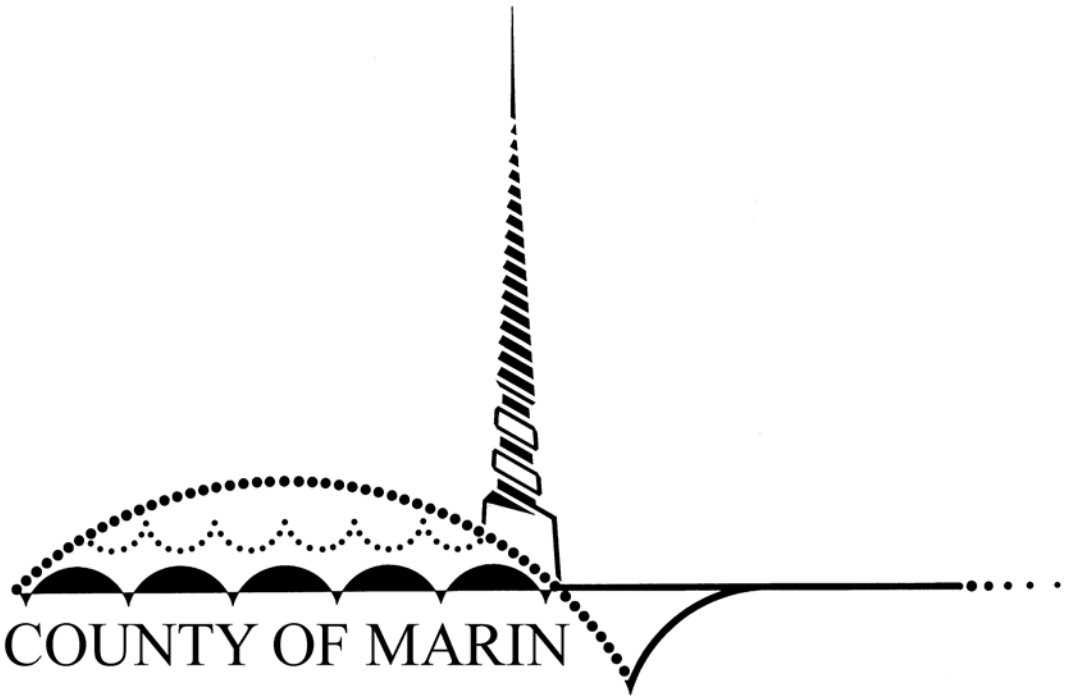

Marin County Department of Health & Human Services
Division of Community Mental Health Services

Mental Health Services Act
Prevention & Early Intervention Plan

Contents

PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN FACE SHEET

Form No. 1

MENTAL HEALTH SERVICES ACT (MHSA)

PREVENTION AND EARLY INTERVENTION COMPONENT

OF THE THREE-YEAR

PROGRAM AND EXPENDITURE PLAN

Fiscal Years 2007-08 and 2008-09

County Name: Marin	Date: 1/29/09

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

County Mental Health Director	**Project Lead**
Name: Bruce Gurganus	Name: Kristen Gardner
Telephone Number: 415-499-6769	Telephone Number: 415-205-9111
Fax Number: 415-499-3791	Fax Number: 415-499-3791
E-mail: bgurganus@co.marin.ca.us	E-mail: kgardner@co.marin.ca.us
Mailing Address: 20 North San Pedro Rd • Suite 2028 • San Rafael, CA 94903	

AUTHORIZING SIGNATURE

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

Signature _____ _____

County Mental Health Director Date

Executed at _____, California

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

County: Marin **Date: 1/29/09**

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**

Bruce Gurganus, Mental Health Director, had overall responsibility for the planning process. Functions included, but were not limited to: coordinating the Community Program Planning Team; ensuring that State guidelines are met in the planning process and the resulting plan; ensuring participation of the full range of stakeholders, including consumers and families, underserved and unserved cultural populations, and provider agencies; responding to specific stakeholder feedback; and providing leadership and direction for the process.

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

Community Program Planning Team

Kristen Gardner, PEI Coordinator, was hired in March 2008 to coordinate the completion of the planning process. She planned and carried out Community Program Planning Team meetings, PEI Committee meetings and workgroup meetings, key informant interviews, focus groups and other community engagement meetings. She was the primary developer of written materials, including this proposal.

Kathy Kipp, MHSA Coordinator, organized and assisted in the general activities of the planning process. PEI Committee meetings, trainings, stakeholder meetings, and the public hearing were all organized and coordinated by Ms. Kipp. She maintained the email communication system for the process and the MHSA portion of the CMHS website.

Ann Pring, Youth and Family Services Program Manager, attended trainings, facilitated and participated in PEI workgroups, trained and oriented staff, organized and participated in key informant meetings, and assisted with developing the written proposal.

Bobbie Wunsch, a principal with Pacific Health Consulting Group, planned and facilitated the PEI Committee meetings and overall process. Ms. Wunsch also provides strategic planning and meeting facilitation for a wide variety of health-related organizations, including Marin County clinics, hospitals, and county agencies. Ms.

Wunsch is familiar with Marin County's Community Mental Health Services programs through many years of work both with the county's mental health division, as well as with many individual community agencies. Ms. Wunsch developed the county's mental health plans in 1990 and 1995, assisted the county in the development of the Marin Mental Health Medi-Cal Managed Care Plan, facilitated a priority planning process for possible budget reductions several years ago, facilitated Marin's MHSA CSS planning process and facilitated the State's stakeholder and workgroup process for the MHSA.

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

The Community Program Planning Team all ensured that stakeholders had the opportunity to participate by identifying who needed to be included, how to facilitate their participation, keeping people informed about opportunities to participate, keeping the website up-to-date with meeting announcements and minutes, and responding to inquiries from and suggestions for additional participants.

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

Marin County Community Mental Health Service's (CMHS) Mental Health Services Act (MHSA) planning process was designed to be inclusive, open and transparent. CMHS began to plan a needs assessment in October 2004, in anticipation of the passage of MHSA and in recognition of the need for an updated strategic plan. The steps included:

- Focus groups throughout the county that resulted in the participation of 310 attendees in 22 focus groups. These focus groups covered both CSS and PEI issues and targeted priority populations, including:
  * Consumers and families: parents of adults with serious mental illness, Clozapine Club, National Alliance on Mental Illness, Enterprise Resource Center;
  * Underserved cultural populations: Latino parents, residents of Marin City which has a large African-American population and is also a concentrated area of poverty, residents of the Canal which has Marin's largest Latino population and a concentrated area of poverty;
  * Geographically isolated populations: West Marin.
- Anonymous survey that targeted consumers and families as well as the general public. It was distributed in print and also made available on-line, through the CMHS website. The survey was promoted through providers, peer-to-peer agencies, social service agencies, referral sources, focus groups and advertisement in our local daily newspaper. The survey was completed by 529 people, 42% of whom identified themselves as consumers or family members of consumers. The breakdown of consumer and family member respondents closely match the county's demographics. The survey was made available in English, Spanish and Vietnamese. More than 10% of those who completed the survey stated that they had never accessed county mental health services.

- 2 town hall public meetings. The data from the focus groups and surveys identified gaps. The town hall meetings helped to develop a consensus around priorities to address the identified gaps. To announce the Town Hall meetings, fliers were circulated to all providers, contractors and social service agencies; advertisements in the local newspaper were also utilized. Approximately 70 community members attended the April 2005 town hall meeting, while approximately 55 community members participated in the September 2005 meeting.

Marin's MHSA Strategic Planning Steering Committee began meeting in March 2005. The Steering Committee included 9 clients and family members in addition to service providers, law enforcement, Marin's First Five Commission, County Division of Social Services, representation from the Latino, Asian and African American communities, Marin County Office of Education, the Mental Health Board (MHB), National Alliance for the Mentally Ill (NAMI), and Community Mental Health Services (CMHS) staff. The 28 member Steering Committee recommended CSS strategies for Marin based upon feedback they received from their respective constituencies. This committee developed a number of Special Topic Workgroups, including Prevention and Early Intervention. This workgroup has expanded to become the PEI Committee and the Steering Committee has become the MHSA Implementation Committee (see member list pg. 13).

The PEI Committee (see member list pg. 14) began meeting in May 2007. The PEI Committee was responsible for developing PEI strategy and program recommendations. The meetings were open and continuously grew in membership due to ongoing outreach. Meeting announcements and minutes were published on the CMHS website. The PEI Committee timeline has been extended twice in order to ensure that the recommendation development was thorough and well informed. The following steps were conducted over 16 months:

- PEI Committee reviewed information from the MHSA CSS process; gathered and reviewed relevant data; developed specific workgroups based on age. Topic focused workgroups were developed as needed.
- Workgroups met multiple times to review additional data; consider information gathered through the community engagement process; confirm emerging Community Mental Health Needs and Priority Populations; and develop PEI program recommendations.
- Workgroups presented key findings, rationale, and program recommendations to the PEI Committee. Further research and program development was conducted as needed.
- PEI Committee conducted a transparent, multi-dimensional voting procedure to identify PEI program priorities to be recommended to the MHSA Implementation Committee.
- The Mental Health Board was updated about the process on an ongoing basis and hosted the Public Hearing of the draft PEI Plan.

The MHSA Implementation Committee, including Mental Health Director Bruce Gurganus, discussed the PEI Recommendations at each of their meetings and was responsible for approving them. Funding allocations were based on budget estimates

prepared by PEI Committee workgroups that developed the recommendations, then reconciled by CMHS staff based on priorities determined by the PEI Committee, further research, and the MHSA PEI funds available.

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

The MHSA CSS planning process identified the following unserved or underserved populations:

- The Latino population is the most underserved/unserved by Community Mental Health Services. They are seriously underserved when compared to their percentage of the poverty population. This is less true for the older adult Latino population, possibly due to the fact that the Latino population is predominantly under 60 years old.
- Asian Pacific Islanders are also somewhat underserved. In particular, the Vietnamese community is small, but has a significant language barrier.
- African Americans are somewhat over-represented among CMHS clients. It is difficult to determine if the high penetration rates for African-Americans, especially children, are the result of over identification because of stereotypes, or due to the fact that they are over represented in the juvenile justice system (over 50% of the children in the juvenile justice system in Marin County are children of color), or other factors.
- Males have a higher penetration rate than females.
- By age, the greatest penetration rates are for children ages 12-17, which is confounded by Special Education mental health services, an entitlement regardless of income, provided by CMHS. Adults ages 45-54 are the next largest group. It should also be noted that the fastest-growing age group in Marin County are older adults, however, this group has significantly lower penetration rates for all races and ethnicities in the mental health system.
- Finally, there is a pattern of lower penetration rates in the outlying area of the County. The West Marin area, farthest from the central population centers of San Rafael and Novato, has lower penetration rates.

