to **\$224,468**

- a. Facility Cost. **\$31,504**
- b. Other Operating Expenses. Other operating expenses are estimated at **\$192,964** and include costs for office supplies, program supplies, equipment, travel/mileage, and computers/printers for staff. These Operating Expenditures include non-recurring, start up expenses. Once projects are fully implemented, we expect the operating expenditures percentage to be reduced from 49% to 34% or less.

SUBCONTRACTS/PROFESSIONAL SERVICES

- a. **Initial Training of Staff on Treatment Models - \$80,000.** This represents costs for training by outside contractors in Triple P Parenting, an evidenced based practice. Treatment staff will be trained in Triple P, Levels 4 and 5, while training in Triple P, Levels 2 and 3 will be provided to staff in schools, primary care and community based settings. Training will be extended to additional county and community based providers in order to extend service capacity in the county beyond PEI funded services.
- b. **Ongoing training/support to ensure program fidelity - \$11,000.** In order to ensure the integrity and fidelity of the evidence based practice, periodic staff training will be provided as well as support from the training entities.

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TOTAL PROPOSED PEI BUDGET

- a. The overall expenditure level for this project is \$709,272.
- b. Other revenues for this program are estimated at \$269,013 in MediCal revenue.

TOTAL FUNDING REQUESTED FOR PEI PROJECT - \$440,259. The total funding requested is the difference between the total expenditures of **\$709,272** and **\$269,013** in offsetting MediCal revenue.

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County: Ventura

PEI Project Name: Early Signs of Psychosis Intervention

Date: June 2009

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project: 1. Disparities in Access to Mental Health Services 2. Psycho-Social Impact of Trauma 3. At-Risk Children, Youth and Young Adult Populations 4. Stigma and Discrimination 5. Suicide Risk		X		

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

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

The recommended PEI Project, Early Psychosis Intervention, is the result of a community-based needs assessment effort spearheaded by the VCBH in collaboration with a 44 member PEI Planning Committee, representative of all PEI sectors and the County. The community-based needs assessment involved stakeholders at multiple levels who were identified to participate in the process based on their geographic representation, and representation within the following MHSA categories: age group, community sector, priority populations, and key PEI community mental health needs. The needs assessment was designed to collect both quantitative and qualitative data from various community sources as well from community stakeholders to inform the identification of PEI Projects. Quantitative data included existing data from multiple sources on key data indicators representative of the MHSA defined priority populations. Qualitative data included direct input from community stakeholders in the form of 1) key individual interviews; 2) focus groups (area-based and countywide groups with specific populations); 3) Area Work Group data review meetings; and, 4) community forums. Please refer to Form #2 for specific details about the needs assessment program planning process.

The focus of this section will be twofold. First to describe the role stakeholders played at multiple levels in the selection of the Early Signs of Psychosis Intervention PEI Project; and, second to show how the quantitative and qualitative data collection strategies, analysis, and review process directly informed the selection of the Early Signs of Psychosis Intervention PEI Project as well as the recommended interventions to be implemented as part of the Project.

Stakeholder Input

A countywide grass roots outreach effort was conducted to invite stakeholder participation in the PEI Planning process at multiple levels. The 44 member PEI Planning Committee guided the overall planning process and formed area-based Work Groups responsible for reviewing the quantitative and qualitative data collected through the needs assessment and use those findings to recommend the Early Signs of Psychosis Intervention PEI Project and select the evidence-based intervention models corresponding to community needs and populations.

To reach the point at which Work Groups were able to review and use data to make PEI project recommendations, other stakeholder input was gathered through a systematic data collection process. Key individual interviews were conducted across the County with 25 stakeholders who were not only identified to participate in the process based on specific demographic and MHSA categories, but also were knowledgeable about a specific community, issue, or problem related to mental health prevention and early intervention. These individuals were asked to provide input on community and mental health needs, age group priorities and priority populations, existing and needed PEI services, and recommendations for providing effective PEI services.

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Focus groups were conducted at two levels: 1) By geographic area of the County (at least two in each area); and, 2) Countywide representing 13 distinct populations: African Americans, Ambulatory Care professionals, Consumers, Deaf and hard of hearing, developmental disabilities, Pre-K and elementary school students, High school and college students, Faith-based community members, Immigrants and farm workers, Juvenile probation, Older adults, Transitional-age youth, and Veterans. The purpose of the focus groups was to conduct in-depth discussions with different community leaders, gatekeepers and other community members. Participants were selected because they were knowledgeable about their constituency and had insight into community mental health needs and strategies for PEI.

