Plumas County Mental Health’s PEI Program Plan & Expenditure report March 2009.

**PEI PROGRAM AND EXPENDITURE PLAN FACE SHEET Form No. 1**

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

<table>
<thead>
<tr>
<th>County Name: Plumas</th>
<th>Date: 3/11/2009</th>
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<tbody>
<tr>
<td>COUNTY’S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):</td>
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<table>
<thead>
<tr>
<th>County Mental Health Director</th>
<th>Project Lead</th>
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<tbody>
<tr>
<td>Name: John Sebold, LCSW</td>
<td>Name: Pat Leslie</td>
</tr>
<tr>
<td>Telephone Number: 530-283-6307</td>
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<tr>
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<td>E-mail: <a href="mailto:pleslie@kingsview.org">pleslie@kingsview.org</a></td>
</tr>
<tr>
<td>Mailing Address: 270 County Hospital Rd, Suite 109, Quincy CA 95971</td>
<td></td>
</tr>
</tbody>
</table>

**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 I have 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. Furthermore, I agree to conduct a local outcome evaluation for at least one PEI strategy, as identified in the County PEI Plan, in accordance with state parameters and will fully participate in the State Administered Evaluation.

Signature [Signature]
County Mental Health Director
Executed at Quincy, California

Plumas edited PEI application submitted March 2009
Plumas County Mental Health’s PEI Program Plan & Expenditure report March 2009.

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Signature ________________________ _______________
County Mental Health Director  Date

Executed at Quincy, California
Plumas County Mental Health’s PEI Program Plan & Expenditure report March 2009.

**Acronyms and definitions within this application.**

CPS = Child Protective Services, a function of Social Services Departments.

CSOC = Children’s System of Care is a service delivery model, provided by Plumas County Mental Health, that provides counseling and case management for children.

CSS = Community Services and Support, a component of the Mental Health Services Act.

DMH = California Department of Mental Health. DMH is the state oversight agency for county mental health programs.

JJ = Juvenile Justice. Juvenile Justice involvement means children and youth at risk of or experiencing behavioral/emotional problems in the legal system.

MHSA = Mental Health Services Act. The Act has five components of funding categories and related services: community services and supports; workforce education and training; prevention and early intervention; technology and capital facilities; and housing.

NAMI = National Alliance on Mental Illness is a grass roots effort to educate and provide advocacy for individuals living with mental illness.

PCIT = Parent Child Interactive Therapy. PCIT is a service delivery style for mental health treatment involving young children and their primary care provider.

PCMH = Plumas County Mental Health. PCMH is the authorized Plumas County provider of mental health services for the MediCal population.

PEI = Prevention and Early Intervention. PEI is an approach in the way a mental health system can provide services. Prevention programs provide public education initiatives and dialogue to enable access to mental health services at the earliest possible concern. MHSA Early Intervention services are short-duration (usually less than one year), relatively low-intensity, and 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.

PESI = Principles of Empirically Supported Interventions. PESI is comprised of seven guidelines for evaluating clinical interventions.

TBD = To be determined.

WET = Workforce Education and Training is a component of the larger Mental Health Services Act.
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</tr>
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</table>
1. The county shall ensure that the Community Program Planning Process is adequately staffed. **Describe which positions and/or units assumed the following responsibilities:**

   a. **The overall Community Program Planning Process.** The Director of Plumas County Mental Health (PCMH) undertook the planning process with the assignment of a PCMH manager.

   b. **Coordination and management of the Community Planning Process.** The assigned lead manager (a multi-tasking manager with duties of MHSA Coordination) managed the MHSA PEI planning process with guidance from the Director of Plumas County Mental Health.

   c. **Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process.** The MHSA Coordinator is responsible for facilitating the stakeholder process.
2. **Stakeholder participation.** Explain how the county ensured that the stakeholder participation process accomplished the following objectives:

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<tbody>
<tr>
<td><strong>a.</strong> Included representatives of unserved and/or underserved populations and family members of unserved/underserved populations.</td>
<td></td>
</tr>
<tr>
<td><strong>b.</strong> Provided opportunities to participate for individuals reflecting the diversity of the demographics of the County, including but not limited to, geographic location, age, gender and race/ethnicity</td>
<td></td>
</tr>
<tr>
<td><strong>c.</strong> Included outreach to clients with serious mental illness and/or serious emotional disturbance and their family members, to ensure the opportunity to participate</td>
<td></td>
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</table>

The following response combines 2 a, b and c:

**Background on Plumas Community Program Planning**

Plumas County is a geographically large (2,553 square miles) rural region comprised of four (4) living centers (only 1 city). Plumas has an average of eight (8) persons per square mile, for a total of just over 21,000 people as noted in the 2007 census. The 2007 Census data provides the following demographic information on Plumas County:

- 18% of population is less than 18 years of age;
- 19% of populations is more than 65 years of age;

Racial and ethnic composition is:

- 0.8% Asian;
- 1.1% African American;
- 2.8% Native American;
- 7.3% Hispanic.
- 86.5% White (non-Hispanic)

Plumas County Mental Health (PCMH) strives to be part of the community rather than an independent element. PCMH views the promotion of health and happiness as inseparable from its mission of partnership with consumers and family members to promote wellness and recovery.

Plumas leveraged scarce PEI dollars by building on its 2005 CSS planning effort, which assessed the community’s priorities for mental health prevention and early intervention as well as for treatment, and included diverse sectors of the community. (More details are provided in Lessons Learned from CSS Planning Process.) Plumas also experienced and participated in other assessments and strategic planning efforts that are highly relevant to PEI. Examples include the California Child and Family Services Review and System Improvement Plan (October 2005-2008) and the Child Abuse Prevention Plan (2005-2008). Collectively, these planning efforts provided vital information about the
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community’s needs and resources for addressing prevention services (across different areas of human services), as well as coordinated services through collaborative efforts. Since these assessments covered similar content areas and no statistically significant economic or demographic shifts have subsequently occurred in the community, the identified priorities are consistent and remain valid. Limited resources and efficiency inspired and required Plumas conservatively to build on these planning efforts.

Plumas felt that an appropriate venue to utilize limited funding resources was to meet with key representatives who provide the community voice, by proxy. Plumas has strong relationships between community members and service provider(s) through a community network of reliable, consistent, flexible, and trusting exchanges. PCMH respects that many of its citizens who could benefit from PEI and other mental health programs generally dislike and distrust the government and remain disengaged from any community planning processes. At the same time disenfranchised individuals feel supported and well represented by the local community network of nonprofit providers. PCMH respects their distrust and their choice to communicate their concerns through their trusted community network.

PCMH maintains a strong relationship with providers that act as a conduit for the community voice and concerns. Thus, Plumas acquires the input of these disengaged residents via the local network of private non-profit provider(s). Many of these network providers are on the PCMH Commission and PCMH maintains MOUs that support and define functional agreements of longstanding duration. In short, despite the fact that these individuals do not attend meetings or participate directly in community planning, Plumas is not missing their voice at the table because of the close network of relationships in a rural community. This approach is particularly effective in a small county where service delivery is built on trusted relationships.

PCMH’s PEI planning process elicited input and guidance regarding PEI needs and priorities from these community representatives through numerous meetings from October through December 2007. These venues included:

- As a regular agenda item at ongoing Mental Health Advisory Board meetings.
- Multi-agency communications during ongoing Interagency Case Management Team meetings;
- Meetings of the Plumas County Juvenile Justice Commission community strategic planning process including: youth representatives; Probation staff; the District Attorney; Attorneys; Alcohol and Drug Department (A&D); and A&D Prevention Community Coalition; Public Health (education and services); Youth Violence Prevention Group; Foster Youth Liaison for Plumas Unified School District; Plumas Crisis Intervention & Resource Center; Family Focus Network; Family Empowerment Center; Plumas Rural Services Youth Center; and the Child Abuse and Prevention Council.

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- A Round table discussion with the District Attorney for a “family court” process and interaction with a family therapy plan.

Plumas County conducted additional stakeholder outreach with the following:

- Representatives from education, social services and private non-profits during interagency meetings
- Representative from the local Family Empowerment Center
- Individual contacts with: judges, Probation Chief, Directors of Social Services, Health and Alcohol and Drug
- Individual contacts with representatives of Native American tribes, community staff of Latino service organizations, and other non-profit staff
- Case conferencing at Social Services
- Communications at the Health and Human Services Cabinet
- Informal feedback from families in the juvenile justice system.
- Feedback from the small pilot project (solution focused family model) participants.

Once the “word was out” that PCMH was taking input from stakeholders, the following organizations/individuals made additional contacts:

- Horses Unlimited, sought a “therapist” who worked with horses as a means of therapy;
- Greenhorn Ranch, a local private guest ranch sought input regarding the potential for an equine base treatment program similar to Horses Unlimited.
- Plumas Crisis Intervention and Resource Center sought funding for the operational expenses of the non-profit’s crisis line (not to be confused with PCMH’s 24/7 call line).