This data was validated by the experience of the stakeholders. For example, FIRST 5 Marin and Marin Community Foundation have identified high priority populations that coincide with those identified by CMHS and the MHSA process.

In order to ensure participation by these unserved and underserved populations, the PEI Planning process included:

- Consultation with key informants:

Population	Agency
Latino	Canal Alliance Bahia Vista Elementary School Community Mental Health Services
Vietnamese	Community Action Marin – Asian Advocacy Project
African American	Isoji - MultiDisciplinary Team Marin City Network

	Marin City Health and Wellness Center Family Service Agency Center for Restorative Practice

- Community Engagement Meetings and Focus Groups:
  The focus groups were all organized by appropriate local leaders and many were co-facilitated by the local leader. They were located throughout the county, most of them taking place at already existing meetings. Three were conducted in Spanish and one in Vietnamese.

Group	Location	Target Population	Participants
School Readiness	West Marin	Parents of young children	6
Novato Youth Center	North Marin	Parents, Low income, Latino, Immigrant	10
Parent Services Project	Canal District	Parents, Low income, Latino, Immigrant	5
Huckleberry Youth Programs	Central	TAY, Cultural Mix	4
Teen Mental Health Board	Central	Teens, TAY	3
Various meetings	South Marin	African American	19
Whistlestop	Central	Older adults, Latino, Immigrant	27
NAMI / CHADD	Phone	Consumers, Families	14
Enterprise Resource Center	Central	Consumers	9
Focus Group	Central	Vietnamese, Immigrant	20
		TOTAL	**117**

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

The county identified the following diversity that affects access to services in our county:
- North and Central Marin (Canal District) have significant low-income, Spanish speaking, Latino populations
- West Marin has significant low-income population and low-income, Spanish speaking, Latino population. This is a geographically isolated region on the coast.
- South Marin has a significant low-income African American population.
- Central Marin has a mono-lingual Vietnamese speaking population.
- Older adults are a growing population with mobility barriers.

As noted at the beginning of Question 2, early in the planning process 22 focus groups and two town hall meetings were held in different locations, with translation (Spanish and Vietnamese), and with broad outreach. Later in the process additional community engagement meetings and focus groups were held (see 2a) that were organized

through existing local leaders and networks, held in locations where the target populations already gather, and were conducted in appropriate languages (Spanish and Vietnamese). The parent groups included childcare accommodations, most groups included food, and specific focus groups were conducted at the time and place identified by the local leader who assisted with coordination. Many of the focus groups were held at an existing meeting, such as playgroups, senior support groups, and others.

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

As noted above, multiple meetings were held with existing groups of consumers and families, including NAMI and Enterprise Resource Center. The Director of Mental Health holds a monthly meeting at Enterprise Resource Center to discuss mental health services with consumers. One month the meeting was dedicated to PEI planning. Consumers and family members participate in the MHSA Implementation Committee and PEI Committee. An invitation to provide input through phone interviews was distributed to over 100 NAMI and CHADD (Children & Adults with Attention Deficit/Hyperactivity Disorder) contacts to reach those who did not attend focus groups or planning meetings.

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

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

- **Individuals with serious mental illness and/or serious emotional disturbance and/or their families**

As noted in 2c, consumers and their families participated through a number of targeted focus groups. Phone interviews were also conducted with family members that volunteered when notified through NAMI and CHADD contact lists. In addition, consumers and family representatives sat on the MHSA Implementation Committee and PEI Committee. To encourage participation, a stipend of $20 to offset travel costs was made available to consumers and families for all meetings.

- **Providers and Advocates**

A wide array of providers and advocates were included in the PEI planning process:

Sector	Participation
Education	• MHSA Implementation Committee • PEI Committee • Key Informant Interviews • Community engagement meetings

Mental Health	• MHSA Implementation Committee • PEI Committee • Key Informant Interviews • Community engagement meetings
Health	• MHSA Implementation Committee • PEI Committee • Key Informant Interviews • Community engagement meetings
Social Services	• MHSA Implementation Committee • PEI Committee • Key Informant Interviews • Community engagement meetings
Law Enforcement	• MHSA Implementation Committee • PEI Committee • Key Informant Interviews • Community engagement meetings
Community-Family Resource Centers	• MHSA Implementation Committee • PEI Committee • Key Informant Interviews • Community engagement meetings
Advocates for interests of consumers and families	• MHSA Implementation Committee • PEI Committee • Key Informant Interviews • Community engagement meetings

See below (#4) for specific participating agencies from each sector.

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

- The Community Program Planning Team read all MHSA PEI guidelines and supporting documents.
- A number of PEI Committee members attended the April 26, 2007 MHSA PEI Stakeholders workshop and presented the information at the May 1, 2007 PEI Committee meeting.
- Bobbie Wunsch provided training regarding MHSA guidelines and resource materials to the PEI Committee and MHSA Committee at the beginning of the process and overviews of the guidelines and local planning process at the beginning of all following meetings.
- Kristen Gardner, PEI Coordinator, and three PEI Committee members attended the Regional Roundtable in Emeryville, providing a report back for the other team members.
- PEI webcasts were announced and made available to all PEI Committee members. Community Program Planning Team members, as well as other PEI Committee members from the community, attended some of the webcasts.
- Orientations about the PEI guidelines and local planning process were provided at the beginning of community engagement meetings and focus groups.

- Meeting notes, handouts, and updates were posted on the website.

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

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

During the early MHSA strategic planning and CSS planning processes a number of tools were used that proved successful and therefore incorporated into the PEI planning process:

- Working with cultural brokers who have experience working with County agencies and have a trusted relationship with underserved communities. These individuals helped to provide background about County-community relationships and created links with key informants and community groups.
- Working with key informants to develop resource maps and coordinate community engagement meetings. In some cases this was coordinating a focus group, at other times it was getting PEI on the agenda of existing meetings.
- Developing cooperative working relationships with communities and local agencies in order to develop effective MHSA strategies and collaborations. During the PEI planning process we have deepened and expanded the relationships.
- Continuing the MHSA Steering Committee as the MHSA Implementation Committee in order to facilitate ongoing community and stakeholder input. This committee reviewed the work of the PEI Committee and finalized the PEI strategy and program recommendations.

The primary challenges faced during the CSS planning process were:

1. It was difficult for community members to fully understand the very complex State guidelines and how the many components inter-related.

2. It was difficult to sustain involvement from a diverse group of community members who are not traditional stakeholders. This included providers and representatives from un- or underserved communities.

3. The amount of need identified was much more than could be served with the available funds.

These were addressed in the PEI process by:

1. Planning focus group formats that allowed us to gather the input needed without requiring the participants to understand MHSA and PEI in great detail. Providing a clear list of criteria to the PEI Committee that program recommendations must meet. Providing a brief orientation at the beginning of each PEI Committee meeting for new and ongoing participants.

2. Individual meetings were held with many PEI Committee participants part-way through the process to get their feedback about the process and gather specific information and ideas from them. Additional key informant interviews and community meetings were targeted toward communities or stakeholder sectors that were not adequately represented in the PEI meetings.

3. The orientation at the beginning of PEI Committee and workgroup meetings included a reminder about the amount of funds available. As recommendations were developed, workgroups were continuously encouraged to identify their highest priorities, as well as opportunities for leveraging other resources, so that the number of recommendations brought forward for final consideration were more closely in alignment with what was financially possible.

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

The PEI planning process was effective in eliciting the participation of representatives from un- and underserved communities. According to records, participants who were specifically representing un- or underserved communities in community engagement meetings:

Latino	53
African American	22
Vietnamese	20
Consumers/Families	24
Geographically Isolated	16
TAY	14
Older Adults	30

Stakeholders from a wide array of sectors were also successfully engaged through the MHSA Implementation Committee, PEI Committee, key informant interviews and community engagement meetings:

Sector	**Agencies**
Education	Marin County Office of Education Tamalpais USD Novato USD FIRST 5 SELPA Community School Adult Education Bahia Vista Elementary School Sausalito Marin City USD Marin City Network

	School Readiness Programs School Linked Services Childcare Council
Mental Health	CMHS: Children, Adult, Older Adult Mental Health Board Buckelew TAY Services Center for Restorative Practice Sunny Hills Services Teen Mental Health Board Bay Area Community Resources
Health	County Public Health: Maternal, Child Adolescent Health Coastal Health Alliance Marin City Health and Wellness Center Marin Community Clinics County Health and Human Services Clinics Huckleberry Youth Programs Novato Teen Clinic Marin AIDS Project
Social Services	Department of Social Services: Children, Adult Differential Response Employment and Training Branch
Law Enforcement	San Rafael Police Department Adult and Juvenile Probation
Community-Family Resource Centers	Matrix Parent Network (special needs) Catholic Charities CYO Marin City Senior Center Family Service Agency Jewish Family and Children's Services Novato Youth Center Parent Services Project
Consumer/Family/ Underserved	Canal Alliance Senior Peer Counselors Parent Partners NAMI CHADD Commission on Aging Isoji - Multi Disciplinary Team Community Action Marin: Asian Advocacy Project Isoji
Other	County Alcohol, Drug & Tobacco Program Marin Housing - Family Self Sufficiency Legal Aid of Marin Marin Abused Women's Services Marin Community Foundation

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

a. The date of the public hearing:

November 17, 2008, Monday 6:30 P.M

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

The PEI Plan Executive Summary and compete PEI Plan were published on the Marin County Mental Health website and the Network of Care website for public comment from October 17 to November 16, 2008. Notices were published in the Marin Independent Journal, our local newspaper, and copies were made available at all the mental health service sites including contractor sites and the consumer run Enterprise Resource Center. Copies were emailed to the Mental Health mailing list; MH contractor list; all participants in PEI focus groups, stakeholder meetings or interviews who provided an email address; all Health and Human Services employees; and Mental Health Board members. The executive summary was published in English as well as Spanish and Vietnamese

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

1. *That services for 0-3 year olds be more clearly defined, including location of services.* The specific needs of 0-3 year olds were discussed in the planning process, resulting in the inclusion of "infant and toddler" specific training for caregivers within the Early Childhood Mental Health consultation services. Language in the PEI Plan and Requests for Proposals have been reviewed to be sure this is apparent.