The PEI Planning Committee members also provided input on the types of key data indicators that would supplement, add to, and validate the qualitative findings from the key individual interviews and focus groups. Quantitative data were compiled on 46 primary indicators representing and categorized by the priority populations. Examples relevant to Early Signs of Psychosis Intervention will be provided in the *Data Analysis and Review* section. A complete presentation of the key indicator data compiled can be found in the Key Indicator Data Report in Appendix I.

Once the key indicators and the findings from the key individual interviews and focus groups were compiled, the five PEI Planning Committee Area Work Groups were convened and provided with copies of the Area-based reports along with a presentation of key findings across all three data collection strategies. (Interview and focus group reports are located in Appendix II.) Work groups were asked to react to and comment on the findings presented, as well as asked to use the findings to identify needed PEI services. The needed PEI services identified by each of the five Area Work Groups were compiled and an additional meeting was held with all five Area Work Groups present to review and comment upon the PEI Projects summarized in this report.

One additional level of stakeholder input was sought from community members throughout the County. Three Community Forums were held in one of each of three regions: East County, West County, and Santa Clara Valley. These forums were designed to share the needs assessment findings, present the recommended PEI Projects that emerged from the process, and obtain additional comments and suggestions on the recommended PEI Projects and their corresponding interventions.

The Early Psychosis Intervention PEI Project is one of five PEI Projects recommended as a result of input from stakeholders at multiple levels. The next section describes the community mental health needs, priority populations, and barriers reported by stakeholders that guided the Project selection and recommended interventions.

Data Analysis and Review

Based upon findings across the three data collection strategies—key indicators, key individual interviews, and focus groups—Early Psychosis Intervention arose as one of the needed PEI projects. Interviewees noted that the rate of unidentified and/or unaddressed mental health issues is increasing, resulting in exacerbated symptoms, with individuals reaching a state of crisis before receiving any form of intervention. Concomitantly,

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interviewees and focus group participants noted that mental health issues are left undetected and unaddressed because community members lack the ability to recognize the signs and symptoms of mental illness. As a result, there is a high need across Ventura County to address disparities in access to mental health services.

Stakeholders in interviews and focus groups reported that more and more transition-age youth are experiencing psychotic breaks, with some seeking services for co-occurring disorders because the first disorder went undetected and untreated. According to stakeholders, the onset of serious psychiatric illness among at-risk transition-age youth may be left undetected for two key reasons: 1) once youth become 18 they are legally independent and not required to seek help; or, 2) they do not know what services are available to them or how to access them. Furthermore, stakeholders reported that parents, as well as community members who come in contact with transition-age youth on a regular basis, lack the ability to identify the signs and symptoms of mental health issues. Those key points of contact are critical to the early identification of serious mental illness and include family members, teachers, primary care physicians, faith-based professionals, landlords, social service agency representatives, and police officers—all identified by interviewees and focus group participants.

Consequently, stakeholders across interviews and focus groups emphasized a high need to incorporate outreach strategies to reach families, service providers, and community members about the prodromal symptoms of mental illness as a means of reducing disparities to access among transition-age youth. Recommended strategies included media campaigns in various forms, as well as formal education for parents and service providers—those key points of contact mentioned above. Successfully implemented community outreach efforts along these lines are needed in order to promote early detection and intervention, and thereby reduce or prevent the incidents of psychotic breaks and chronic, long-term mental illness.

Overall, the Early Psychosis Intervention Project was considered best suited to address the lack of early detection and intervention services for transition-age youth at-risk of serious mental illness. At the same time, this Project is well positioned to reduce the disparities in access to mental health by raising awareness about early onset of serious mental illness and educating individuals who interact frequently with transition-age youth. Specifically, this PEI Project has the ability to:

- Increase awareness and early identification of the onset of serious mental illness, particularly among transition-age youth;
- Address signs and symptoms of mental illness before they escalate, become long-term, persistent, and more difficult to manage;
- Educate parents on how to identify someone who is showing signs of poor mental health; and,
- Educate and train those who serve as key points of contact for young adults—teachers, physicians, landlords, police officers, social service agency representatives, and faith-based professionals—to be able to identify the prodromal signs of the early onset of mental illness.