A key ongoing venue for PEI planning is the monthly Interagency Case Management Team. This network of human service providers, mainly paraprofessionals, receives regular support (for their own skill development and professional guidance) through PCMH case conferences. In case conferencing arenas, open discussion and planning occurs not only for case plans but also related to the fullness of service delivery to the individual/family. In a small community, this approach has particular value.

Plumas County Mental Health participated in the Juvenile Justice –Delinquency Prevention Commission’s Strategic Planning in November 2007. One Plumas County strategy is to implement a Juvenile Justice Prevention and Aftercare project which targets youth involved in or at-risk of being involved in the juvenile
justice system; and their families. During this community meeting, PCMH provided the JJ Commission information on mental health services and the potential for growth of services. These Juvenile Justice Commission members were invited to comment on their hopes and desires for services to the youth in the local law enforcement system.

Plumas County’s Mental Health Commission provides an important venue for voice by the constituents, including for each public hearing. The Plumas County Mental Health Commission serves as advisory group for public input, monitoring implementation, and program evaluation (for all programs, not just MHSA). The Commission receives regular updates on the progress of MHSA.

**Reaching Unserved/Underserved Stakeholders Reflecting Plumas Demographics**

Simultaneously with MHSA transformation of the service system, the Plumas County Mental Health Commission continues to work to seat new members across the diverse populations. The Commission tries to mirror the demographic and the needs of clients. Commission members continue to focus on disparity reduction through recruitment of members. For example, the Commission includes several members of the private non-profit community who conduct outreach and work closely with members of the Latino and Native American Communities. Plumas utilizes these key representative members of the commission to provide guidance and evaluation on services. Plumas’ Commission currently has either active membership from, or ongoing communication with, the following representatives:

- geographic locations from 2 of the 4 population centers;
- chronically mentally ill adults;
- older adults and senior companion program representatives;
- Conservator;
- parent of children;
- Head Start;
- representatives from non-profits (i.e. Plumas Rural Services, Plumas Crisis Intervention and Resource Center). These agencies provide crisis services (homeless, brokerage and linkage, food network, CASA, etc.), and stabilization services (in-home parenting, etc.);
- Special needs population (Family Empowerment Center);
- NAMI;
- public health;
- district attorney;
- victim witness;
- child abuse prevention council representative;
- alcohol and drug;
- probation;
- veterans; and
- superior court judge.
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Plumas continues to conduct outreach to and communication with key cultural groups. Supported by MHSA CSS funding, Plumas County Mental Health sought input in December 2008 from a focus group with Hispanic community members and discussions with Native American representatives. Plumas used a cultural broker within the existing network described above to identify and invite Hispanics to attend. This outreach was successful, with 20 adults and 14 children attending (childcare was provided). Primarily, the needs of the Hispanic community were: education about non-reporting to INS; knowing and spreading the word that Plumas County Mental Health already provides bus passes for clients, as transportation was a cited issue; have more scheduled access (like a drop in center) with a bilingual staff member; and having adult group services. Plumas has Spanish interpreters as extra help employees, provides transportation support via bus passes, and has a work plan to hire a case manager from within the Hispanic community (this effort is delayed due to an all-county hiring freeze).

Plumas’ outreach to the Native American community occurred through the sharing of information during interviews with several key informants. They applauded the recently enhanced access to services that MHSA CSS supported with the development of a mental health services site in their geographical area (Greenville) in 2008. The Native American representatives identified several general community issues, including “reading ability”, alcohol and drugs; decreasing community size (attrition of numbers), and that individuals seek services at point of crisis (not preventative or stabilization). The representatives provided a suggestion for enhanced collaboration with the Family Advocate at the Round House council, Plumas will work to strengthen this linkage.

Outreach to Clients and their Family Members

Plumas County has developed and operated mental health services from a strengths-based, recovery-oriented and consumer-driven perspective for over ten years using a Solution Focused model. The Solution Focused Model was one of the first models to shift the language of change from that of “patient” and “client” to “consumer” and “partner”; from “therapist” to, “partner in change”. Over time, this transition fundamentally shifted how Plumas County Mental Health (PCMH) delivered services.

As a direct result of this fundamental transformation, PCMH began to invite consumers and family members to be directors and designers of their service delivery plans. In addition, Plumas County Mental Health implemented departmental employments of consumers at the professional case management level ten (10) years ago. Other consumer positions have developed, and are filled in office reception and fiscal and technical support work. Currently over 50% of PCMH employees have consumer or family member histories.

Plumas implemented consumer and family surveys to assure involvement in program development three (3) years prior to California Department of Mental Health (DMH) requiring consumer surveys of all mental health plan providers.
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The PCMH administrative model evolved throughout this process by blending consumer, provider and community partner input into its program development process. This access is capable of assuring that PCMH has numerous continuously inviting portals for employee, consumer, consumer family members and community partner input.

Over the past three years consumer/family involvement in the Plumas County Mental Health Commission has increased significantly. NAMI family representatives have over a 2-year history of consistent involvement with virtually no turnover. Please refer to the list in the previous section for more information about consumer and family representation on the Plumas County Mental Health Commission.

Result of PEI Community Program Planning

Across all of its planning efforts, including planning specific to the PEI plan, Plumas identified that the target population of need and best use of limited resources would be the key community need of At-Risk Children, Youth and Young Adult Populations. The Priority Populations of services for Children/Youth in Stressed Families and Children/Youth At Risk of or Experiencing Juvenile Justice Involvement, and their families. This service population choice is not only consistent with feedback from the larger community but resonates with PCMH staff who have repeatedly noted that the children and adolescents they serve require more intense and focused family early intervention services to function safely and effectively in the community and school.
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 Section 3200.270, CCR, 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

Please refer to the response to Question 2 a, b, and c above regarding how Plumas County ensured the involvement of required stakeholders. In addition, the following table summarizes the key venues Plumas County used to secure the involvement of all required stakeholder sectors.

<table>
<thead>
<tr>
<th>Underserved Communities</th>
<th>County Mental Health Commission, individual non-profit staff member communications, individual communication with liaisons from Native American and Latino communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>County Mental Health Commission, Foster Youth Liaison for Plumas Unified School District</td>
</tr>
<tr>
<td>Individuals with Serious Mental Illness and/or their Families</td>
<td>County Mental Health Commission, families participating in the pilot run of the family therapy model, informal feedback from families in the juvenile justice system, youth representatives to Juvenile Justice Commission</td>
</tr>
<tr>
<td>Providers of Mental Health Services</td>
<td>County Mental Health Commission, Interagency Case Management Team meetings</td>
</tr>
<tr>
<td>Health</td>
<td>County Mental Health Commission, individual non-profit staff member communications, Health and Human Services Cabinet, Alcohol and Drug Department including A &amp; D Prevention Community Coalition, Public Health (education and services)</td>
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</tbody>
</table>
b. Training for county staff and stakeholders participating in the Community Program Planning Process.

PCMH provided an overview of the MHSA principles, the Prevention and Early Intervention (PEI) funding allotment, goals and requirements at all planning meetings related to PEI. In addition, the MSHA Coordinator participates regularly in the state supported conference calls from their training and technical assistance contractor.

PCMH views training for staff, consumers and the Mental Health Commission as an integral continuous process of development. PCMH strives to implement and sustain a relationship in which all parties are fully informed in a transparent manner, are invited and expected to discuss and act as partners in decision making and are expected to evaluate outcomes of those decisions.

PCMH has 32.9 full time equivalent employees with less than 5% turnover in professional level staff in any 5-year period and very limited turnover in non-professional level staff. As a result, staff are well informed, well trained and prepared for involvement in a participatory management model of operation.

In addition, the Mental Health Commission has a long standing core membership as a result of very limited turnover and strong commitment. The size of the Commission is comparatively large, significantly exceeding the mandate. The Commission has utilized CIMH training opportunities on three occasions in the past 5 years to expand their knowledge of specific issues including how to advocate specific positions. In addition, PCMH continuously informs the

| Social Services                                                                 | County Mental Health Commission, case conferencing at Social Services, individual non-profit staff member communications, Health and Human Services Cabinet, Youth Violence Prevention Group, Plumas Crisis Intervention & Resource Center, Family Focus Network, Family Empowerment Center, Plumas Rural Services Youth Center, Child Abuse and Prevention Council, Representative from the local, Horses Unlimited, Greenhorn Ranch |
| Law Enforcement                                                                 | County Mental Health Commission, Plumas County Juvenile Justice Commission including Probation staff, District Attorney open discussions, attorneys, round table discussion with District Attorney for a “family court” process and interaction with family therapy plan |

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Commission of its activities and provides on going education regarding DMH initiatives, budgets personnel distributions, resource allocations and access/service challenges and modifications.