2. *That a broad array of stakeholders be included in the development of services.* Marin County CMHS will establish a PEI Implementation Committee that includes a wide array of stakeholders, including providers, families and clients. This Committee will participate in the implementation and evaluation of the PEI programs.

3. *That additional mental health services (i.e. good psychiatric care, medication and ongoing counseling) be developed, especially for the uninsured or underinsured.* The PEI Plan provides services for un- and underinsured populations within the PEI guidelines. It was recognized during the PEI planning process that there is a high need for more in-depth services not allowed within the PEI guidelines. The purpose of PEI services is to reduce the need for more lengthy services. In addition, PEI programs should track data that will better document the need for further services, which will assist in advocacy for appropriate services and resources.

4. *That PEI projects with large budgets should have more specificity regarding the use of those funds prior to the Request for Proposal process.*

Since the posting of the draft PEI Plan, more detailed budgets for each PEI project have been developed for inclusion in the PEI plan submitted to the California Department of Mental Health (DMH) and Oversight and Accountability Commission. The RFP process will develop these estimated budgets in great detail.

5. *That services be provided for individuals with concerns other than depression.*
   Depression is the most common presenting problem for individuals seeking mental health treatment. While depression has been identified as one of the primary diagnoses for underserved populations in Marin County, none of the programs are limited to responding to depression alone. The Early Childhood Mental Health consultation program is focused on a variety of services for 0-5 year olds and their families. It includes depression screenings for caregivers due to the high rate of unidentified post-partum depression in new mothers.

6. *That services for adults, youth and transition age youth be provided for Marin City residents in sites other than schools.*
   At this time it has not been determined where most of the PEI services will be provided or what organizations will be providing those services. The PEI Plan includes services for transition age youth in a variety of settings and adults in health care clinics. Both programs are expected to be provided in more than one site in the county. The exact locations of these services will be determined through the Request for Proposal process. While not all services will be available in all areas of the county to begin with, some services will be provided in most sections of the county. Once the services have been piloted, successful programs may be expanded to other areas of the county as funding permits.

d. The estimated number of participants:

50 Marin residents attended the public hearing along with 13 Mental Health Board members and four CMHS staff.

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

MHSA Steering Committee Members

1	Barbara Coley	Peer Provider
2	Joe Costa	Contractor Representative for Children's Mental Health Services
3	Kim Denn	Consumer Representative/Mental Health Board
4	Mary Donovan	Social Services
5	Roberta English	NAMI Marin
6	Elberta Erickson	Community Representative
7	Joel Fay	San Rafael Police Department
8	Jill Fisher	Parent/Parent Partner
9	Margaret Hallett	Contractor Representative for Adult Mental Health Services
10	Dawn Hensley	Parent/Community Action Marin
11	Mark Hering	Vice President, Center Point, Inc. Drug Treatment Program
12	Jacqueline Janssen	Mental Health Board, Family Member
13	Hilarie Kane	Consumer Representative/Mental Health Board
14	Beverlee Kell	NAMI Marin; CHADD of Marin; Mental Health Board
15	Cesar Lagleva	Mental Health Practitioner/Union Steward SEIU 535
16	Larry Lanes	Community Mental Health Medical Director
17	Myra K. Levenson	Mental Health Board /Past Chair
18	Vinh Luu	Contractor, Asian Advocacy Program
19	Rene Mendez-Penate	Adult Care Management, CMHS
20	Drew Milus	Adult Mental Health Services, SEIU 535
21	Vicki Nightingale	Administrative Support Staff, CMHS
22	Michael Payne	Peer Provider
23	Ann Pring	Youth & Family Chief, CMHS
24	Amy Reisch	First 5 Marin Children and Families Commission
25	Lisa Schwartz	Special Education Local Plan Area (SELPA)
26	John Severson	Executive Director, Coastal Health Alliance
27	Diane Slager	Adult Program Chief, CMHS

PEI Committee Members

Sandra Ramirez-Griggs	Bahia Vista Elementary School, CMHS
Kathy Eagle Claire Zurack	Buckelew TAY Services
Nicole Livingston	Cal Works
Sandy Ponek Melisa Martin	Canal Alliance
Laurie Buntain	Catholic Charities CYO
Marcus Small	Center for Restorative Practice
John Severson	Coastal Health Alliance
Chrisula Asimos Roberta Romeo	Commission on Aging
Vinh Luu	Community Action Marin – Asian Advocacy Project
Dawn Hensley	Community Action Marin - Family Partners
Lisa Schwartz	Community School
Kim Denn Ann Stoddard	Consumer
Gary Najarian Catherine Condon D. J. Pierce	County Alcohol, Drug and Tobacco Program
Cicily Emerson	County Public Health Clinics
Michelina Gautieri	CMHS - Children
Rene Mendez-Penate	CMHS - Adults
Patty Lyons	CMHS – Older Adults
Christine Miller Iris Mutio	CMHS – Youth and Family Services
Rebecca Smith Sparkie Spaeth Donna West	County Public Health - Maternal, Child, Adolescent Health
Carmen Tristan	County Social Services – Differential Response
Sheryl Morgan	Early Childhood Education Consultant
Susanne Kreuzer	Easter Seals
Ruth Cashmere	Family Self Sufficiency
Diane Suffridge Jeff Hall	Family Service Agency Family Service Agency: Southern Marin Service Site
Amy Reisch	FIRST 5 Marin
Susan Quigley	Huckleberry Youth Programs
Ricardo Montcrief Elberta Eriksson	Isoji Isoji – Multi Disciplinary Team
Nancy Masters Bonne Reiser	Jewish Family Children Services
Paul Cohen	Legal Aid of Marin
Donna Garske	Marin Abused Women Services
Marie Gaines	Marin City CDS Senior Services

Terrie Harris-Green Marlene Jones Essie Blau	Marin City Health & Wellness Center
Sharon Turner Juanita Edwards	Marin City Network
Georgianna Farren John Shen Nina Sutton	Marin Community Clinics
Charisse Ma Lebron	Marin Institute
Kate Gillespie Dan Leach	Mental Health Board
Melissa Fike	Novato Teen Clinic
Alaina Cantor	Novato Youth Center
Myra Levenson	Former Mental Health Board Chair
William Burke	Probation Chief
Alexandra Siliezar	Psychiatric Emergency Services
Ladonna Bonner	School Readiness Program – Marin City
Barry Feinberg	Sunny Hills Services
Carol Eber	Tamalpais UHSD
Gavin Front	Teen Mental Health Board

PEI PROJECT SUMMARY

Form No. 3

County: Marin **PEI Project Name: Children and Youth Prevention & Early Intervention** **Date: 1/29/09**

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

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

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

PEI PROJECT SUMMARY

Form No. 3

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

The PEI Committee incorporated many sources of information in developing their recommendations: the data resulting from the early MHSA planning process described above (Form 2); prevalence and penetration data from the County; resource mapping; client demographics and needs assessments from relevant organizations; and data from the PEI Community Engagement Process described above (2-3). Data from all of these sources was presented to the PEI Committee at appropriate times throughout the process.

PEI-related Themes from Stakeholder Input from Pre-MHSA and CSS Planning Process:
• Support families and communities to increase their resilience (wellness factor)
• Provide culturally appropriate education and early intervention in the community so it is more accessible
• Increase provider awareness (schools, clinics, etc) so they identify and respond earlier and more effectively
• Increase public awareness about mental health to increase access to resources and reduce stigma
• Parenting education and early intervention for parents (i.e. for substance abuse and depression)
• Increase number of culturally and linguistically competent providers
• Services for unserved clients who do not meet current financial or medical necessity criteria
• Address basic needs first (housing, shelter, employment, medical care) so that mental health services are more effective
• Build effective community partnerships between CMHS and law enforcement, schools, substance abuse services, etc.

The PEI Committee developed 4 workgroups to develop the strategies and program recommendations: Prenatal-5, Youth (6-15), TAY (16-25), and Adult/Older Adult. The Prenatal-5 and Youth developed the recommendations included in this project. Participants included representatives from FIRST 5, Jewish Family and Children's Services, CPS/Differential Response, CMHS, HHS, Marin Head Start, Community Action Marin, Novato Youth Center, Isoji, and Tamalpais Unified High School District. Data specific to these age groups that the workgroups considered included:

- Demographic data
- FIRST 5, CPS, KidsData.org, and other sources: Marin based data about prevalence of risks for young children
- Department of Education: rates of attendance, achievement, and other data broken down by regions of the county
- Marin Childcare Council report
- CMH primary diagnoses summary. CMH serves adolescents with the following primary diagnoses: Mood Disorders (49%), Disruptive Behavior Disorders (33%), and Anxiety Disorders (12%). The remaining 6% is distributed among Adjustment Disorders, Substance-Related, and other concerns.

Some of MHSOAC's data points that seemed most relevant to Marin's demographics and experience are:

- An estimated 50% of children in many California public schools, especially those in high-stress low-income neighborhoods, have psycho-social problems that place them at risk for more serious disorders. Approximately 70% of kindergarten children with developmental problems could have been identified earlier, but were not.
- Early experiences have a major impact on the development of a child's brain, which undergoes 90% of its growth during infancy and early childhood.
- A parent's depression is among the most consistent risk factors for children's anxiety, depression, and major behavior problems. Research shows that a parent's recovery from depression has a major positive impact on children.

Community engagement meetings, focus groups and key informant meetings were held by the PEI Coordinator to solicit input about community needs, as well as test the appropriateness of the strategies under discussion. For example, for young children, 5 focus groups were held with parents from target populations to answer questions such as needs they and their children have, where they are best reached, and what types of services they would like.

As a result of the data, community input, and stakeholder input, Prenatal-5 and Youth workgroups identified the following key community needs: "Disparities in Access" and "At-risk Children, Youth and Young Adult Populations" and priority populations: "Children and Youth in Stressed Families" and "Underserved Cultural Populations." The workgroups recognize that issues of trauma, school failure and juvenile justice will also be addressed.