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Using the findings from stakeholder input, the PEI Planning Committee Area Work Groups were able to identify the Early Psychosis Intervention Project as an appropriate and needed approach to raising awareness of the early signs and symptoms of mental health issues and promoting screening, early identification, and early intervention among transition-age youth. This includes educating teachers, doctors, clergy, social service agency representatives, landlords, and police officers, as well as other key providers, in addition to parents as a means of increasing community capacity to catch mental health issues early on and prevent them from becoming exacerbated and full-blown serious mental illnesses. These findings led to the recommendation to implement the promising practice Early Detection and Intervention for the Prevention of Psychosis (EDIPP), as the primary service for this PEI Project. The applicability and benefits of the EDIPP for Ventura County will be discussed in detail in the following sections.

3. PEI Project Description:

Early Psychosis Intervention Project

The Early Psychosis Intervention Project is specifically responsive to the priority, as identified by the community planning process, to support a broad multilevel selective prevention and early intervention response targeting Transition Age Youth (TAY) showing the early signs of psychosis. This project primarily involves implementation of the Early Detection and Intervention for Prevention of Psychosis (EDIPP) model, targeting the entire county.

The early psychosis prevention and early intervention (EDIPP) team will be responsible (in coordination with all of the Community Coalitions) for an education/training campaign directed at high school and college teachers, primary care staff, and law enforcement. Moreover, this team will be mobile, providing screening/assessment and when indicated early intervention services that are home and community based. Formal linkages to the county's FSP and related supports (e.g. TAY Tunnel Wellness and Recovery Center) will be established.

The EDIPP model is specifically designed to advance Ventura County's interest in supporting the early identification and intervention of early psychosis. This is a promising model that is currently the subject of effectiveness research. The early findings are very promising in regards to forestalling or limiting the impact of psychotic disorders.

Specifically, the model focuses on the pre-illness (prodromal) phase of a developing psychotic process, which is a time when psychotic disorders are highly treatable and interventions may set the foundations for an unusually good outcome and long-term prognosis. This model includes early identification of those individuals with prodromal and active symptoms, as well as early intervention that is designed to continue, perhaps in a less intense form, for as long as the person remains vulnerable.

Adolescents and young adults between the ages of 15 and 25 will be the target population for this project. Youth/young adults showing possible signs of early psychosis will be referred (typically by trained school, primary care, or law enforcement staff) for assessment (using the Structured Interview for Prodromal Syndromes).

**Ventura County Behavioral Health Department
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The early psychosis team will consist of a full-time social worker, full-time nurse, half-time occupational therapist, half-time education/employment specialist, and consulting psychiatrist. The team will be mobile, working countywide, providing early intervention when early psychosis is confirmed. The team will have the capacity to support 20 youth/young adults per year. Key components of the program will include community outreach, assessment and intervention, as follows:

Community Outreach—The goal of community outreach is to reach those school and healthcare professionals and community members, such as families and youth workers, who interact frequently with young people. Those community members are in a key position to detect early changes in an adolescent's or young adult's functioning and behaviors, and once given appropriate information about early signs of psychosis, they can intervene on that young person's behalf.

The early intervention team will (1) Educate and train the provider community, particularly school-based professionals, primary care physicians and law enforcement, about the early warning signs of severe mental illness; (2) Teach community members (families, clergy, youth workers, students) how to identify young people who are manifesting prodromal or active symptoms of major psychotic disorders; and (3) Establish a community wide system of early detection and intervention of youth and young adults at-risk for prodromal psychosis. The outreach and education work will be coordinated with all Community Coalitions, and offered to all county high schools, Ventura County Community College, Cal State Channel Islands, and primary care clinics.

Assessment—The intervention team will respond to referrals from throughout the county. Standardized measures specific and sensitive to early psychosis will be used. Early intervention services, provided by the team, will be offered if early psychosis is confirmed. Other referrals will be offered, including linkages to VCBH Mental Health Plan and FSP programs, when mental health needs, other than early psychosis, are identified during the assessment.