As a result of the above stated factors, training specific to PEI focused on informing participants in detail of the use and purpose of PEI funding including the budget implications of the anticipated funding. PCMH provided an overview of the components of the state framework for PEI community mental health needs and populations.

4. Provide a **summary of the effectiveness** of the process by addressing the following aspects:
   a. **The lessons learned from CSS process and how these were applied in the PEI process.**

Plumas’ community planning process, which occurred in 2005 and is described in the CSS plan, utilized expansive outreach efforts, experienced large participation of diverse community members and resulted in a listing of needs for services. The list of priorities the community identified was more expansive than the mere “Community Service and Support” component, with many directly applicable to PEI. A summary of these Plumas County issues and needs is presented below to illustrate that Plumas addressed an inclusive breadth of issues, considered risk factors and identified areas of priority for prevention. (Community-identified needs/issues focused on prevention or early intervention are presented in italics.)

1. **Better collaboration/coordination of services** (funded by CSS, could be enhanced with PEI);
2. Senior Services (funded by CSS);
3. **More intensive parenting education and family mentoring.** Along with the Child Protective Service’s “redesign initiative”, MHSA funded some efforts here with CSS. There remains more identified to do when future categorical funding becomes available.
4. **Children aged five and under** (As an offshoot of the CSS planning process this issue was assessed by Plumas County Mental Health by implementing a formal referral process, collecting and evaluating subsequent data. A CSS plan was then funded through CSS.)
5. **Mental health services in elementary schools.** An existing resource for this service, already in place is MediCal and SAMSHA funded. PCMH is looking to MHSA funds for expansion if allowable, both CSS and PEI.
6. **Children aged 5-10 years.** Expand the resources of referrals for Children System of Care to receive more referrals for this age group. (to be funded by CSS.)

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7. Improved crisis response. To be addressed through enhanced protocols of interagency responses.

8. More suicide prevention. (Plumas County Mental Health implemented a procedure to track and evaluate all suicides in the county to determine what policy and procedure changes might decrease suicides. An electronic shared file regarding suicide assessment skills and research related to suicide prevention is maintained and continuously expanded in PCMH.)

9. More case management services (i.e. build on the success of developing long-term relationships with youth and families). “More” case management services was described as more staff for more contact time per case, more services in more geographic diversity; case management services to adults currently without services; etc.

10. Hospital based therapy and case management (co-location of mental health staff at primary health care environments). Previously PCMH implemented a rural partnership with a regional hospital that was partially funded by the Sierra Rural Health Foundation. Because of space and personnel hiring constraints PCMH had to withdraw from the project. In addition, PCMH historically has implemented a similar model in a Native American rural health clinic for multiple extended periods. This model was discontinued due to the instability of tribal leadership that disrupted clinical care. PCMH has a history of working in collaboration with three regional hospitals to develop assessment and treatment protocols for a variety of emergency room problems including, dementia, psychosis and alcohol and drug presentations.

11. More services for people who are homeless (Two levels of supported housing are funded by CSS).

12. Peer mentoring (funded by CSS), Plumas has a long history of employing consumers. Clients, both adult and youth, are engaged with a network of services, become connected and more socially capable, increase their own skills, and then desire to share it with peers.

13. Transitional housing (funded by CSS and housing component) Current efforts are underway to assess and develop a collaborative transitional and supportive housing project with multiple partners including; Plumas Corporation, the local housing authority, County Board of Supervisors representatives, local landowners, Plumas Crisis Intervention Services and a contracted engineering firm.

14. More mental health training for other agency staff (funded by Workforce Education and Training).
15. **More services for family caretakers** (parents, spouses, children of adults, etc.). The community described “more services” as including, but not limited to, receiving guidance on individual skill development (anger management, parenting, etc.) and family dynamics.

16. Help with accessing psychiatric medications (funded by CSS).

17. **Increased services for Latinos.** PCMH has consistently expanded accessibility to interpreter-based services to improve access to mental health services. PCMH was a partner in evaluating and improving Latino health care via the Sierra Institute Proyecto Salud project and continues its dialogue with the Latino population as part of the prevention planning process. Plumas' prevention model's focus on the family is intended to both recognize and respect, “Familialism” one the Latino cultures most important values. Familialism is associated with family loyalty and the identification and connection with immediate and extended family members throughout the life cycle. The model design assures that the integrity and importance of the Latino family is recognized as a key to successful sustainable adaption and change. Other important values such as, Respeto, bien educadio, simpatia are also consistent with this model. The Plumas prevention model will require that the associated prevention staff are familiar with these values through the use of trainings and educational materials. Our Solution Focused model is designed to help families utilize and sometimes rediscover the cultural strengths and resources that may have been disrupted by transitional turmoil or trauma.

18. **Support CSOC programs** (funded by CSS). The identified success is the development of long-term relationships with an adult authority figure and the interactions are typically outside the office. To be partially financially supported by CSS.

19. More therapeutic recreation programs. The department had operated a summer Wilderness therapeutic program for 12 years prior to expanding to year-round with the addition of winter wilderness activities. Again, the core is the long-term relationships with adults, while performing challenging group and individual activities that are “normal” activities for the general community member (backpacking, rock climbing, snowshoeing, snow boarding, winter camping, etc.)

The above listing is shared with reviewers to illustrate the extent to which the community of Plumas County discussed broad risk factors and community needs (not just service gaps) in its CSS Planning, and had eleven (11) areas of need (italics) that overlap “prevention and intervention”. It was important that the PEI planning process built on the extensive and valuable community planning that occurred during CSS.

In addition, Plumas County’s CSS process identified the following five things learned about the community with regard to children ages zero through five:
1. One need identified for children aged zero through five is for assurances of community partnerships with government and community based organizations to deliver Parent Education. The outcome was that Plumas County Mental Health will partner with other agencies (community based organization, First Five Commission, and Social Services) to support enhancing the training of providers among agencies to be skilled in Parent Child Interactive Therapy (PCIT). Plumas County Mental Health intends to support this project with resources from within the MHSA component of Workforce Education and Training (WET), not PEI.

2. A second need identified for children aged zero through five is for mental health professionals to train and educate child care center staff. This service was undertaken soon after the 2005 CSS assessment process. Plumas County Mental Health clinical staff is regionally assigned in the county and have been supportive of on-site observations of children and education of staff at the regional Head Start facilities. Plumas County is not utilizing MHSA funding to perform this strategy.

3. A third need identified for children aged zero through five, was to have Plumas County Mental Health collaborate with Plumas First Five Coalition, Plumas Unified School District and community based organizations to fund paraprofessionals to conduct behavioral health interventions in child care settings. Plumas County is currently incorporating this need as noted above.

4. A need identified for children aged five through ten years of age, was to adapt the Children’s System of Care (CSOC) program for younger ages. Although the Plumas CSOC program was already adapted to serve this age range, it was learned that the communities’ perception was that CSOC only served teens. Plumas CSOC educated agencies and requested referrals be made for this age range in an effort to attain data regarding the possible unmet need in this area of concern. After an aggressive effort to increase awareness of service availability, only a limited number of referrals have actually been made in the past three years (no more than prior to this community outreach effort).

5. A general need of “more services for family caretakers” was identified in the CSS process. No strategy was identified at that time, nor was a clear definition of which population of caretakers (adult, paraprofessionals, adults of minors, etc.) needed services. From this request, Plumas County Mental Health has been supporting, with CSS funding, the local NAMI chapter’s efforts in helping families through “Family to Family” and support groups. In addition to this effort, Plumas County Mental Health pursued additional information in the PEI planning process to determine if it should remain a priority with additional applied strategies.

The key lessons learned from CSS planning are to stretch scarce resources by building on all relevant planning efforts and by leveraging all possible community...
resources to meet identified community priority needs. This holistic, integrated planning reflects the strong community basis of Plumas County’s overall approach to community mental health.

b. **Measures of success that outreach efforts produced an inclusive and effective community program planning process**

The MHSA PEI Guidelines developed by DMH indicate that a goal of the planning process is to work through a logic model. Briefly the logic model is to: ID needs, target population, asset mapping, desired outcomes, program/service selection, detail the services, and include quality measurements. PCMH has accomplished the planning processes while engaging the required community “sectors, systems, organizations and people that contribute to particular mental health outcomes in successful prevention and early intervention programs.” (page 12 of guidelines). Success is also indicated by the high level of unanimity among many diverse contributors to planning about the priority of Plumas County’s proposed family therapy program. Details of the basis for the selection of this program are included in the next section.