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

In the early MHSA planning process, community members identified a need to support families and provide services in non-traditional sites for mental health services that are accessible to families. Parenting education, school based services, and increasing provider awareness (schools, clinics, etc) so they identify and respond earlier and more effectively were specifically recommended. The Prenatal-5 and Youth workgroups considered strategies that met these interests, addressed underserved cultural populations, and focused on the identified community need and priority populations. In addition, stakeholders not represented in the workgroups were contacted to discuss the appropriateness of the strategies under discussion, including past experiences with similar programs and other strategies they recommend. Using the community input, stakeholder input, data analysis, and desired outcomes, appropriate programs were identified and researched by the workgroups

The programs selected build on existing services in Marin County, incorporate evidence-based practices, and are provided in widely agreed upon settings. Early Childhood Mental Health consultation services are currently available to all

subsidized pre-schools by Jewish Family and Children's Services. PEI funds will be used to expand these services to more sites and to incorporate additional evidence-based practices, including parental depression screening, child adjustment screening, and provider skill building in developing their own relationship with infants/toddlers and supporting parents in this. In addition, Triple P (Positive Parenting Program) training will be made available to a wide variety of providers working with families. While a variety of parenting classes are available in Marin, many parents are best reached "in the moment", as Triple P is designed to do.

Expand Early Childhood Mental Health Consultation Services for Pre-Schools

Twenty-five subsidized pre-schools have access to Early Childhood Mental Health consultation services through Jewish Family and Children's Services, supported by FIRST 5 Marin, Bella Vista Foundation and Marin Community Foundation. Services currently provided include:

- identifying children whose behavior indicates social/emotional difficulties;
- conducting assessments within the child-care setting (including parents, caregivers and consultant observation);
- coordination and consultation with assessments of possible developmental/physical concerns through Easter Seals
- developing and case managing intervention plans for home and childcare settings that:
  - strengthen the ability of providers to meet the children's needs
  - are consumer-driven and mobilize resources for children and families;
- providing or facilitating clinical interventions with children and their families as needed;
- increase the childcare provider's communication skills necessary to work effectively with parents;
- working with centers to improve the site's infrastructure and environment to better support the children and caregivers.

While the current services are shown to have benefit (see #7 Intended Outcomes), stakeholders identified expanding the depth of consultation services to these sites as first priority. In order to increase the ability of the consultants and child-care providers to identify and appropriately respond to issues more frequently and earlier, PEI funds will be used to integrate the following key elements:

- providing children adjustment screenings (such as ABLE-Snapshot or ASQ-SE) and referrals to services as needed;
- providing parental depression screenings (such as Edinburgh Tool, Beck Inventory) and referrals to services as needed;
- building provider skills in developing their own relationship with infants/toddlers and supporting parents in this (such as Promoting First Relationships or Parent Infant Toddler Caregiver).

Early Childhood Mental Health consultants will be trained in the evidence-based screening and caregiver education programs. They will incorporate these into their consulting practices by training the child-care providers in implementing

the screening tools and care-giving skills, as well as using them directly with the families as needed. PEI funds will be used to fund the training and additional staff time necessary to provide more extensive consultation to the subsidized preschools.

This program specifically reaches children enrolled in subsidized pre-schools. These pre-schools are located throughout the county, serving low-income families and a high proportion of culturally diverse communities.

Milestones & Tasks	Estimated Timeline
• Establish providing agency through an RFP process	Dec 2008-Feb 2009
• Establish contract and monitoring agreements to assure effective implementation	Feb-April 2009
• Hire additional culturally competent and bi-lingual ECMH consultant	June 2009
• All ECMH consultation staff will receive training in evidence-based screening and caregiver education	July-August 2009
• Providing agency, with County assistance, will establish referral process and relationships for children and parents identified as needing further services	July-August 2009
• Establish baseline data necessary to track outcomes	July 2009
• Integrate new evidence-based tools into consultation practices	September 2009
• Train and support sites to implement new evidence based tools	Ongoing
• Participate in regular PEI Committee meetings to develop collaborations, problem-solve implementation challenges, and assist in evaluation of PEI projects	Ongoing
• Collect outcome data	Ongoing
• Review outcome data with PEI Committee	March 2012
• MHSA Implementation Committee performs program review and reauthorization	April 2012

<u>Early Childhood Mental Health Consultation for Family and Community Based Sites</u>

Provide one Mental Health Consultant (MHC) to provide the expanded ECMH services described above to home daycare sites and other community-based sites, such as Evenstart, School Readiness and other family programs, so that children not in preschool programs will have access to early identification and intervention for mental health concerns. The providing agency would work with networks of family daycare providers and community based programs, such as the FIRST 5 funded School Readiness Initiative, Community Action Marin, and Marin County Childcare Commission, to identify sites that would most benefit from consultation services. The MHC will establish an MOU with each site that includes each party's responsibilities. Each site will be worked with intensively for one-year, at which point some of the

responsibilities are transferred to the childcare site. The MHC will then provide ongoing support and consultation on a less frequent basis, allowing the MHC to work with additional sites.

Family daycare and community based sites serve a high proportion of low-income families (an indicator of being a "stressed family") and underserved cultural populations. Due to the limited availability of subsidized pre-schools and inability of families to afford other forms of day-care, it is essential to reach out to sites where low-income income families are in organized group care of play-group settings. This program will specifically target Marin City, the Canal, Novato and West Marin, where there are high rates of low income, Latino, African American and Vietnamese families. This expansion also increases services for infants and toddlers.

Milestones & Tasks	Estimated Timeline
• Establish providing agency through an RFP process	Dec 2008-Feb 2009
• Establish contract and monitoring agreements to assure effective implementation	Feb-April 2009
• Hire additional culturally competent and bi-lingual ECMH consultant	June 2009
• Staff will receive training in evidence-based screening, caregiver education and consultation role	July-August 2009
• Providing agency, with County assistance, will establish referral process and relationships for children and parents identified as needing further services	July-August 2009
• Establish baseline data necessary to track outcomes	July 2009
• Providing agency will identify and develop MOUs with implementation sites	August 2009
• Begin consultation and training process with implementation sites; provide services listed above	September 2009
• Participate in regular PEI Committee meetings to develop collaborations, problem-solve implementation challenges, and assist in evaluation of PEI projects	Ongoing
• Collect outcome data	Ongoing
• Providing agency identify and develop MOUs with additional implementation sites	August 2010
• Review outcome data with PEI Coordination Committee	March 2012
• MHSA Implementation Committee performs program review and reauthorization	April 2012

<u>Triple P (Positive Parenting Program): Provider Training and Support</u>

Stakeholders in the Prenatal-5 and Youth workgroups identified evidence-based parenting education and support as a high priority. A curriculum selection workgroup, including members from the Prenatal-5 and Youth workgroups, as well as current parenting education providers, researched and discussed a variety of evidence-based programs and chose Triple P (Positive Parenting Program). Focus group participants expressed a desire for more parenting education, especially in

family program settings that they were already accessing. Providers of those programs expressed interest in providing additional education. A number of parenting classes are already available, so there was more interest in a Triple P model that provides "in the moment" education and support. In addition, conversations with Mendocino County FIRST 5, which is already implementing Triple P, and CIMH supported the feasibility of implementing Triple P effectively in Marin County.

To implement the parenting education component, the contractor will work with a wide array of organizations that serve the target populations, including Social Services, FIRST 5 funded School Readiness Initiatives, all PEI contractors, schools (via School Linked Services, Student Study Teams, special education), CalWorks, health clinics, pediatric services, and others to identify providers to be trained in Triple P and to establish referral systems to link families they serve with parenting education services as needed. A broad array of providers working with families will be trained in Triple P Level 2 and 3 to provide brief, in the moment parenting support and education, as well as limited follow-up. Providers could include medical assistants, social workers, public health nurses, school counselors, school resource officers, daycare directors and staff, family/parent liaisons, and many others. In addition, mental health providers working with families will be trained in Level 4 to provide more intensive parent support and education. Parent Child Interaction Therapy (PCIT) is considered an appropriate referral for families needing further support and is currently provided in Marin.

The contracting agency's role is to coordinate the implementation of Triple P in the county. Responsibilities include:

- Leveraging other resources for the implementation of Triple P;
- Coordinating with Triple P America and/or CIMH to establish training and implementation plans and protocols;
- Building commitment from local participating agencies;
- Coordinating training and providing technical assistance for local participating agencies;
- Ensuring sustainability of and fidelity to the model by coordinating replacement training, providing on site coaching, providing a forum for ongoing skill-building, etc. for local participating agencies;
- Purchasing and distributing Triple P materials;
- Developing and conducting evaluation protocols.

Milestones & Tasks	Estimated Timeline
• Establish providing agency through an RFP process	Dec 2008-Feb 2009
• Establish contract and monitoring agreements to assure effective implementation	Feb-April 2009
• Contracting agency hires Triple P Coordinator	June 2009
• Triple P Coordinator will receive training in Triple P	July-August 2009
• Providing agency, with County assistance, will establish referral process and relationships for	July-August 2009

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children and parents identified as needing further services	
• Develop implementation plan	Sept-Nov 2009
• Establish baseline data necessary to track outcomes	October 2009
• Providing agency will identify and develop MOUs with implementation sites	Nov 2009-ongoing
• Begin training providers	Jan 2010-ongoing
• Participate in regular PEI Committee meetings to develop collaborations, problem-solve implementation challenges, and assist in evaluation of PEI projects	Ongoing
• Collect outcome data	Ongoing
• Review outcome data with PEI Coordination Committee	March 2012
• MHSA Implementation Committee performs program review and reauthorization	April 2012

Our implementation partners for this project will be determined through an RFP process. They will be required to show that they can serve the target populations effectively, such as ability to work with the targeted settings.

The programs identified are expected to achieve the desired outcomes because:
- Community members and current providers have identified the need for these types of services and interest in accessing and implementing them;
- The sites identified for providing these services are accessed and trusted by the target populations;
- They are building on services that are already proving effective, such as ECMH and School Readiness programs;
- They incorporate evidence-based programs that have been shown to be effective with diverse populations.

These programs address a number of priorities identified by the community during the planning process:
- Support families and communities to increase their resilience (wellness factor)
- Provide culturally appropriate education and early intervention in the community so it is more accessible
- Increase provider awareness (schools, clinics, etc) so they identify and respond earlier and more effectively
- Parenting education and early intervention for parents (i.e., for substance abuse and depression)
- Increase number of culturally and linguistically competent providers
- Build effective community partnerships between CMHS and law enforcement, schools, substance abuse services, etc.
- Reaching children who are not able to access subsidized pre-schools.