Early Intervention—Early intervention will involve a combination of pharmacologic and psychosocial interventions to promote functioning including: (1) Family psychoeducation; (2) Family-aided assertive community treatment; (3) Supported education/employment; and (4) Low-dose medication, as indicated.

In sum, this project will promote awareness and education concerning the onset of serious mental illness, with the goal of early identification leading to more effective and accessible intervention. The core intervention will be an educational campaign that will leverage the efforts and resources of schools, notably high schools and community colleges as forums for education and outreach concerning the onset of serious mental illness. Staff in academic and other community institutions will be trained to identify signs of possible prodromal signs of psychosis. When individuals are identified, they will be referred to a mobile screening and assessment team, made up of clinicians from county and/or organizational providers. Upon confirmation of early psychosis, individuals will be offered corresponding intervention services.

**Ventura County Behavioral Health Department
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Individuals, who demonstrate a need for services beyond the scope of PEI activities, will be linked to VCBH FSP programs.

Key milestones are as follows:

- Establish the early psychosis intervention (EDIPP) team and collaboration with primary care centers, schools, colleges and law enforcement
- Conduct and coordinate education and outreach activities with the Community Coalitions
- Complete EDIPP training
- Initiate EDIPP screening/assessment and early intervention activities
- Developing formal linkages with FSP and related programs

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	
EDIPP	Individuals:1,000	Individuals: 20	12
TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED	Individuals: 1,000	Individuals: 20	

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

Community members receiving PEI services under the Early Psychosis Intervention project will have access to the full array of services available through VCBH. Moreover, formal referral channels FSP programs will be established.

6. Collaboration and System Enhancements

The Early Psychosis Intervention project (through the EDIPP model) builds upon and enhances community efforts to respond to the needs of youth/young adults at-risk of serious mental illness. This initiative includes an innovative education and training component for schools, colleges, primary care centers and law enforcement. PEI will fund the training; however, early identification and referral is sustained through the in-kind efforts of the collaborating agencies.

Again, formal linkages with the counties Mental Health Plan and FSP programs will be established for those individuals who show a need for assistance beyond the PEI episode. Finally, VCBH will leverage Medi-Cal and EPSDT funding for the EDIPP intervention services when appropriate, which will be important for sustaining these activities.

**Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN**

7. Intended Outcomes

Early Psychosis Intervention activities are expected to reduce stigma, increase early identification and access to proven interventions for early psychosis experienced by transition age youth. Specific intended outcomes include:

- Education and training of key stakeholders
- Establishing formal referral channels
- Increased identification of early psychosis
- Improved educational/vocational performance
- Improved quality of life
- Reduced need for inpatient treatment

8. Coordination with Other MHSA Components

Formal referral structures will be in place to ensure that individuals in need of more extensive treatment level services will have access to Full Service Partnership programs when appropriate.

**Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN**

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: **Ventura** Date: June 9, 2009
 PEI Project Name: **5. Early Signs of Psychosis Intervention**
 Provider Name (if known): **Various (See Below)**
 Intended Provider Category: **Mental Health Treatment/Service Provider**
 Proposed Total Number of Individuals to be served: FY 09-10 10
 Total Number of Individuals currently being served: FY 09-10 0
 Total Number of Individuals to be served through PEI Expansion: FY 09-10 10
 Months of Operation: FY 09-10 12

Proposed Expenses and Revenues		Total Program/PEI Project Budget		
		FY 09-10		Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
b. Benefits and Taxes @ _____ % 44%		\$0	\$0	\$0
c. Total Personnel Expenditures		0.00	\$0	\$0
2. Operating Expenditures				
a. Facility Cost				
b. Other Operating Expenses		\$0	\$0	\$0
c. Total Operating Expenses		\$0	\$0	\$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
TBD		\$220,000	\$0	\$220,000
Initial training of staff on treatment models		\$80,000	\$0	\$80,000
Ongoing training/support to ensure program fidelity		\$22,000	\$0	\$22,000
			\$0	\$0
a. Total Subcontracts		\$322,000	\$0	\$322,000
4. Total Proposed PEI Project Budget		\$322,000	\$0	\$322,000
B. Revenues (list/itemize by fund source)				
Medi-Cal		\$103,455	\$0	\$103,455
1. Total Revenue		Medi-Cal	\$103,455	\$103,455
5. Total Funding Requested for PEI Project		\$218,545	\$0	\$218,545
6. Total In-Kind Contributions		\$0	\$0	\$0

**Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN**

BUDGET NARRATIVE

Project #5 – Early Signs of Psychosis Intervention

ESTIMATED PERSONNEL

No personnel costs are included for this project.