5. Provide the following information about the required **county public hearing**:
   a. The date of the public hearing: March 26, 2008. Eleven members of the public attended.

   b. A description of how the plan was circulated to representatives of stakeholder interests and any other interested parties who requested it.
   - Electronic notification of the availability of the document was sent to all stakeholder individuals, agencies and departments who provide PCMH with email address.
   - A News article ran once in the weekly Feather River Bulletin.
   - The documents were posted on the county website [www.countyofplumas.com](http://www.countyofplumas.com).
   - While attending meetings, PCMH administrators announced this public review process was underway.

   c. A summary and analysis of any substantive recommendations for revisions
   There were no substantive recommendations for revisions.
Plumas County Mental Health’s PEI Program Plan &
Expenditure report March 2009.

**PEI WORKPLAN SUMMARY Form No. 3**
Plumas County Mental Health proposes only one PEI project; thus, there is only one completed “form 3” within this application.

**County:** Plumas  
**Workplan Name:** 12-15 session Family Therapy  
**Date:** 3/10/2009

### 1. PEI Key Community Mental Health Needs

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Select as many as apply to this workplan:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Disparities in Access to Mental Health Services</td>
</tr>
<tr>
<td></td>
<td>2. Psycho-Social Impact of Trauma</td>
</tr>
<tr>
<td></td>
<td>3. At-Risk Children, Youth and Young Adult Populations</td>
</tr>
<tr>
<td></td>
<td>4. Stigma and Discrimination</td>
</tr>
<tr>
<td></td>
<td>5. Suicide Risk</td>
</tr>
</tbody>
</table>

### 2. PEI Priority Population

Note: All workplans must address underserved cultural populations

<table>
<thead>
<tr>
<th>Age Group</th>
<th>A. Select as many as apply to this workplan:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Trauma Exposed Individuals</td>
</tr>
<tr>
<td></td>
<td>2. Individuals Experiencing Onset of Serious Psychiatric Illness</td>
</tr>
<tr>
<td></td>
<td>3. Children and Youth in Stressed Families</td>
</tr>
<tr>
<td></td>
<td>4. Children and Youth at Risk for School Failure</td>
</tr>
<tr>
<td></td>
<td>5. Children and Youth at Risk of Juvenile Justice Involvement</td>
</tr>
</tbody>
</table>

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PEI WORKPLAN SUMMARY Form No. 3

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

PCMH’s PEI planning process consisted of eliciting input and guidance with regard to needs, priorities, ongoing or planned efforts and resources through methods described in the previous section. PCMH (during Interagency Case Management Team meetings; case conferencing at Social Services; individual non-profit staff member communications, and communications at the Health and Human Services Cabinet meetings) repeatedly highlighted the underserved family situations. The following summarizes the input and data relevant to PEI.

Please see response to Question 2, “Result of Community Program Planning,” for response to this question.

Selection of Targeted Approach to At-Risk Youth and Their Families

Having identified the target population as youth in stressed families and at-risk and juvenile youth, planning participants agreed on the highest priority: to contribute to the breadth of services and fulfill a remaining, unmet service need by utilizing the limited Plumas County PEI financial resources for a family therapy model with at-risk teenagers.

Addressing the Need

Perhaps the most damaging experience a rural child/adolescent can experience is placement outside their community in an urban correctional facility or group home. When this occurs the child or adolescent is exposed to a more sophisticated and often more dangerous contingent of urban offender. In such situations a rural child is culturally disadvantaged and thus vulnerable as potential victims and is more easily negatively influenced. Rural Native American and rural Hispanic youth are even more at risk of harm in these situations because of the vulnerabilities generated by their cultural/racial identification as well as their rural culture naïveté. When a rural child is placed in a group home or a correctional facility they are most often removed great distances from their sources of family and community support. In most cases they are placed 60+ miles away from any known person or support system. Research is increasingly showing that human health, happiness and well-being are dramatically embedded in social networks and that disrupting those networks results in extremely poor results. There are numerous historical examples that underline the damage done by removing individuals from their cultural context.

It is Plumas’ contention that if we are to be committed to preventing damage to rural youth we need to commit resources to support and build their social networks and the core of those networks are their families. To accomplish this, Plumas’
network chose to provide a family early intervention service. Plumas plans to identify individuals (youth/teens) that are at risk for entering the criminal justice system or who have had an initial brush with law enforcement.

The Plumas prevention plan attempts to identify individuals that if not assisted will enter a criminal justice system that by all measures will promote failure in all personal and social dimensions. Youth involved in the Plumas County Juvenile Justice System, while in-county (not in placement), may be receiving individual counseling through memorandums of understanding between Plumas County Mental Health and Juvenile Justice. Multi-agency communications received by Plumas County Mental Health recognizes that prevention is best implemented early in the life cycle and as a result, many years ago, PCMH developed the elementary school intervention project that offers in school mental health services. At the same time, PCMH recognizes that early intervention is a relative term in that some problems do not arise or are not identified until late childhood or early adolescence. The functioning of family and social networks are not linear in that some families that are essentially functional in the early developmental years are overly stressed and non-functional in the later years. Thus, it is important to have preventative processes through the child/adolescent life cycle and to identify key times where relatively low cost, short-duration, low intensity intervention will prevent children/adolescents from falling into the Juvenile Justice System abyss.

Such a prevention approach is not simply a, “fill the gaps” approach as it specifically attempts to prevent long-term serious harm by expanding the capacities of families at a critical time in their developmental cycle. It is important to keep in mind that the majority of Plumas’ first time offenders in the Plumas County Juvenile Justice are not existing clients for Mental Health, the families have little/no connection to the network of services described above, and are typically not eligible for MediCal. A court referral will often be the communities’ first opportunity to work with this child and family. A second important point is that the Plumas law enforcement community, like many rural law enforcement communities is highly reactive, citing and charging young people more aggressively and proactively. This has some negative implications but it also creates an opportunity for early identification and intervention if the resources are available to respond.

Plumas County’s PEI plan addresses the communities’ most pressing need for family therapy as an early intervention resource. For PCMH adult consumer’s, collective feedback indicated that the expansion and integration of larger social networks may be indicated as a long-term goal. PCMH has addressed some of this need through the development of socialization processes, employment programs and activities, educational opportunities, art programs and its relationship with NAMI. In spite of this, much work is yet to be done and the foundation itself is yet to be complete. One of the missing elements for parents, children and adolescents is being able to access services that strengthen and support the family unit. Clearly, PCMH has received the message from multiple vested parties that this element is largely inadequate or missing especially for the non-MediCal families.
In addition PCMH attained confirmation of consumer support of this type of initiative when it implemented a family early intervention group process in 2000. The vast majority of consumers involved in the project strongly advocated its continuance but PCMH was forced to cut the program due to budget constraints.

Building on Strengths

Plumas County’s planning not only assessed needs but also identified and built on community strengths including existing Plumas County services and supports. A recently issued matrix of “strategic prevention plans in Plumas County”, collated by the Alcohol & Drug Prevention Community Coalition, records seven (7) prevention coalitions or mission oriented agencies and their efforts across twelve (12) prevention domains. This matrix demonstrates the work being done in the County with parenting skills, child abuse prevention (both curriculum and individual case support), enhancement of inclusion and adequacy of community child care, domestic violence prevention, etc.

PCMH reviewed the input of numerous stakeholders, data from 2005 CSS planning and from numerous prevention plans within the community to determine community assets and needs. From this data, PCMH identified a selected theme(s) of community identified needed services for at-risk youth. The community identified needs (relevant to PEI) for children and youth including the following: alcohol and drug education and intervention; life skills, education of; positive behavior support specialties (in schools); care program (after school); general early intervention services; more case managers; peer counseling; and strengthen families (parents need services so they can work with difficult children; develop and increase parenting skills, earlier referrals for intensive services).

The community of Plumas already conducts a number of services for stressed families and youth at risk across the age ranges. Examples include:

- mental health assessments and consultations in Head Start school sites;
- mental health assessments, counseling and case management at elementary, junior, and high school sites throughout the county;
- collaborative agreements with a non-profit for parent-child interaction training for children with behavioral problems;
- collaboration with a non-profit for in-home parenting guidance;
- mental health assessments and counseling for youth (ages 13-18) active in Juvenile Justice;
- collaborative work with Child Protective Services regarding foster-child assessments and counseling; and
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- adult and child case management services in support of anger management, socialization, etc.; and
- mental health outreach, with collaboration from PASSAGES, to the senior population.

Plumas’ plan is designed to build on the strength of this existing capacity and network of community services.

Selection of Specific Intervention

Plumas’ service delivery model is consistent with the DMH guideline of “early intervention (that) 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…”

PCMH utilized expertise with California Institute of Mental Health (CIMH) to assess potential best practices in family therapy early intervention models that serve the target population and that may meet the identified goals. PCMH also took input from Dr. Troy Armstrong, Director of the Center for Delinquency and Crime Policy studies at California State University in Sacramento. Those models that were considered, included: Functional Family Therapy; Multi-dimensional Family Therapy; and Multisystemic Therapy. Plumas’ plan is designed in alignment with the project selections provided by the State Department of Mental Health in its Resource Materials.