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4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through **June 2010** by type		Number of months in operation through **June 2010**
	Prevention	Early Intervention	
Expand Early Childhood Mental Health Consultation Services for Pre-Schools	Individuals: 1000 Families: 800	Individuals: 100 Families: 100	13
Early Childhood Mental Health Consultation for Family and Community Based Sites	Individuals: 50 Families: 50	Individuals: 5 Families: 5	13
Triple P: Provider Training and Support	Individuals: 100 Families: 100	Individuals: 100 Families: 100	13
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 1100 **Families**: 900	**Individuals:** 150 **Families**: 150	

Prevention activities include: provider education, parent education, consultation, screening
Early intervention activities include: parent education (Triple P Level 2-4), assessment and intervention services for identified families

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

Marin County is a medium sized county (250,000) with extensive relationships among providers. The CSS and PEI planning processes have increased the level of collaboration and linkages. Marin County CMHS will continue to convene the MHSA Implementation Committee and initiate a PEI Implementation Committee. This will be an opportunity for ongoing linkage improvement. Marin County aims to create a network of care that includes CMHS, other Health and Human Services Divisions, CMHS contractors, and many other stakeholders that have participated in the planning process or are identified within the resource map. This network of care will provide a continuum of care in which

individuals are effectively linked to the services they need, such as further mental health assessment and treatment, or other needed services.

Parents or children identified as needing further assessment or treatment than is available through this project will be referred to the most appropriate provider, including primary health care provider, local mental health providers, County mental health clinic, and/or insurance provider. Staff hired by PEI funds will assist with coordinating services for families to ensure successful linkages. Mental Health Consultants (MHCs) will maintain an updated list of local providers and maintain relationships with referral sites. Formal referral linkages will be developed among CMHS, other County departments, and CMHS contractors. CMHS contractors include approximately thirty local community-based organizations that provide mental health assessment and treatment, physical health care, substance abuse, domestic violence interventions, housing, and employment services. Linkage relationships will be developed with many of the organizations that participated in the MHSA planning process (see Form 2 for complete lists).

The selected programs are sufficient to achieve the desired outcomes listed in question 7 by:
- providing services in settings that already serve target populations;
- providing evidence-based education and support to families and childcare providers and families to meet children's needs more effectively;
- identifying and addressing underlying issues, such as parental depression.

Implementing agencies will be required to show that they can implement with fidelity, develop and maintain the collaborations described below, and provide the expertise and logistical support that will ensure effectiveness leading to positive outcomes.

6. Collaboration and System Enhancements

Our implementation partners will be determined through an RFP process. They will be required to show that they can serve the target populations effectively, such as having culturally and linguistically appropriate staff, experience serving identified population, and ability to work with the targeted settings. They must also show their ability to implement the project effectively, meet the goals, and meet fiscal, administrative and evaluation responsibilities. Each program description above discusses how the contracting agency will collaborate with others to identify participating sites and families. RFPs will encourage formal collaborations to be developed before submitting a proposal to the County.

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Jewish Family and Children's Services currently provides ECMH consultation to subsidized pre-schools, with support from FIRST 5, Bella Vista, and Marin Community Foundation. Bella Vista Foundation is also funding parental depression prevention and alleviation services in the community, such as support groups and home visits. These agencies will collaborate with the contracting agency to ensure a coordinated approach.

CMHS will coordinate with the PEI Committee and MHSA Implementation Committee to review outcome data and determine reauthorization or adjustments to this and other projects to achieve identified outcomes.

For families served by these programs that are in need of further services, there will be referral processes in place to connect them to a range of services. As described above, linkages will be developed with mental health and other services. Specifically, CMHS has contracts with most of the non-profit mental health providers in the county, and will develop formal referral processes between them and the PEI contractors. In addition, CMHS has formal relationships with health care clinics serving low-income residents, including co-locating mental health providers within County clinics and primary care providers. Both CSS funds and PEI funds contribute to providing mental health professionals at these sites. Referral processes are in place and will be expanded to include new PEI contractors.

The staffing requirements, and therefore budget, for the ECMH program takes into account that childcare providers will be trained to provide some of the family services. The staffing requirements, and therefore budget, for Parenting Education takes into account that the actual parenting education will be provided by existing providers. For Level 2 and 3, these are generally providers, such as childcare providers, teachers, public health nurses, promotoras and others, who already provide some parenting education that may or may not be evidence-based. For Level 4, eligible mental health providers can bill Medi-Cal for Triple P interventions. In addition, much of the infrastructure for the ECMH services is already developed, including key collaborations and implementation and evaluation procedures. Contracting agencies will be expected to provide office space and supervision.

This model of increasing provider capacity and developing referral processes helps to multiply and sustain the PEI efforts. Through the RFP process, agencies will be required to demonstrate their ability to fiscally manage and sustain this program. We anticipate that these programs will be ongoing PEI projects, depending on the outcome data, community input, and review by PEI and MHSA Implementation Committees.

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7. Intended Outcomes

ECMH consultation is a model that has been shown to be a promising practice for the prevention of child abuse and the early intervention and detection of problems that can be effectively addressed before they become insurmountable challenges. A formal Jewish Family and Children's Services ECMH project evaluation overseen by Dr. Sharon Lynn Kagan of Columbia and Yale Universities confirmed the efficacy of the service model. Triple P has an extensive evidence base for a variety of parenting challenges and cultural communities. In recent publications by Yale University, the National Center for Children in Poverty, and the California Mental Health Services Oversight and Accountability Commission, mental health consultation to childcare settings and parent education and support are identified as effective strategies for supporting young children's social and emotional health and school readiness.

On the individual and family level, expanded ECMH services will enhance the capacity of early childhood education/care sites to identify individuals and families with social, emotional and behavioral issues; respond to the needs effectively in the childcare setting; and provide effective referrals for appropriate additional services. This will increase the number of underserved families receiving prevention and early intervention services, leading to:
• Increase in parental depression identification and effective linkage to brief intervention (provider reported)
• Improvements on the behavioral assessment scale for children (assessment tool)
• Maintaining children in regular childcare settings that previously would not have been (provider reported)

On the individual and family level, Triple P services will enhance the capacity of current family providers to provide effective and consistent parenting education and support. This will increase the number of underserved families receiving prevention and early intervention services, leading to:
• Reduction in disruptive behavior by children (parent reported)
• Increase in parenting confidence and efficacy (parent reported)
• Reduction in dysfunctional parenting (parent reported)

On the system level, these services will result in:
• Participating childcare sites having a formal process for identifying children/families with emotional or behavioral issues;
• Participating childcare sites having increased capacity to provide prevention and early intervention services;
• An increased number of children/families being identified and receiving early intervention services;
• More effective cross-referrals between childcare sites and mental health and other services.

On the program level, ECMH is expected to expand services currently provided to 1000 children and newly serve an additional 50. All of these children will receive prevention services and approximately 105 of those children and families will need early intervention services. Triple P is expected to serve 100 families in 2009-10, with significant increases in future years as more providers are trained. Some of the families receiving Triple P services may also be receiving ECMH Consultation services.

8. Coordination with Other MHSA Components

Within the PEI programs, families identified by the ECMH services can be referred to Triple P providers and primary care-givers identified through depression screening can be referred to health care clinics, and CBO's participating in PEI programs. Families receiving parenting education in need of further services can be referred to the same range of services, often coordinated by the provider who originally linked the family to the parenting education services. The PEI Committee will meet regularly to assist with implementation, including ensuring effective referral processes among organizations. In addition, CMHS will likely coordinate evidence based practices trainings that can be useful for multiple PEI providers, such as Problem Solving Therapy.

Protocols for referral from PEI projects to CSS programs will be developed in conjunction with PEI contracts. The MHSA Implementation Committee will include representatives from PEI programs as well as CSS programs to continue working on effective linkages. PEI project needs are being considered in the development of the Workforce Education and Training plan. For example, Parent Child Interaction Therapy (PCIT) training is being considered, a service in the continuum of parenting education. The Capital Facilities and Technology plan is in development and will take into consideration the needs of PEI projects.

9. Additional Comments (optional)

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County: Marin **PEI Project Name: Student Assistance Program** **Date: 1/29/09**

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

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

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

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

The PEI Committee incorporated many sources of information in developing their recommendations: the data resulting from the pre-MHSA planning process described above (Form 2); prevalence and penetration data from the County; resource mapping; client demographics and needs assessments from relevant organizations; and data from the PEI Community Engagement Process described above (2-3). Data from all of these sources was presented to the PEI Committee at appropriate times throughout the process.

PEI-related Themes from Stakeholder Input from Pre-MHSA and CSS Planning Process:
- Support families and communities to increase their resilience (wellness factor)
- Provide culturally appropriate education and early intervention in the community so it is more accessible
- Increase provider awareness (schools, clinics, etc) so they identify and respond earlier and more effectively
- Increase public awareness about mental health to increase access to resources and reduce stigma
- Parenting education and early intervention for parents (i.e., for substance abuse and depression)
- Increase number of culturally and linguistically competent providers
- Services for unserved clients who do not meet current financial or medical necessity criteria
- Address basic needs first (housing, shelter, employment, medical care) so that mental health services are more effective
- Build effective community partnerships between CMHS and law enforcement, schools, substance abuse services, etc.

The PEI Committee developed 4 workgroups to develop the strategies and program recommendations: Prenatal-5, Youth (6-15), TAY (16-25), and Adult/Older Adult. The Youth and TAY workgroups developed the recommendation included in this project. Participants included representatives from CMHS, Community Action Marin, Novato Youth Center, Isoji, Tamalpais Unified High School District, Family Service Agency, Novato Wellness Center, Huckleberry Youth Programs, Marin Abused Women's Services, County Alcohol, Drug and Tobacco Program, as well as three high school students. Data specific to these age groups that the workgroups considered included:

- Department of Education: rates of attendance, achievement, and other data broken down by regions of the county
- CMH primary diagnoses summary. CMH serves adolescents with the following primary diagnoses: Mood Disorders (49%), Disruptive Behavior Disorders (33%), and Anxiety Disorders (12%). The remaining 6% is distributed among Adjustment Disorders, Substance-Related, and other concerns.
- Local substance use and other risk-behavior data for this age group (County ADT Program)

Some of MHSOAC's data points that seemed most relevant to Marin's demographics and experience are:
- An estimated 50% of children in many California public schools, especially those in high-stress low-income neighborhoods, have psycho-social problems that place them at risk for more serious disorders.