OPERATING EXPENSES

No operating expenses are included for this project.

SUBCONTRACTS/PROFESSIONAL SERVICES

- a. **Contractor - \$220,000.** This represents costs for a contractor to provide early psychosis prevention and early intervention (EDIPP) services to transitional age youth showing early signs of psychosis. It is assumed that funding will support one EDIPP team which will provide screening, assessment and early intervention treatment services to up to 20 transitional age youth per year. The team will also provide community outreach and education in coordination with the community coalitions.
- b. **Initial Training of Staff on Treatment Models - \$80,000.** This represents costs for training by outside contractors in EDIPP. Treatment staff will be trained in Triple P, Levels 4 and 5, while training in Triple P, Levels 2 and 3 will be provided to staff in schools, primary care and community based settings. Training will be extended to additional county and community based providers in order to extend service capacity in the county beyond PEI funded services.
- c. **Ongoing training/support to ensure program fidelity - \$22,000.** In order to ensure the integrity and fidelity of EDIPP, periodic staff training will be provided as well as support from the training entities.

TOTAL PROPOSED PEI BUDGET

- a. The overall expenditure level for this project is **\$322,000.**
- b. Other revenues for this program are estimated at **\$103,455** in MediCal revenue.

TOTAL FUNDING REQUESTED FOR PEI PROJECT - \$218,545. The total funding requested is the difference between the total expenditures of **\$322,000** and **\$103,455** in offsetting MediCal revenue.

**Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN**

FORM No. 7 – Local Evaluation of a PEI Project

County: Ventura

Date: June 15, 2009

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

PEI Project Name:

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

VCBH proposes to evaluate its PEI Parenting Project (Triple P Parenting program).

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

The Parenting Project was selected due to its breadth and anticipated impact. It is a multilevel initiative involving a broad universal prevention public media campaign, a selective prevention component that will be available at numerous schools, primary care clinics and resource centers, and an early intervention parenting course.

In a recent random clinical trial of the Triple P Parenting model, conducted in South Carolina with support from the Centers for Disease Control, community level outcomes including reduced child maltreatment and injury rates, and as well as reduced need for group home care was demonstrated. There is strong interest in evaluating the program/system and individual/family impact of this project in reducing risk factors experienced by stressed families.

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

Expected person/family-level outcome include:

- Improved child behavior
- Improved school performance
- Reduced incidences of disruptive behavior in school
- Reduced child maltreatment and school failure
- Reduced family stress

Expected program/system-level outcomes include:

- Positive parenting media campaign
- Increased interagency collaboration between primary care clinics, schools, resource centers, and Triple P providers

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3. Describe the numbers and demographics of individuals participating in this intervention. Indicate the proposed number of individuals under each priority population to be served by race, ethnicity and age groups. Since some individuals may be counted in multiple categories, the numbers of persons on the chart may be a duplicated count. For “other”, provide numbers of individuals served for whom a category is not provided (i.e., underserved cultural populations; e.g., gay, lesbian, bisexual, transgender, questioning; hearing impaired, etc.). Please indicate at the bottom of the form an estimate of the total *unduplicated* count of individuals to be served. If the focus of the intervention is families, count each person in the family.

PERSONS TO RECEIVE INTERVENTION

POPULATION DEMOGRAPHICS <u>ETHNICITY/ CULTURE</u>	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/DISCRIMINATION
African American			15%	15%			
Asian Pacific Islander			5%	5%			
Latino			60%	60%			
Native American							
Caucasian			20%	20%			
Other (Indicate if possible)							
<u>AGE GROUPS</u>							
Children & Youth (0-17)			24,000 ¹ 750 240	24,000 750 240			
Transition Age Youth (16-25)							
Adult (18-59)							
Older Adult (>60)							
TOTAL							
Total PEI project estimated <i>unduplicated</i> count of individuals to be served						<u>24,000</u>	

¹ The Parenting Project is expected to encompass in excess of 24,000 families with its public media campaign, 750 families with its selective prevention (brief) parenting guidance, and 240 families with its early intervention parenting course.

**Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN**

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

Person/family-level outcomes will be measured using a combination of approaches as follows:

- a. Improved child behavior will be measured using a standardized measure of child behavior (Eyberg Child Behavior Inventory) completed prior to and immediately following a course of Level 4 or 5 intervention
- b. Family stress levels will be measured using a standardized measure (Parenting Stress Index or other measure) completed prior to and immediately following a course of Level 4 or 5 intervention
- c. Improved school performance will be measured comparing STAR scores between schools district who have received Triple P Levels 2/3 and 4/5 services and those that do not, collected annually
- d. Similarly, incidences of suspensions and expulsions will be tracked, and comparison with participating and non-participating schools compared, collected annually
- e. Child maltreatment rates will be measured using county child welfare data for allegations and substantiated incidences (as reported in the CWS/CMS data system) comparing participating and non-participating communities, collected annually

Program/system-level outcomes include:

- Number public media activities (television and radio spots, newsletters, newspaper articles, community fairs, and so forth) per year
- Interagency collaboration will be measured using number of Level 2/3 contacts and Level 4/5 referrals, collected annually

5. How will data be collected and analyzed?

VCBH intends to subcontract for evaluation supports including data collection, analysis and reporting as follows:

- Person/family-level outcome data that involve pre- and post-measures will be collected by the practitioners as the intervention is starting and ending. The completed measures will be sent to the designated VCBH evaluator.
- Person/family-level school data will be gathered, by the VCBH evaluator, annually from participating and select non-participating school districts from existing databases used for tracking STAR test scores and suspensions/expulsions.
- Person/family-level child maltreatment data will be gathered, by the VCBH evaluator, annually from the statewide CWS/CMS database.
- Program/system data involving public media events will be tracked by the Community Coalitions and Triple P Level 1 providers on a monthly log submitted to the VCBH evaluator.

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- Program/system data involving Level 2/3 contacts and Level 4/5 referrals will be tracked by the participating schools, primary care clinics and resource centers using a monthly log submitted to the VCBH evaluator.

Three types of analysis will be conducted as follows:

1. Descriptive/qualitative analyses of program/system data including public media activities and Level 2/3 contacts and Level 4/5 referrals.
2. Quantitative analyses of pre- post- measures (child behavior and family stress) associated with Level 4/5 interventions.
3. Quantitative analyses comparing school performance and maltreatment rates between schools and communities receiving Triple P interventions and those that do not.

Quantitative analyses will include tests of statistical significance.

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

Triple P Parenting, by virtue of its multilevel and flexible components, is expected to be successful with diverse ethnic and culturally groups. To test this, the qualitative analyses will examine the degree to which the public media campaign is tailored to each ethnic/cultural group. Moreover, for the Level 2/3 activities, Level 4/5 referrals, and Level 4/5 interventions, participation rates, and level of improvement (as measured by the individual/family outcomes) will be examined for differences across gender and ethnicities. Any differences will be explored and adjustments to the program tried to improve cultural sensitivity of the project. Outcomes of particular relevance to one or more cultural groups will be incorporated as appropriate.

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

All Level 2/3 and 4/5 practitioners will complete the full Triple P Parenting training protocol as required by the national training center. Adherence to the model is promoted through a certification process and will be monitored using “dashboard” program performance reports, completed twice annually, that summarize indicators of program activity and outcomes. Any departure from expected levels of achievement will be investigated and additional training or supervision provided to improve adherence to the program.

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

Annual evaluation reports, and bi-annual “dashboard” reports, will be broadly disseminated to all participating schools, primary care centers, and resource centers. In addition, they will be shared with the Community Coalitions, and posted on the VCBH website for review by the community at large.

**Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN**

Administration Budget Worksheet

Form No. 5

County: **Ventura**

Date: June 9, 2009

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2009-10		Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator (BH Manager I)		1.00	\$83,101		\$83,101
b. PEI Support Staff (Management Assistant II)		1.00	\$44,160		\$44,160
c. Other Personnel (list all classifications)					\$0
_____					\$0
_____					\$0
_____					\$0
d. Employee Benefits			\$56,631		\$56,631
e. Total Personnel Expenditures			\$183,892	\$0	\$183,892
2. Operating Expenditures					
a. Facility Costs			\$14,711		\$14,711
b. Other Operating Expenditures			\$90,107		\$90,107
c. Total Operating Expenditures			\$104,818	\$0	\$104,818
3. County Allocated Administration					
a. Total County Administration Cost			\$564,119	\$0	\$564,119
4. Total PEI Funding Request for County Administration Budget			\$852,829	\$0	\$852,829
B. Revenue					
1 Total Revenue			\$191,886	\$0	\$191,886
C. Total Funding Requirements			\$660,943	\$0	\$660,943
D. Total In-Kind Contributions			\$0	\$0	\$0

**Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN**

**BUDGET NARRATIVE
Administration**

ESTIMATED PERSONNEL

Costs for salaries and wages amount to **\$183,892**. This includes:

- a. PEI Coordinator (Behavioral Health Manager I) – 1 FTE at \$83,101**
This position will provide overall oversight, management and administration of the PEI funded projects, serving as primary liaison to the State, contracted service providers and community coalitions.
- b. Management Assistant II – 1 FTE at \$44,160**
This position will provide administrative support to PEI Coordinator and to the PEI projects in general.
- c. Employee Benefits**
Benefits and Taxes. Benefits are estimated at **\$56,631** and include FICA, health and dental coverage, SDI, workers compensation insurance, state and federal payroll taxes.

OPERATING EXPENSES

Total Operating Expenses amount to **\$104,818**

- a. Facility Cost. \$14,711**
- b. Other Operating Expenses.** Other operating expenses are estimated at **\$90,107** and include costs for office supplies, program supplies, equipment, travel/mileage, and computers/printers for staff. These Operating Expenditures include non-recurring, start up expenses. Once projects are fully implemented, we expect the operating expenditures percentage to be reduced from 49% to 34% or less.

COUNTY ALLOCATED ADMINISTRATION

The Behavioral Health Department is part of the County Health Care Agency (HCA). The HCA administrative allocation totals **\$564,119**. The HCA allocation is a systematic distribution of Health Care Administrative and Support Services Division cost to the (HCA) budget unit receiving the service. The cost consists of Health Care Agency (HCA) Financial, Human Resources, Information Systems, Patient Accounting, and Compliance support services.

TOTAL PROPOSED PEI BUDGET

- a. The overall expenditure level for this project is \$852,829**
- b. Other revenues for this program are estimated at \$191,886 in MediCal revenue.**

TOTAL FUNDING REQUESTED FOR PEI PROJECT - \$660,943. The total funding requested is the difference between the total expenditures of **\$852,829** and **\$191,886** in offsetting MediCal revenue.

**Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN**

Exhibit E-4 PEI Funding Request

**FY 2009/10 Mental Health Services Act
PEI Component Plan Funding Request**

County: VENTURA

Date: 6/9/2009

PEI Work Plans			FY 09/10 Required MHS Funding	Estimated MHS Funds by Type of Intervention			Estimated MHS Funds by Age Group			
No.	Name	Universal Prevention		Selected/ Indicated Prevention	Early Intervention	Children, Youth, and Their Families	Transition Age Youth	Adult	Older Adult	
1.	1	Community Coalitions	\$622,000	\$373,179	\$248,821		\$285,500	\$100,500	\$153,000	\$83,000
2.	2	Primary Care	\$1,747,429		\$247,565	\$1,499,864	\$290,988		\$970,961	\$485,480
3.	3	School Based	\$1,084,081		\$162,612	\$921,469	\$1,084,081			
4.	4	Parenting	\$440,259	\$66,039	\$44,026	\$330,194	\$440,259			
5.	5	Early Psychosis	\$218,545			\$218,545		\$218,545		
6.										
7.										
8.										
9.										
10.										
11.										
26.	Subtotal: Work Plans^{a/}		\$4,112,314	\$439,218	\$703,024	\$2,970,072	\$2,100,828	\$319,045	\$1,123,961	\$568,480
27.	Plus County Administration		\$660,943							
28.	Plus Optional 10% Operating Reserve		\$477,326							
31.	Total MHS Funds Required for PEI		\$5,250,583							

a/ Majority of funds must be directed towards individuals under age 25--children, youth and their families and transition age youth.
Percent of Funds directed towards those under 25 years= 59%

**Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN**

**FY 2009/10 Mental Health Services Act
EXHIBIT E - Summary Funding Request**

County: VENTURA

Date: June 11, 2009

	MHSA Component				
	CSS	CFTN	WET	PEI	Inn
A. FY 2009/10 Planning Estimates					
1. Published Planning Estimate ^{a/}				\$6,889,700	
2. Transfers ^{b/}					
3. Adjusted Planning Estimates	\$0	\$0	\$0	\$6,889,700	\$0
B. FY 2009/10 Funding Request					
1. Required Funding in FY 2009/10 ^{c/}				\$5,250,583	
2. Net Available Unspent Funds					
a. Unspent FY 2007/08 Funds ^{d/}				\$474,249	
b. Adjustment for FY 2008/09 ^{e/}					
c. Total Net Available Unspent Funds	\$0	\$0	\$0	\$474,249	\$0
3. Total FY 2009/10 Funding Request	\$0	\$0	\$0	\$4,776,334	\$0
C. Funding					
1. Unapproved FY 06/07 Planning Estimates					
2. Unapproved FY 07/08 Planning Estimates				\$1,409,700	
3. Unapproved FY 08/09 Planning Estimates				\$3,366,634	
4. Unapproved FY 09/10 Planning Estimates					
5. Total Funding^{f/}	\$0	\$0	\$0	\$4,776,334	\$0

a/ Published in DMH Information Notices

b/ CSS funds may be transferred to CFTN, WET and Prudent Reserve up to the limits specified in WIC 5892b.

c/ From Total Required Funding line of Exhibit E for each component

d/ From FY 2007/08 MHSA Revenue and Expenditure Report

e/ Adjustments for FY 2008/09 additional expenditures and/or lower revenues than budgeted

f/ Must equal line B.3., Total FY 2009/10 Funding Request, for each component

**Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN**

**Training, Technical Assistance and Capacity Building Funds Request Form
(Prevention and Early Intervention Statewide Project)**

Date: June 15, 2009	County Name: Ventura
Amount Requested for FY 2008/09: \$125,300	Amount Requested for FY 2009/10: 125,300
<p>Briefly describe your plan for using the Training, Technical Assistance and Capacity Building funding and indicate (if known) potential partner(s) or contractor(s).</p> <p>Ventura County Behavioral Health Department will work with a contractor that we have yet to identify that has the demonstrated ability and experience to develop projects that provide statewide training, technical assistance, and capacity building programs in partnership with local and community partners. The contractor will identify and link us with other counties that have similar training and capacity building needs and will partner with local and community partners via sub-contracts or other arrangements in order to help assure the appropriate provision of prevention and early intervention activities in our local communities. The contractor will use training methods that have demonstrated capacity to increase skills and promote positive outcomes consistent with the MHSA and PEI proposed guidelines.</p>	
<p>The County and its contractor(s) for these services agree to comply with the following criteria:</p> <ol style="list-style-type: none"> 1) This funding established pursuant to the Mental Health Services Act (MHSA) shall be utilized for activities consistent with the intent of the Act and proposed guidelines for the Prevention and Early Intervention component of the County's Three-Year Program and Expenditure Plan. 2) Funds shall not be used to supplant existing state or county funds utilized to provide mental health services. 3) These funds shall only be used to pay for the programs authorized in WIC Section 5892. 4) These funds may not be used to pay for any other program. 5) These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by WIC Section 5892. 6) These funds shall be used to support a project(s) that demonstrates the capacity to develop and provide statewide training, technical assistance and capacity building services and programs in partnership with local and community partners via subcontracts or other arrangements to assure the appropriate provision of community-based prevention and early intervention activities. 7) These funds shall be used to support a project(s) that utilizes training methods that have demonstrated the capacity to increase skills and promote positive outcomes consistent with the MHSA and PEI proposed guidelines. <p>Certification</p> <p>I HEREBY CERTIFY to the best of my knowledge and belief this request in all respects is true, correct, and in accordance with the law.</p> <p style="text-align: center;"></p> <p>_____ Director, County Mental Health Program (original signature)</p>	