Please see response to #5, Alternate Strategies, for a more complete description of the proposed family therapy model.

Data analysis: Why Certain Stakeholder Priorities Were Not Selected

PCMH met with stakeholders to review and data capture on a desired strategy of “more services for family caretakers” (previously identified within the CSS process as a community need relevant to PEI). The PEI collaborative planning process illuminated the following:

- Considered several populations and strategies for “caretakers”. The following were discussed and not selected as a top priority either for reasons of concern regarding supplanting of funds or for reason(s) indicated: pregnant women with depression to be addressed with the four P’s program. The home visiting team is doing a great job at meeting with women and potentially identifying cases needing referral for mental health services. Plumas County Mental Health would like to initially see the local First Five Commission support a prenatal depression support program and from that, the local need could be further developed. Also considered an “aide worker wellness program” because of the statistics tying depression to workers who provide care and meals. Although a strong fit to PEI and a need, it was not identified as a top priority in the community input avenue.
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• Defined the neediest (of mental health services) subpopulation of “caretakers” as parents/guardians of at-risk or juvenile justice youth aged 10-18.

• Reconfirmed that even 2.5 years post the initial CSS community assessment process, effective services to this targeted population of caretakers is minimal. Thus, a service that intervenes with children/youth in stressed families was set as the desired service goal.

• Discussion and research for the best fit service model. During this phase PCMH received guidance from California Institute of Mental Health; Functional Family Therapy LLC and the input of Dr. Troy Armstrong.

• PCMH identified that the optimal point of investment would be a short-duration (12-15 session) family therapy program that combines the best of family models, such as Functional Family Therapy, but flexibly structured and culturally sensitive to a small and rural community. The PCMH 12-15 session family therapy model shall successfully apply established clinical theory and supported principles, and extensive clinical experience with solution focused therapy.

3. PEI Project, Work Plan Description:
PCMH will simultaneously target children & youth in stressed families who are at risk of or experiencing juvenile justice involvement, and the caregivers of these children. PCMH will provide a new, structured, short-term (12-15 session) therapeutic family program that is supported by MHSA PEI resources. The goals of the 12-15 session family therapy service model are: 1) successfully engage and motivate the members of the family through strength-based relationship processes; 2) Reduce and eliminate the problem behaviors and accompanying family relationship patterns; and 3) progress to more generalized adaptation skills.

Despite the network of strengths of Plumas, there are families that remain outside the network of services (isolated/hermit/antigovernment). For many of these families the children do not attend schools and the family is generally not involved in normal/regular social functions. These families typically are “unserved” individuals in the mental health field. These families usually access services only upon legal involvement and/or at times of crisis. Many of these families will only follow through with obtaining and maintaining services, if they receive an order by a court of law. Outpatient services remains voluntary, and the individual/family can/does opt to not engage in mental health services. It is the families, with teen children, that often come into the Juvenile Justice system with first offenses. They are a resource for first access that Plumas wants to use as the beginning of services in the network.
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There is importance for these individuals to receive a “court order” to attend services, especially mental health services. A court order allows clients to receive services without looking to their peers as if they are seeking government help and acknowledge that they are part of the system (“I only go to get the law off my back”). Plumas identifies that this is an access point for beginning to develop trusting relationships with the child(ren) and adults. From that new place of trust, to then address the issues of anger, defiance of authority figures, substance abuse, inadequate parenting, etc. The individual and family provide input (voice and choice) in their service plan development. A process of both informal and formal “brokerage and linkage” will be made for clients, as determined in their individual service plan.

Location of Services

Demographics, geography and economy of scale all impact Plumas County Mental Health’s decision making regarding where to provide services. To maximize efficiency and to serve as many families as possible we must have a plan that optimizes resources. Plumas’ family therapy services are to be provided in a building that houses most of the government programs for human services (i.e. public health, social services, veterans, senior services, etc.). This co-housing/one-stop location allows for adequate use of public transportation, numerous parking slots, plowed roads, and clients can/do set a series of appointments across providers for the day. Regularly, a staff member from one service department is observed walking a client to another department as an introduction and means of obtaining access to services (i.e. utilizing trusting relationships). The other reason for locating family therapy services in the main mental health clinic, is that the Director is housed there and he will be providing clinical supervision to this program; thus, services need to be in proximity to the Director. Additionally, having many services in close proximity (within the human services building) facilitates the efficiency of services, the leveraging of connections/network, enables (easier) the convening of multi-agency meetings (for case conferencing), etc.

While Plumas County Mental Health is already providing services at all public school sites and provides weekly scheduled mental health services at all the county’s elementary schools, it is not feasible to locate this program in school sites. Many disenfranchised families are not participating in formal school settings. There is a high degree of home schooling, some reasons are anti-government sentiment; a child has been expelled from school; or the family feels that the school inadequately or unfairly interacts with their child and removes the child from school, etc. In addition, studies on similar models have shown that there is little or no value to in home services for this population. Such home-based strategies increase cost but show no better commitment from families nor do they indicate better outcomes.

Personnel timeline and key milestones:

Plumas edited PEI application submitted March 2009
## Plumas County Mental Health’s PEI Program Plan & Expenditure report March 2009.

<table>
<thead>
<tr>
<th><strong>Anticipated Time period</strong></th>
<th><strong>Activities</strong></th>
<th><strong>Who performs</strong></th>
<th><strong>Key outcome</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2008 – April 2009</td>
<td>Apply for funding</td>
<td>MHSA Coordinator &amp; Director</td>
<td>Get funding</td>
</tr>
<tr>
<td>June-July 2009</td>
<td>Recruit clinical staff</td>
<td>County HR &amp; PCMH administration</td>
<td>Hire staff</td>
</tr>
<tr>
<td>July 2009</td>
<td>Train clinical staff</td>
<td>Director</td>
<td>Capable clinical skills</td>
</tr>
</tbody>
</table>

### Infrastructure timeline and key milestones:

<table>
<thead>
<tr>
<th><strong>Anticipated Time period</strong></th>
<th><strong>Activities</strong></th>
<th><strong>Who performs</strong></th>
<th><strong>Key outcome</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2009</td>
<td>Develop office for clinician</td>
<td>Administrative staff</td>
<td>Functional staff office</td>
</tr>
<tr>
<td>June 2009</td>
<td>Develop/acquire database software</td>
<td>Administrative staff along with IT vendor</td>
<td>Database that records assessment, case tracking/training, supervision, &amp; outcomes.</td>
</tr>
<tr>
<td>July 2009</td>
<td>Develop clinical rooms</td>
<td>Clinician and Director</td>
<td>Functional clinical rooms</td>
</tr>
<tr>
<td>July 2009</td>
<td>Purchase program supplies</td>
<td>Fiscal &amp; technical support unit</td>
<td>Program supplies are available</td>
</tr>
<tr>
<td>July 2009 – ongoing</td>
<td>Case conferencing</td>
<td>Clinical support team</td>
<td>Diverse input for family planning.</td>
</tr>
</tbody>
</table>

### Program operations timeline and key milestones:

<table>
<thead>
<tr>
<th><strong>Anticipated Time period</strong></th>
<th><strong>Activities</strong></th>
<th><strong>Who performs</strong></th>
<th><strong>Key outcome</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2009</td>
<td>Outreach to juvenile justice, courts, social services, etc informing them of new services</td>
<td>Administrative staff</td>
<td>Referrals are made to PCMH</td>
</tr>
<tr>
<td>1 week from referral</td>
<td>Telephone outreach to referred family</td>
<td>Clinician</td>
<td>Family volunteers for first contact meeting. Develop credibility and alliance with families.</td>
</tr>
<tr>
<td>July 2009 &amp; ongoing</td>
<td>Regular weekly family sessions (for 12-15 weeks)</td>
<td>Clinician and family</td>
<td>Families receiving support.</td>
</tr>
<tr>
<td>Semi-annually</td>
<td>Evaluation of program. Evaluation of client/family’s behaviors.</td>
<td>QA &amp; Administrative staff</td>
<td>Assessment of fidelity to plan, lessons learned, adaptations made, etc.</td>
</tr>
</tbody>
</table>

Families, timeline and key milestones:

Plumas edited PEI application submitted March 2009
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<table>
<thead>
<tr>
<th>Anticipated Time period</th>
<th>Activities</th>
<th>Who performs</th>
<th>Key outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2009 &amp; ongoing</td>
<td>Accept referral to PCMH</td>
<td>Families</td>
<td>Developed relationship with clinician</td>
</tr>
<tr>
<td>12-15 weeks</td>
<td>Engage in weekly family therapy sessions</td>
<td>Clinician and families</td>
<td>Develop positive interpersonal skills.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Brokerage and linkage</td>
<td>Clinician and treatment team members.</td>
<td>Enhanced support system available for family’s utilization.</td>
</tr>
</tbody>
</table>

Fiscal Year 2007/08 funds will be consumed predominantly in Fiscal Year 2009/10 by planning and “gearing up” toward implementation, for example:

a. Ensure service positions are staffed (with clinical staff that has high availability, one part-time clinician (70%) per every #19 active cases), trained in interpersonal skill interventions (strength-based & solution focused, validation, positive interpretation, reattribution, reframing, and sequencing) and have administrative support (office, computer, furniture, program management, etc).

b. Set-up the clinical setting(s) for services in ways that support access especially for people currently unserved or underserved.

c. Target outreach to receive referrals for youth ages between 10 and 18 year-olds, all ethnic and cultural groups, from at-risk adolescents and their families. These referrals will be from underserved families with diverse family organization, presenting problems, cultures.

d. Clinical support team, consists of a small group of clinicians, staff and peers (members of other families when appropriate), to view video and direct observations.

e. Develop the systematic training, supervision, process, and outcome assessment components.