- Children with unaddressed mental health problems are highly likely to drop out of school, go to jail as adults, and suffer other negative outcomes.
- According to the US Surgeon General, the burden and disability in the US from mental disorders is carried disproportionately by children/youth and people of color.

Community engagement meetings, focus groups and key informant meetings were held by the PEI Coordinator to solicit input about community needs, as well as test the appropriateness of the strategies under discussion. For example, 7 focus groups were held with parents from target populations and teens from diverse backgrounds to answer questions, such as needs they and their children have, where they are best reached, and what types of services they would like.

As a result of the data, community input, and stakeholder input, workgroups identified the following key community needs: "Disparities in Access to Mental Health Services and "At-risk Children, Youth and Young Adult Populations" and priority populations: "Children and Youth in Stressed Families" and "Underserved Cultural Populations", recognizing that these would also include issues of trauma, school failure and juvenile justice involvement.

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

In the early MHSA planning process, community members identified a need to support the family and provide services in non-traditional sites for mental health services that are accessible to families. School-based services and increasing provider awareness so they identify and respond earlier and more effectively were specifically recommended. The workgroups considered strategies that met these interests, addressed underserved cultural populations, and focused on the identified community need and priority populations. In addition, stakeholders not represented in the workgroups were contacted to discuss the appropriateness of the strategies under discussion, including past experiences with similar programs and other strategies they recommend. Using the community input, stakeholder input, data analysis, and desired outcomes, appropriate programs were identified and researched by the workgroup.

Student Assistance Programs (SAP) build on existing services in Marin County, incorporate evidence-based practices, and are provided in a widely agreed upon setting. SAPs funded by PEI would aim to complete the levels of services currently offered in the implementing schools:

1. School Wide Interventions: Marin County Office of Education has developed a list of evidence-based school-wide interventions approved by the California Department of Education, from which many schools in the County have selected locally appropriate programs to implement. These include behavioral or anti-bullying curriculum, suicide

awareness and prevention, school attendance review boards, and other systems or policy level programs. Examples include Teen Screen, BEST, Signs of Suicide, and Second Step.

2. Targeted Short Term Supplemental Services: Most schools identified this as the area of greatest need. All high schools and some middle schools have school study teams to identify students with academic or behavioral problems, but not enough resources to follow-through effectively. Many students are not identified and provided services until there is a serious problem.
3. Intensive Individual Services: These services are generally available to students eligible for Special Education.

PEI funds would provide staff time to assist schools in assessing what resources currently exist within the school and wider community, what additional services are needed, and how to develop them. The staff person would also provide some of those services directly, especially Level 2 services such as:

- Training and support for teachers and school staff to identify and refer students to SAP services;
- Work with school study teams to conduct individual assessment and multi-disciplinary case coordination for students;
- Evidence-based student interventions one-on-one, in small groups or with family members. These may include family counseling, anger management, problem solving, resolving conflict, dealing with peer pressure and bullying, communication skills, grief counseling, or other concerns as needed;
- Age appropriate activities for students that enhance self-esteem and self-expression;
- Education and support for parents, teachers and school staff to support/implement the case plan and strategies;
- Increase collaboration between schools and mental health/substance abuse/other services to improve services for students and families (screening, treatment, crisis intervention, referrals);
- When/if schools are able, train the school to sustain the program.

To begin with, one pilot SAP will be implemented in Martin Luther King Middle School (MLK) in south Marin. After the current programs are evaluated, expanding SAPs to additional schools will be considered. MLK was selected due to school-based performance data, including drop out rates, and community input from south Marin identifying middle school as a key time for intervention in that community. Students at MLK are primarily low-income African American children.

- South Marin students have a suspension rate of approximately 25% in elementary and middle school.
- There is an overrepresentation of African American and Latinos in County Community Schools and Juvenile Justice. While Marin's population is 3.5% African American, 13.5% Hispanic, and 77% Caucasian, the average daily population in Marin County Juvenile Hall is 37.6% African American, 34.4% Hispanic and 27.4% Caucasian.
- Concerted efforts in the south Marin elementary school has resulted in positive outcomes in the last couple of years.

The implementing school will participate in choosing the community-based organization to provide the services. This builds on a model of services currently in place in the south Marin elementary school. The SAP will collaborate with the

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elementary and high schools to assist with higher retention of students through these key transitions. The target community is fairly small and already has established a number of partnership mechanisms, including a multi-disciplinary team that meets monthly, including a subgroup to specifically address youth. Within the schools, the elementary and middle schools share the same principal, as well as some of the staff. Due to the size and experience of this community, SAP staff will work with parents to develop a preventive and positive approach, rather than what is usually experienced as a punitive approach.

Milestones & Tasks	Estimated Timeline
• Establish providing agency through an RFP process	Dec 2008-Feb 2009
• Establish contract and monitoring agreements to assure effective implementation	Feb-April 2009
• Hire additional culturally competent PEI staff	June 2009
• New PEI staff will receive training in key evidence-based practices	June-July 2009
• Providing agency will develop MOU with MLK Middle School	July 2009
• Providing agency, with County assistance, will establish referral process and relationships for children and parents identified as needing further services	July-August 2009
• Establish baseline data necessary to track outcomes	July-August 2009
• Assess resources existing in school and community, identify additional needed services	Sept-Oct 2009
• Make contact with all parents to establish a collaborative relationship	Sept-Oct 2009
• Work with school and community services to increase access to needed services	Oct-Nov 2009
• Develop specific services SAP staff will provide	Nov-Dec 2009
• Train school staff in mental health issues, identification, and resources	Feb 2010
• Participate in regular PEI Committee meetings to develop collaborations, problem-solve implementation challenges, and assist in evaluation of PEI projects	Ongoing
• Collect outcome data	Ongoing
• Review outcome data with PEI Coordination Committee	March 2012
• MHSA Implementation Committee performs program review and reauthorization	April 2012

Our implementation partners for this project will be determined through an RFP process. They will be required to show that they can serve the target populations effectively, such as ability to work with the targeted settings. The target school staff and parents will participate in choosing the providing agency.

The programs identified are expected to achieve the desired outcomes because:

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- Community members and current providers have identified the need for these types of services and interest in accessing and implementing them;
- They are provided in a setting already serving the target population and can be offered in a non-stigmatizing way;
- They incorporate evidence-based programs that are shown to be effective with diverse populations.

These programs address a number of priorities identified by the community during the planning process:
- Support families and communities to increase their resilience (wellness factor)
- Provide culturally appropriate education and early intervention in the community so it is more accessible
- Increase provider awareness (schools, clinics, etc) so they identify and respond earlier and more effectively
- Increase number of culturally and linguistically competent providers
- Build effective community partnerships between CMHS and law enforcement, schools, substance abuse services, etc.

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through **June 2010** by type		Number of months in operation through **June 2010**
	Prevention	Early Intervention	
Student Assistance Program – MLK Middle School	Individuals: 60 Families: 30	Individuals: 30 Families: 20	13
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 60 **Families**: 30	**Individuals:** 30 **Families**: 20	

Prevention services include: school staff training, proactive relationship development with families
Early intervention services include: brief interventions such as counseling and group activities with students

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

Marin County is a medium sized county (250,000) with extensive relationships among providers. The CSS and PEI planning processes have increased the level of collaboration and linkages. Marin County CMHS will continue to convene the MHSA implementation Committee and initiate a PEI Implementation Committee. This will be an opportunity for ongoing linkage improvement. Marin County aims to create a network of care that includes CMHS, other Health and Human Services Divisions, CMHS contractors, and many other stakeholders that have participated in the planning process or are identified within the resource map. This network of care will provide a continuum of care in which individuals are effectively linked to the services they need, such as further mental health assessment and treatment, or other needed services.

Students or family members identified as needing further assessment or treatment than is available through this project will be referred to the most appropriate provider, including primary health care provider, local mental health providers, County mental health clinic, and/or insurance provider. Staff hired by PEI funds will assist with coordinating services for families to ensure successful linkages. SAP staff will maintain an updated list of local providers and maintain relationships with referral sites. Formal referral linkages will be developed among CMHS, other County departments, and CMHS contractors. CMHS contractors include approximately thirty local community-based organizations that provide mental health assessment and treatment, physical health care, substance abuse, domestic violence interventions, housing, and employment services. Linkage relationships will be developed with many of the organizations that participated in the MHSA planning process (see Form 2 for complete lists).

The selected program is sufficient to achieve the desired outcomes listed in question 7:

- Student Assistance Programs have been shown to reduce school violence and substance abuse while increasing school attendance, academic performance, and access to services (see evidence base for Project SUCCESS, Positive Action, Masonic Model SAP, SAP of Vermont and Washington State Prevention and Intervention Services);
- The South Marin elementary school that feeds into MLK Middle School has experienced improvement in behavior and academic outcomes since implementing a similar model;
- MLK Middle School, providers, and community members in south Marin participated in the development of this plan and have expressed willingness to participate and support it;
- Serving the families of the students is an effective method for children this age.

Implementing agencies will be required to show that they can implement with fidelity, develop and maintain the collaborations described below, and provide the expertise and logistical support that will ensure effectiveness leading to positive outcomes.

6. Collaboration and System Enhancements

Our implementation partners will be determined through an RFP process in which the target school staff and parents participate. They will be required to show that they can serve the target populations effectively, such as having culturally and linguistically appropriate staff, experience serving identified population, and ability to work with the targeted settings. They must also show their ability to implement the project effectively, meet the goals, and meet fiscal, administrative, and evaluation responsibilities.

CMHS will coordinate with the PEI Committee and MHSA Implementation Committee to review outcome data and determine reauthorization or adjustments to this and other projects to achieve identified outcomes.

For students or families served by these programs that are in need of further services, there will be referral processes in place to connect them to a range of services. As described above, linkages will be developed with mental health and other services. Specifically, CMHS has contracts with most of the non-profit mental health providers in the county, and will develop formal referral processes between them and the PEI contractors. In addition, CMHS has formal relationships with health care clinics serving low-income residents, including co-locating mental health providers within County clinics and Federally Qualified Health Centers (FQHCs). Both CSS funds and PEI funds contribute to providing mental health professionals at these sites. Referral processes are in place and will be expanded to include new PEI contractors.