Fiscal Year 2008/09 funds will begin the service program start-up year expected to be Fiscal Year 2009/10 of the 12-15 session family therapy program and involve the following:

**Engaging families:**

- Establish links with and receive referrals and support to and from partner agencies (schools, social services, human service non-profits and juvenile justice probation, and courts)
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- Immediate responsiveness (small/no wait time for services) and staff able to meet with families when they are able to meet;
- Telephone outreach to referred families;
- Client assessment, case tracking/monitoring system, and outcome assessments;
- Develop credibility and alliance with families (be responsive, engaging, and demonstrate desire to listen and help);
- Make twelve to fifteen (12-15) family sessions regular and predictable for families.

**Therapeutic Family Sessions (12)**

- On average, a dedicated session per week, with parent/guardian participation;
- Structure of 1 hour sessions, typically, to be: 5 minutes socialize; 10 minutes review of week; 5 minutes to select a single problem; 25 minutes for formal problem solving; 10 minutes team debrief/agreement on family input; 5 minutes summarize and socialize;
- Strength based; relationship process i.e. develop relationship and interpersonal skills;
- Divert and interrupt negative patterns;
- Develop plans for behavior change (change habitual problems and interactions);
- Develop conflict resolution and communication skills;
- Develop creative responses with the sensitivity to family, culture, abilities, needs, etc.;
- Apply changes to general community situations;
- Develop relapse prevention and intervention plans; and
- Develop plan for supportive links to community resources and other support systems.

**Brokerage and linkages:**

The operation of the family therapy program will further enhance the links with people who are likely to recognize early signs of mental illness and intervene or refer the youth to Plumas County Mental Health.

During the 12-15 therapeutic sessions the therapy team may feel it appropriate to help an individual or family obtain and/or link to additional mental health assessment and treatment or to other services and supports, i.e. substance abuse prevention and treatment; basic needs (food, housing, employment, etc.). The family therapy session will also provide opportunities to refer family members to other services and supports that can benefit them. Referrals that build on a web of relationships tend to be most effective in Plumas County for building, maintaining and enhancing support systems.
Evaluation:
System/program outcomes:
- Fidelity to a family psychoeducation fidelity scale utilized by New York State.
- More community organizations providing identification and early intervention for short-term mental health services. The measurable result = increase in number of appropriate individuals and families identified as needing, and who receive, prevention program and early intervention services.
- Increase family access to early mental health services.
- Increase family access to other relevant services and supports

Individual/family outcomes: (short, non-intrusive measures of client’s perspective and clinician’s broad and general assessments); trend analysis to compare the pattern of change for pre and posttests (time TBD).
- Enhance behaviors related to protective factors (…self-esteem, decision making and its applicability, personal control, interpersonal communication, prosocial group behavior, prosocial activities)
- Reduction in behaviors related to risk factors (….impulsiveness, poor decision making and coping skills, learned helplessness, poor social/interpersonal skills, susceptibility to negative peer influences, nonparticipation in school/social activities)
- Reduce removal of children from home and in placement.
### PEI WORKPLAN SUMMARY Form No. 3
#### 4. Programs/Strategies

<table>
<thead>
<tr>
<th>Strategy Title</th>
<th>Proposed number of individuals or families through PEI expansion to be served through June 2010 by type</th>
<th>Number of months in operation through June 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevention</td>
<td>Early Intervention</td>
</tr>
</tbody>
</table>
| 12-session family therapy | Individuals: 57<sup>a</sup>  
                       | Families: 19<sup>b</sup>                                                                 | Individuals:  
                       |                                                                                               | Families:  
                       |                                                                                               | July 2009 – June 2010 = 12 |
| n/a                                                                                     |                                                                                               | Individuals:  
                       |                                                                                               | Families:  
                       |                                                                                               | 
| n/a                                                                                     |                                                                                               | Individuals:  
                       |                                                                                               | Families:  
                       |                                                                                               | 
| n/a                                                                                     |                                                                                               | Individuals:  
                       |                                                                                               | Families:  
                       |                                                                                               | 
| n/a                                                                                     |                                                                                               | Individuals:  
                       |                                                                                               | Families:  
                       |                                                                                               | 
| n/a                                                                                     |                                                                                               | Individuals:  
                       |                                                                                               | Families:  
                       |                                                                                               | 
| Total Work Plan estimated, unduplicated, count of individuals to be served.               | Individuals: 57  
                       | Families: 19                                                                                   | Individuals:  
                       |                                                                                               | Families:  
                       |                                                                                               | 

**Notes:**

a. estimating that “families” will consist of 3 individuals (either 2 adults and 1 child or 1 adult and 2 children) on average.
b. estimated 19 families per 12-15 week sessions with four sets per year.
PCMH’s proposed 12-15 session family therapy program is an adaptation of several strategies identified in the PEI Resource Materials.

PCMH reviewed several “best-practice” service models for the county’s PEI target population (adolescents with disruptive disorders, delinquency, etc). PCMH researched the following models: Parent Child Interactive Therapy; Functional Family Therapy (developed in Utah, 1973); Multidimensional Family Therapy (developed in Missouri & South Carolina, 1992); (MST, Multi-Systemic Therapy, 1990); Structural Family Therapy (1989); Brief Strategic Family Therapy; and Aggression Replacement Training (developed in New York). Local review/research of each service model found them to be costly and unyielding for application to small and rural implementation. PCMH’s research on service models found: high cost for implementation (not cost effective due to small scale of cases); several lacked addressing family conflict; considered the identification and referral of the appropriate case may not be suitable in Plumas County; and had concerns that any adaptation to a pre-formed model may destabilize the potential stated outcomes. Sexton & Alexander (2002) indicate that family-based interventions, as a multisystemic treatment model, can make positive clinical changes if implemented with regard to PESI guidelines. The Juvenile Justice Bulletin of December 2000 (from Office of Juvenile Justice and Delinquency Prevention) also had previously cited that family-based interventions that adopt a multisystemic perspective are well suited to treating the broad range of problems found in juveniles who engage in delinquent and criminal behavior."

PCMH has successfully implemented solution-focused therapy for several years with other target populations. Thus, PCMH proposes to utilize universal components of service, from the researched models, and design an adapted program to implement a family therapy model that is suited for this rural, small county. This program will be complementary, not competitive, to any existing services the child and family are participants in. PCMH shall annually evaluate this 12-15 session family treatment model for level of adherence to the framework of the family psychoeducation fidelity scale.
PEI WORKPLAN SUMMARY Form No. 3

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

Plumas believes that the outcomes achievable for the child/family from the family therapy program will be complementary and/or sequential to the community network of services. The Plumas MHSA PEI proposal is integrated, strengths-based, accessible through the network, and culturally competent. During the 12-15 therapeutic sessions the therapy team may feel it appropriate to help an individual or family obtain and/or link to additional mental health assessment and treatment or to other services and supports, i.e. substance abuse prevention and treatment, including the network of services supported by MHSA; basic needs (food, housing, employment, etc.); child services providers (non-profits) and informal community networks. The strong, ongoing supportive network among service providers in Plumas County will facilitate these referrals.

6. Collaboration and System Enhancements

The operation of the family therapy program will further enhance the links with people who are likely to recognize early signs of mental illness and intervene or refer the youth to Plumas County Mental Health. Additionally, this new service model (12-15 session family therapy for at risk youth) moves PCMH toward prevention and early intervention and not just providing services for treatment and recovery.

The collaboration of Juvenile Justice and Child Protective Systems, as well as from mental health professionals, will be the primary resources of referrals for the family therapy program. Additionally, it viewed that should Plumas County’s Family Court become fully operational that this system will not make referrals but make requirements within family court orders to make connection with the family therapy program.