The budget for the program takes into account that supervision, office space and other costs will be leveraged by the school and community organization contracted to implement the program. This model of increasing the capacity of existing providers and coordinating/expanding access to existing services multiplies and sustains the PEI efforts. Through the RFP process, agencies will be required to demonstrate their ability to fiscally manage and sustain this program. We anticipate that this program will be ongoing PEI project, depending on the outcome data, community input, and review by PEI and MHSA Implementation Committees.

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7. Intended Outcomes

Student Assistance Programs (SAP) are an evidence-based practice that have been implemented to improve outcomes in school settings. SAPs, such as Project SUCCESS, Positive Action, and the Masonic Model, have been shown to reduce school violence and substance abuse while increasing school attendance, academic performance, and access to services.

On the individual and family level, SAPs will enhance the capacity of schools to increase resilience and protective factors among students; engage families in a proactive way; identify students with social, emotional and behavioral issues; respond to the needs effectively in a coordinated manner; and provide effective referrals for appropriate additional services. This will increase the number of underserved families receiving prevention and early intervention services, leading to:

- Reduction in student drop-out rate (school reported)
- Reduction in behavioral issues at school, such as expulsions and suspensions (school reported)
- Increase in academic performance (school reported)

On the system level, SAPs will coordinate service plans and increase access to services by facilitating linkages and working to develop a better network of services. Providing services that include the family will also increase the effectiveness of services. On the program level, the MLK SAP is expected to serve 60 students and 30 families. This includes students attending Martin Luther King Middle School, as well as students transitioning in or out of middle school. All of these children will receive prevention services and approximately 30 of those children and 20 families will receive early intervention services.

8. Coordination with Other MHSA Components

Within the PEI programs, families identified by SAP services can have their services coordinated by SAP staff while being referred to Triple P providers and CBO's participating in PEI programs. The PEI Committee will meet regularly to assist with implementation, including ensuring effective referral processes among organizations. In addition, CMHS will coordinate evidence based practices trainings that can be useful for multiple PEI providers, such as Problem Solving Therapy.

Protocols for referral from PEI projects to CSS programs will be developed in conjunction with PEI contracts. The MHSA Implementation Committee will include representatives from PEI programs as well as CSS programs to continue working on effective linkages. PEI project needs are being considered in the development of the Workforce Education and Training plan. For example, Parent Child Interaction Therapy (PCIT) training is being considered, a service in the continuum of parenting education. The Capital Facilities and Technology plan is in development and will take into consideration the needs of PEI projects.

9. Additional Comments (optional)

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County: Marin **PEI Project Name: Transition Age Youth Prevention & Early Intervention** **Date: 1/29/09**

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

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

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

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

The PEI Committee incorporated many sources of information in developing their recommendations: the data resulting from the pre-MHSA planning process described above (Form 2); prevalence and penetration data from the County; resource mapping; client demographics and needs assessments from relevant organizations; and data from the PEI Community Engagement Process described above (2-3). Data from all of these sources was presented to the PEI Committee at appropriate times throughout the process.

PEI-related Themes from Stakeholder Input from Pre-MHSA and CSS Planning Process:
• Support families and communities to increase their resilience (wellness factor)
• Provide culturally appropriate education and early intervention in the community so it is more accessible
• Increase provider awareness (schools, clinics, etc) so they identify and respond earlier and more effectively
• Increase public awareness about mental health to increase access to resources and reduce stigma
• Parenting education and early intervention for parents (i.e., for substance abuse and depression)
• Increase number of culturally and linguistically competent providers
• Services for unserved clients who do not meet current financial or medical necessity criteria
• Address basic needs first (housing, shelter, employment, medical care) so that mental health services are more effective
• Build effective community partnerships between CMHS and law enforcement, schools, substance abuse services, etc.

The PEI Committee developed 4 workgroups to develop the strategies and program recommendations: Prenatal-5, Youth (6-15), TAY (16-25), and Adult/Older Adult. The TAY workgroup developed the recommendation included in this project. Participants included representatives from high schools and alternative education, clinics and other community-based organizations serving TAY, County Alcohol Drug and Tobacco Program, as well as three high school students. Data specific to this age group that the workgroups considered included:

- CMH primary diagnoses summary. CMH serves adolescents with the following primary diagnoses: Mood Disorders (49%), Disruptive Behavior Disorders (33%), and Anxiety Disorders (12%). The remaining 6% is distributed among Adjustment Disorders, Substance-Related, and other concerns.
- Needs assessments conducted by a community-based organization addressing violence and a CBO outreaching to homeless TAY.
- Juvenile and adult justice statistics, including disproportionate detention of youth of color. While Marin's population is 3.5% African American, 13.5% Hispanic, and 77% Caucasian, the average daily population in Marin County Juvenile Hall is 37.6% African American, 34.4% Hispanic and 27.4% Caucasian.
- Results of screenings conducted in teen health clinics.
- Recent local trends in suicide that show an increase among this age group.

- Local substance use and other risk-behavior data for this age group (County ADT Program)

Some of the MHSOAC's data points that are most relevant to this population include:

- Youth ages 15-21 have the highest prevalence of co-occurring substance abuse and mental health disorders. Over 60% of youth with a substance-use disorder also have a mental health disorder. Drug use compounds their mental health problems, creating a downward spiral that becomes more difficult to treat, making prevention and early intervention more critical.
- Children of color are likely to face stressors including issues of identity, acculturation, intergenerational conflict; fewer available services and even fewer culturally competent services; experiences of injustice and discrimination, and trauma.
- First-break – an individual's initial episode of severe mental illness – usually occurs in the late teens or early 20s. Support, developmentally appropriate early intervention, and treatment at the first appearance of symptoms are likely to make a significant, positive difference in both immediate and long-term outcomes.

Community engagement meetings, focus groups and key informant meetings were held by the PEI Coordinator to solicit input about community needs, as well as test the appropriateness of the strategies under discussion. For example, 2 focus groups were held with TAY from diverse backgrounds to answer questions such as needs they have, where they are best reached, and what types of services they would like. In addition, other focus groups included TAY, especially young parents. Specifically, it was recognized that Marin County youth have a high rate of substance use, youth from communities of color are disproportionately represented in the criminal justice system, and TAY need to be reached through different settings than other age groups.

As a result of the data, community input, and stakeholder input, the TAY workgroup identified TAY as a high risk group with the following key community needs: "Disparities in Access to Mental Health Services," "At-risk Young Adult Population," and priority populations: "Underserved Cultural Populations," recognizing that these would also include issues of trauma, suicide risk, onset of serious psychiatric illness, and some youth at risk of school failure and/or experiencing juvenile justice involvement.

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

In the early MHSA planning process, community members identified the need to provide services in non-traditional sites for mental health services that are accessible, increase provider awareness so they identify and respond earlier and more

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effectively, and provide early intervention for parents (i.e., for substance abuse and depression). The TAY workgroup considered strategies that met these interests, addressed underserved cultural populations, and focused on the identified community needs and priority populations. In addition, stakeholders not represented in the workgroups were contacted to discus the appropriateness of the strategies under discussion, including past experiences with similar programs and other strategies they would recommend. Using the community input, stakeholder input, data analysis, and desired outcomes, appropriate programs were identified and researched by the workgroup.

The provider selected to implement the TAY PEI Project will integrate PEI services into teen health clinic settings that currently do not provide mental health treatment services. They will hire at least 1.0 FTE of licensed mental health worker time to provide services in 2 sites that include:

- Training for staff at the 2 health clinic sites and other referring agencies on identifying and effectively referring potential clients.
- Assessment of TAY referred to the TAY PEI Project.
- Brief Intervention for the TAY that will benefit from brief, solution-focused interventions. This may include individual, group or family interventions.
- Client monitoring and outcome measurement in order to adjust the interventions to find the most effective approaches.

The mental health worker(s) will work with provider agency's case managers and peer educators to provide:

- Outreach and education for TAY and their parents on mental health topics of interest to TAY, such as depression, anxiety, signs and symptoms of mental illness, and available services.
- Referral and warm hand-offs to appropriate services will be provided for TAY needing more than what is available at the TAY PEI Project.

The mental health worker(s) will collaborate with the provider agency's Program and Clinical Directors to oversee the implementation and evaluation of the project.

The providing agency currently effectively serves TAY from underserved cultural populations with culturally and linguistically competent services.

Milestones & Tasks	Estimated Timeline
• Establish providing agency through an RFP process	Dec 2008-Feb 2009
• Establish contract and monitoring agreements to assure effective implementation	Feb-April 2009
• Hire additional culturally competent, bi-lingual PEI staff	June 2009
• New PEI staff will receive training in key evidence-based practices	July-Aug 2009
• Providing agency, with County assistance, will establish referral process and relationships for	July-August 2009

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children and parents identified as needing further services	
• Establish baseline data necessary to track outcomes	July 2009
• Assess current resources and how to integrate mental health services	Sept-Oct 2009
• Develop specific services PEI staff will provide	Nov-Dec 2009
• Train staff working with TAY in mental health awareness, screening and referrals	Feb 2010
• Participate in regular PEI Committee meetings to develop collaborations, problem-solve implementation challenges, and assist in evaluation of PEI projects	Ongoing
• Collect outcome data	Ongoing
• Review outcome data with PEI Coordination Committee	March 2012
• MHSA Implementation Committee performs program review and reauthorization	April 2012

Our implementation partners for this project will be determined through an RFP process. They will be required to show that they can serve the target populations effectively within the targeted settings.

The programs identified are expected to achieve the desired outcomes because:
- Community members and current providers have identified the need for these types of services and interest in accessing and implementing them;
- They are provided in a setting already serving the target population and can be offered in a non-stigmatizing way;
- They incorporate evidence-based programs that are shown to be effective with diverse populations.
- Clients will be monitored in order to adjust interventions on an ongoing basis.

These programs address a number of priorities identified by the community during the planning process:
- Support families and communities to increase their resilience (wellness factor)
- Provide culturally appropriate education and early intervention in the community so it is more accessible
- Increase provider awareness (schools, clinics, etc) so they identify and respond earlier and more effectively
- Increase number of culturally and linguistically competent providers
- Services for unserved clients who do not meet current financial or medical necessity criteria
- Build effective community partnerships between CMHS and law enforcement, schools, substance abuse services, etc.