Community efforts are underway for a non-profit group to provide family therapy to the families with children under the age of seven (7), who have experienced or are at risk of experiencing child abuse. PCMH is supportive of these efforts and plans for financial and clinical support and participation in implementing Parent Child Interactive Therapy (PCIT), and will link families to this service, as appropriate.
The 12-15 session family therapy program has the following intended outcomes:

<table>
<thead>
<tr>
<th>Outcome of (who/what)</th>
<th>Description of outcome</th>
<th>Method of measure</th>
<th>Periods of evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>System outcome</td>
<td>Families have enhanced access to services from the justice fields.</td>
<td>Referrals to the PEI program occur. Increased brokerage and linkage to Mental Health from the justice fields. Increased collaboration as measured by attendance at interagency discussions.</td>
<td>Semi-annually</td>
</tr>
<tr>
<td>System outcome</td>
<td>Assess for barriers and successes</td>
<td>• referrals are occurring • therapy timeframe is adequate • family successes • implementation challenges • assessment of the level of extent, quality and nature of collaboration with partner organizations (referring sources)</td>
<td>Semi-annually</td>
</tr>
<tr>
<td>Family outcome</td>
<td>Participating families show fewer negative consequences from emotional and behavioral disturbances</td>
<td>Self-report</td>
<td>Pre and post</td>
</tr>
<tr>
<td>Family outcome</td>
<td>Reduce negative communication &amp; develop family focus</td>
<td>Family perspective to clinician</td>
<td>Pre and post</td>
</tr>
<tr>
<td>Individual (child) outcome</td>
<td>Reduce the behavior of impulsiveness, related to risk factors.¹</td>
<td>Short, non-intrusive measures of client perspective and clinical assessments.</td>
<td>Pre and post</td>
</tr>
<tr>
<td>Individual (child) outcome</td>
<td>Enhance school attendance behaviors related to protective factors.²</td>
<td>Short, non-intrusive measures of client perspective and clinical assessments.</td>
<td>Pre and post</td>
</tr>
</tbody>
</table>

¹. Reduction in behaviors related to risk factors (….impulsiveness, poor decision making and coping skills, learned helplessness, poor social/interpersonal skills, susceptibility to negative peer influences, nonparticipation in school/social activities).

². Enhance behaviors related to protective factors (…self-esteem, decision making and its applicability, personal control, interpersonal communication, prosocial group behavior, prosocial activities)

Potential use of a commercial software evaluation product. PCMH’s research on two potential vendors is still being conducted.
8. Coordination with other MHSA components

The Plumas County Mental Health (PCMH) management team coordinated the Prevention and Early Intervention (PEI) process with additional Mental Health Services Act (MHSA) efforts. The ongoing MHSA Community Support and Services (CSS) efforts were evaluated at FY 2007 first quarterly report period, a review of current service efforts based on stakeholder participation. CSS data was assessed for the potential to extract one or more CSS work plan(s) into the PEI plan. It was determined (by management team and stakeholders) that the limited funding in PEI would best serve the local community by focusing on enhanced services in an underserved area, i.e. not an existing workplan of CSS. Additionally, it was deemed that implementation of PEI would need the clinical staff to receive training and technical assistance; thus, the PEI plan has been incorporated into the Workforce Education and Training (WET) component. [At this date, the PCMH Wet plan is awaiting completion of the 30 day public review (January 23, 2008) and submittal to the state Department of Mental Health for approval and funding.] If fully funded PCMH’s WET plan will assist PCMH to additionally enhance PEI efforts through participation in trainings offered through the state’s efforts around suicide prevention. Additionally, the state’s future efforts regarding anti-stigma campaigns along with the local NAMI’s workplan provide new potential to educate more community members to identify early signs of emotional distress in high-risk youth. Thus, PCMH’s limited PEI funding is not requested for use with diverting a CSS workplan, or with training which can be supported by the WET workplan. PCMH’s PEI plan has as a goal to address children at risk and address the interpersonal relationships with their caregiver(s)/parent.

PCMH is planning for the use of alternative MHSA resources (the Workforce Education and Training component) to support PCIT.

9. Additional comments.

Additionally, it is anticipated that PEI will be incorporated into the Plumas County technology component when developed.
Plumas County’s population, officially recorded in 2004, was less than 21,000; thus, we are a “very small county with population less than 100,000” and opt to exempt ourselves from the requirement of this local outcome evaluation (per DMH PEI Guidelines, page 26).

Workplan Name: 12-15 session Family Therapy

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

1. b. Explain how this workplan and its strategies were selected for local evaluation.

2. What are the expected person-level and system-level outcomes for each strategy?

3. Table of demographics.

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

5. How will data be collected and analyzed?

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

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

8. How will the report on the evaluation be disseminated to interested local constituencies?
Plumas, a network of services (including prevention) in a rural county

PEI Revenue and Expenditure Budget Worksheet

Count Name: Plumas

PEI Project Name: 12-15 Sessions of Family Therapy

Provider Name (if known): Plumas County Mental Health

Intended Provider Category: county agency

Date: 2/13/2009

Plumas County has only one proposed PEI program.

Proposed Total number of Individuals to be served: FY 08-09 -0- FY 09-10 57

Total Number of Individuals currently being served: FY 07-08 -0- FY 08-09 -0-

Total No. of Indivs. to be served through PEI Expansion: FY 07-08 -0- FY 09-10 57

Months of Operation: FY 08-09 -0- FY 09-10 12

<table>
<thead>
<tr>
<th>Proposed Expenses and Revenues</th>
<th>Total Program/PEI Project Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FY 07-08 funds, operation FY 08/09</td>
</tr>
<tr>
<td>A. Expenditure</td>
<td></td>
</tr>
<tr>
<td>1. Personnel (list classifications and FTEs)</td>
<td></td>
</tr>
<tr>
<td>a. Salaries, Wages</td>
<td></td>
</tr>
<tr>
<td>Therapist II (0.8)</td>
<td>0</td>
</tr>
<tr>
<td>Manager/MHSA Coordinator (0.3)</td>
<td>$21,840</td>
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<tr>
<td>Fiscal Officer (0.05)</td>
<td>$2,808</td>
</tr>
<tr>
<td>Fiscal Tech III (0.05)</td>
<td>0</td>
</tr>
<tr>
<td>Director (0.25 &amp; 0.5)</td>
<td>$26,000</td>
</tr>
<tr>
<td>b. Benefits and Taxes</td>
<td>$25,324</td>
</tr>
<tr>
<td>c. Total Personnel Expenditures</td>
<td>$75,972</td>
</tr>
<tr>
<td>2. Operating Expenditures</td>
<td></td>
</tr>
<tr>
<td>a. Facility Cost</td>
<td>$3,407</td>
</tr>
<tr>
<td>b. Other Operating Expenses</td>
<td>$5,424</td>
</tr>
<tr>
<td>c. Total Operating Expenses</td>
<td>$8,831</td>
</tr>
<tr>
<td>3. Subcontracts/Professional Services</td>
<td></td>
</tr>
<tr>
<td>a. Evaluation Software Vendor Contract</td>
<td>$11,197</td>
</tr>
<tr>
<td>b. Plumas Rural Services – Spanish/English Interpretive services</td>
<td>$4,000</td>
</tr>
<tr>
<td>c. Total Subcontracts</td>
<td>$15,197</td>
</tr>
<tr>
<td>4. Total Proposed PEI Project Budget</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

B. Revenues (list/itemize by fund source)

Total Revenue

| Total Funding Requested for PEI Project | $100,000 | $125,000 | $225,000 |

Total In-Kind contributions
Plumas, a network of services (including prevention) in a rural county

Plumas County Mental Health MHSA Prevention and Early Intervention (PEI)

Funding Budget Narrative for FY07-08, operating FY 08/09
Program Work plan
Program Work Plan Name: 12-15 session family therapy

Program Description
The work plan, “12-15 session family therapy” are new activities that will support un(der)served teens (aged 10-18 years) with the PEI funding.

One Time Funding: none

1) Expenditures
   a) Client, Family and Caregiver Support Expenditures
      i) Clothing, Food and Hygiene: None
      ii) Travel and Transportation: None
   b) Housing:
      i) Master Leases: None
      ii) Subsidies: None
      iii) Vouchers: None
      iv) Other Housing: None
   c) Employment and Education Supports: none
   d) Other Support expenditures: none

2) Personnel Expenditures
   a) Current Existing Personnel (from Staffing Detail):
      i) 0.25FTE Program planning and administrative staff oversight by the Director of Mental Health. Planning also involves outreach and communication with community partners.
      ii) 0.3FTE MHSA Coordinator for program support in planning, report writing, coordination of services, liaison to DMH and MHSOAC, etc.
   b) New Additional Personnel Expenditures (from Staffing Detail). none
   c) Employee Benefits: Benefits include unemployment insurance, OASDI contribution, health insurance, retirement contribution and other employee benefits. Benefits are calculated at 50% of the base salary for the year. The benefits are included in the personnel expenditures amounts.

3) Operating Expenditures.
   a. Facility expenses. The Department moved into a new building in 2007, and was charged (by the county) for planned occupied space, of 7,950 square feet, 15.2% of total building. Currently, Mental Health occupies 5,974 square feet, 11.41% of total building. Mental Health administration then allocates the occupancy across funded programs based
Plumas, a network of services (including prevention) in a rural county

on square footage of program utilization $3,407. During the planning years this is 3% and during program operational years this will be 12% (due to special use of conference rooms) $8,714.

b. Office Expense-allocated office expense for office expenses at the annex clinic, such as: telephone, answering service, copier, postage, household, professional insurance, other expenses including paper, pens, ink, paperclips, etc.

4) **Program Management.** Planning and development this year, not implementation.

5) **Estimated Total Expenditures when service provider is not known:**

a. evaluation software vendor contract. $11,197.

b. contract for Spanish/English interpretations for clinical services to Hispanic families (4 families per year, 15 sessions per family, plus communication for brokerage and linkage, etc.) $4,000.
Plumas County Mental Health MHSA Prevention and Early Intervention (PEI)

Funding Budget Narrative for FY08-09, operating FY 09/10

Program Work plan

Program Work Plan Name: 12-15 session family therapy

Program Description

The work plan, “12-15 session family therapy” are new activities that will support un(der)served teens (aged 10-18 years) with the PEI funding.

One Time Funding: none

6) Expenditures

a) Client, Family and Caregiver Support Expenditures
   i) Clothing, Food and Hygiene: None
   ii) Travel and Transportation: Assistance to families of need to attend therapy sessions. Calculated at $105.26 per family for 12 months.

b) Housing:
   i) Master Leases: None
   ii) Subsidies: None
   iii) Vouchers: None
   iv) Other Housing: None

c) Employment and Education Supports: none

d) Other Support expenditures: Financial incentives for families making progress with therapeutic goals. Calculated at $104.37 per family for 12 months.

7) Personnel Expenditures

a) Current Existing Personnel (from Staffing Detail):
   i) 0.05FTE Clinical and program supervision by the Director of Mental Health. For this program, the Director will direct and supervise clinical staff providing services; and represent the department.

b) New Additional Personnel Expenditures (from Staffing Detail).
   i) 0.80FTE Clinician. For this program, the therapist will provide counseling and treatment in family therapy; and data collection and coordination with MHSA Coordinator for reporting.
   ii) 0.05FTE Fiscal Technician III. Provide reception and appointments to the clients. Support direct service providers with back office functions.

c) Employee Benefits: Benefits include unemployment insurance, OASDI contribution, health insurance, retirement contribution and other employee benefits. Benefits are calculated at 50% of the base salary for the year. The benefits are included in the personnel expenditures amounts.
8) Operating Expenditures.
   a. Facility expenses. The Department moved into a new building in 2007, and was charged (by the county) for planned occupied space, of 7,950 square feet, 15.2% of total building. Currently, Mental Health occupies 5,974 square feet, 11.41% of total building. Mental Health administration then allocates the occupancy across funded programs based on square footage of program utilization $3,407. During the planning years this is 3% and during program operational years this will be 12% (due to special use of conference rooms) $8,714.

   b. Office Expense-allocated office expense for office expenses at the annex clinic, such as: telephone, answering service, copier, postage, household, professional insurance, other expenses including paper, pens, ink, paperclips, etc.

9) Program Management. None.

10) Estimated Total Expenditures when service provider is not known: None.
Plumas, a network of services (including prevention) in a rural county

PEI Administration Budget Worksheet

<table>
<thead>
<tr>
<th>Client &amp; Family Member, FTEs</th>
<th>Total FTEs</th>
<th>Budgeted Expenditure FY 07-08</th>
<th>Budgeted Expenditure FY 08-09</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Expenditures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Personnel Expenditures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. PEI Coordinator</td>
<td>0.05</td>
<td>$3,640</td>
<td>$3,640</td>
<td></td>
</tr>
<tr>
<td>b. PEI Support Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Other Personnel</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director of Mental Health</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Fiscal Officer</td>
<td>0.05</td>
<td>$2,808</td>
<td>$2,808</td>
<td>$5,616</td>
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<tr>
<td>Fiscal Tech III</td>
<td>0.05</td>
<td>$1,872</td>
<td>$1,872</td>
<td>$3,744</td>
</tr>
<tr>
<td>d. Employee benefits</td>
<td></td>
<td>$1,404</td>
<td>$4,160</td>
<td>$5,564</td>
</tr>
<tr>
<td>e. Total Personnel Expenditures</td>
<td></td>
<td>$4,212</td>
<td>$12,480</td>
<td>$16,692</td>
</tr>
<tr>
<td>2. Operating Expenditures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Facility costs</td>
<td></td>
<td>$3,407</td>
<td>$8,714</td>
<td>$12,121</td>
</tr>
<tr>
<td>b. other operating expenditures</td>
<td></td>
<td>$3,491</td>
<td>$8,519</td>
<td>$12,010</td>
</tr>
<tr>
<td>c. Total Operating expenditures</td>
<td></td>
<td>$6,898</td>
<td>$17,233</td>
<td>$24,131</td>
</tr>
<tr>
<td>3. County Allocated Administration</td>
<td></td>
<td>$1,933</td>
<td>$8,863</td>
<td>$10,796</td>
</tr>
<tr>
<td>a. Total County Administration costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Total PEI Funding Request for County Administration Budget</td>
<td></td>
<td>$13,043</td>
<td>$38,576</td>
<td>$51,619</td>
</tr>
<tr>
<td>B. Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Total Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Total Funding Requirements</td>
<td></td>
<td>$13,043</td>
<td>$38,576</td>
<td>$51,619</td>
</tr>
<tr>
<td>D. Total In-Kind Contributions</td>
<td></td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Plumas County Mental Health MHSA Prevention and Early Intervention

Funding Budget Narrative for FY07-08, Admin operating FY 08/09 Budget

Personnel Expenditures
a) Current Existing Personnel (from Staffing Detail):
   i) 0.5FTE Department Fiscal Officer for administration of program and reporting.

b) Employee Benefits: Benefits include unemployment insurance, OASDI contribution, health insurance, retirement contribution and other employee benefits. Benefits are calculated at 50% of the base salary for the year for the director and the department fiscal officer. The high cost of group insurance creates a high benefit cost.

Operating Expenditures:
a) Office Expense-allocated office expense for office expenses at the annex clinic, such as: telephone, answering service, copier, postage, household, professional insurance, other expenses including paper, pens, ink, paperclips, etc.

County Allocated Administration
a) A-87 cost is allocated by Plumas County to the MHSA budget.

Funding Budget Narrative for FY08-09, Admin operating FY 09/10 Budget

Personnel Expenditures
a) Current Existing Personnel (from Staffing Detail):
   i) 0.5FTE Department Fiscal Officer fiscal for administration of program and reporting.
   ii) 0.05FTE Fiscal Technician III. Provide reception and appointments to the clients. Support direct service providers with back office functions.

b) Employee Benefits: Benefits include unemployment insurance, OASDI contribution, health insurance, retirement contribution and other employee benefits. Benefits are calculated at 50% of the base salary for the year for the director and the department fiscal officer. The high cost of group insurance creates a high benefit cost.

Operating Expenditures:
a) Office Expense-allocated office expense for office expenses at the annex clinic, such as: telephone, answering service, copier, postage, household, professional insurance, other expenses including paper, pens, ink, paperclips, etc.

County Allocated Administration: A-87 cost is allocated by Plumas County to the MHSA budget.
Plumas, a network of services (including prevention) in a rural county

PREVENTION AND EARLY INTERVENTION BUDGET SUMMARY

Form No. 6
Instruction: Please provide a listing of all Workplans submitted for which PEI funding is being requested. This form provides a Workplan number and name that will be used consistently on all related workplan documents. It identifies the funding being requested for each workplan from the form No. 4 for each workplan by the age group to be served, and the total PEI funding request. Also insert the Administration funding being requested from Form No.5.

County: Plumas County
Date: March 10, 2009

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Funds Requested by Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>List each Workplan FY 07/08</td>
</tr>
<tr>
<td>#</td>
<td></td>
</tr>
<tr>
<td>12-15 session Family Therapy</td>
<td>$100,000</td>
</tr>
<tr>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>$0</td>
<td></td>
</tr>
<tr>
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<tr>
<td>$0</td>
<td></td>
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<tr>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Total PEI Funds</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

Administration is within the program budget, see form No. 4.