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4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through **June 2010** by type		Number of months in operation through **June 2010**
	Prevention	Early Intervention	
Transition Age Youth Prevention & Early Intervention	Individuals: 150 Families: 25	Individuals: 50 Families: 10	13
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 150 **Families**: 25	**Individuals:** 50 **Families**: 10	

Prevention activities include: provider training, client mental health awareness and skill-building, and screenings
Early intervention activities include: assessment, case management, counseling and linkages to services

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

Marin County is a medium sized county (250,000) with extensive relationships among providers. The CSS and PEI planning processes have increased the level of collaboration and linkages. Marin County CMHS will continue to convene the MHSA Implementation Committee and initiate a PEI Implementation Committee. This will be an opportunity for ongoing linkage improvement. Marin County aims to create a network of care that includes CMHS, other Health and Human Services Divisions, CMHS contractors, and many other stakeholders that have participated in the planning process or are identified within the resource map. This network of care will provide a continuum of care in which individuals are effectively linked to the services they need, such as further mental health assessment and treatment, or other needed services.

TAY or family members identified as needing further assessment or treatment than is available through this project will be referred to the most appropriate provider, including primary health care provider, local mental health providers, County mental health clinic, and/or insurance provider. Staff hired by PEI funds will assist with coordinating services for families to

ensure successful linkages. TAY PEI staff will maintain an updated list of local providers and maintain relationships with referral sites. Formal referral linkages will be developed among CMHS, other County departments, and CMHS contractors. CMHS contractors include approximately thirty local community-based organizations that provide mental health assessment and treatment, physical health care, substance abuse, domestic violence interventions, housing, and employment services. Linkage relationships will be developed with many of the organizations that participated in the MHSA planning process (see Form 2 for complete lists).

Currently individuals experiencing first break enter the mental health system by:

- Accessing Psychiatric Emergency Services (PES) if it is an emergency. This service provides 24/7 crises stabilization, screening and referral services.
- Schools or other services referring individuals into CMHS programs. Many times, adolescents experiencing a first break are first identified at their school and CMH services are accessed through a collaborative process with the parents and the Special Education Program at their school.
- The client or family calling CMHS directly.

The services CMHS provides include:

- TAY Full Service Partnership funded by MHSA CSS funds. They are becoming local experts on addressing first break and engaging these youth with their youth focused services.
- Adult Case Management
- Adult or Youth Medication Management

The PEI funds expand training for providers and screening/assessment in a variety of settings, including primary care settings and TAY specific settings, that will assist with identifying individuals at risk for or experiencing first break and providing referrals to appropriate services, including PEI brief interventions, community-based mental health services, or County level services.

The selected program is sufficient to achieve the desired outcomes listed in question 7:

- Specific screening tools and intervention methods will be evidence based, such as Problem Solving Therapy or Brief Strategic Family Therapy;
- The PEI program will be implemented by agencies that already effectively serve TAY.

Implementing agencies will be required to show that they can implement with fidelity, develop and maintain the collaborations described below, and provide the expertise and logistical support that will ensure effectiveness leading to positive outcomes.

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6. Collaboration and System Enhancements

Our implementation partners will be determined through an RFP process. They will be required to show that they can serve the target populations effectively, such as having culturally and linguistically appropriate staff, experience serving identified population, and ability to work with the targeted settings. They must also show their ability to implement the project effectively, meet the goals, and meet fiscal, administrative, and evaluation responsibilities.

CMHS will coordinate with the PEI Committee and MHSA Implementation Committee to review outcome data and determine reauthorization or adjustments to this and other projects to achieve identified outcomes.

For TAY or families served by these programs that are in need of further services, there will be referral processes in place to connect them to a range of services. As described above, linkages will be developed with mental health and other services. Specifically, CMHS has contracts with most of the non-profit mental health providers in the county, and will develop formal referral processes between them and the PEI contractors. In addition, CMHS has formal relationships with health care clinics serving low-income residents, including co-locating mental health providers within County clinics and Federally Qualified Health Centers (FQHCs). Both CSS funds and PEI funds contribute to providing mental health professionals at these sites. Referral processes are in place and will be expanded to include new PEI contractors.

The budget for the program takes into account that supervision, office space and other costs will be leveraged by the community organization contracted to implement the program. In addition, existing staff will conduct initial screenings. This model of expanding the capacity of existing providers and building upon existing services leverages the infrastructure that already exists, including mechanisms to collect data. Through the RFP process, agencies will be required to demonstrate their ability to fiscally manage and sustain this program. We anticipate that these programs will be ongoing PEI projects, depending on the outcome data, community input, and review by PEI and MHSA Implementation Committees.

7. Intended Outcomes

On the individual and family level, TAY PEI services will increase resilience and protective factors among TAY; enhance the capacity of TAY providers to identify TAY with mental health concerns; respond to the needs effectively in a coordinated manner; and provide effective referrals for appropriate additional services. This will increase the number of underserved TAY receiving prevention and early intervention services, leading to:

• Reduced substance use (assessment tool)

• Improved mental health status (assessment tool)
• Increased problem solving skills (client reported)

On the system level, TAY PEI services will coordinate services plans and increase access to services by facilitating linkages and working to develop a better network of services. Providing services that include the family will also increase the effectiveness of services. On the program level, the TAY PEI program is expected to expand services to 150 TAY and 25 families. All of these TAY will receive prevention services and approximately 50 of those TAY and 10 families will need early intervention services.

8. Coordination with Other MHSA Components

Within the PEI programs, individuals or families identified by TAY PEI services can have their services coordinated by TAY PEI staff while being referred to CBO's participating in PEI programs. The PEI Committee will meet regularly to assist with implementation, including ensuring effective referral processes among organizations. In addition, CMHS will coordinate training in evidence based practices that can be useful for multiple PEI providers, such as Problem Solving Therapy.

TAY experiencing "first break" can be referred to the TAY Full Service Partnership funded by MHSA CSS. Many of their clients are "first break" and they are developing an expertise in such services. Protocols for referral from PEI projects to CSS programs will be developed in conjunction with PEI contracts. The MHSA Implementation Committee will include representatives from PEI programs as well as CSS programs to continue working on effective linkages. PEI project needs are being considered in the development of the Workforce Education and Training plan. For example, co-occurring disorder training is being considered, a service often needed by TAY. The Capital Facilities and Technology plan is in development and will take into consideration the needs of PEI projects.

9. Additional Comments (optional)

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County: Marin PEI Project Name: Canal Community-Based Prevention & Early Intervention Date: 1/29/09

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

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

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

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

The PEI Committee incorporated many sources of information in developing their recommendations: the data resulting from the pre-MHSA planning process described above (Form 2); prevalence and penetration data from the County; resource mapping; client demographics and needs assessments from relevant organizations; and data from the PEI Community Engagement Process described above (2-3). Data from all of these sources was presented to the PEI Committee at appropriate times throughout the process.

PEI-related Themes from Stakeholder Input from Pre-MHSA and CSS Planning Process:
- Support families and communities to increase their resilience (wellness factor)
- Provide culturally appropriate education and early intervention in the community so it is more accessible
- Increase provider awareness (schools, clinics, etc) so they identify and respond earlier and more effectively
- Increase public awareness about mental health to increase access to resources and reduce stigma
- Parenting education and early intervention for parents (i.e.,for substance abuse and depression)
- Increase number of culturally and linguistically competent providers
- Services for unserved clients who do not meet current financial or medical necessity criteria
- Address basic needs first (housing, shelter, employment, medical care) so that mental health services are more effective
- Build effective community partnerships between CMHS and law enforcement, schools, substance abuse services, etc.

The PEI Committee developed 4 workgroups to develop the strategies and program recommendations: Prenatal-5, Youth (6-15), TAY (16-25), and Adult/Older Adult. In addition, the Community Engagement process revealed key needs in specific communities that were not addressed adequately by other recommendations under consideration. Community engagement meetings, focus groups and key informant meetings were held by the PEI Coordinator to solicit input about community needs, as well as test the appropriateness of the strategies under discussion. For example, 3 focus groups were held in Spanish with Latino community members, as well as Latino TAY participating in the teen and TAY focus groups, to answer questions such as needs they have, where they are best reached, and what types of services they would like. Some of the specific data considered included:
- The US Census projects the Latino community to be 13.1% of the Marin County population (32,585) in 2006, which is likely an underestimate;
- Penetration rate data shows that Latinos are the most underserved population in Marin.
- The Latino community experiences linguistic, cultural, financial, legal and other barriers to accessing services. Many community members primarily access community-based services within the Canal District;
- Many community members have experienced trauma, separation from family, and other risk factors.

As a result of the data, community input, and stakeholder input, the Latino community was identified as a significantly underserved and high risk group with the following key community needs: “Disparities in Access to Mental Health Services” and “Psycho-social Impact of Trauma” and priority populations: “Trauma Exposed Individuals” and “Underserved Cultural Populations,“ recognizing this would also include some individuals experiencing onset of serious psychiatric illness and some youth at risk for school failure and/or experiencing juvenile justice involvement.

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

In the early MHSA planning process, community members identified the need to provide services in sites that are accessible, increase provider awareness so they identify and respond earlier and more effectively, and provide early intervention for parents (i.e., for substance abuse and depression). In addition, stakeholders not represented in the workgroups were contacted to discus the appropriateness of the strategies under discussion, including past experiences with similar programs and other strategies they would recommend. Using the community input, stakeholder input, data analysis, and desired outcomes, appropriate programs were identified and researched. It became apparent that while community and county clinics serve a large number of Latino clients, there are also many Latino residents that do not access health care and are much more likely to access other types of community based services.

There are a number of services located in the Canal District that are well known by local residents, primarily a Latino and low-income population. The Canal Community-Based Prevention & Early Intervention would provide staff time to provide mental health services through these settings. The providing agency will be selected through an RFP process. Applicants will have to show what the demographics of the clients are and their ability to provide culturally and linguistically competent services.

Key elements of the Canal Community-Based Prevention & Early Intervention Program:

- Outreach to TAY;
- Train current providers, such as outreach workers, family advocates and others, to conduct evidence-based screenings and effectively refer clients to the mental health worker;
- Provide assessment and brief intervention services as needed, such as one-on-one sessions, groups programs, family counseling, case management or linkages to other services.
- Client monitoring and outcome measurement in order to adjust the interventions to find the most effective approaches.

The mental health worker would be responsible for the following:

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- Clinical supervision, education and training for staff regarding PEI including training on recognizing signs and symptoms of mental health concerns, evidence-based screening, and effective referral processes;
- Review and interpretation of all mental health screening results;
- Mental health assessment, education and brief intervention/short term counseling for clients who are identified by mental health screenings;
- Linking clients and caregivers to additional services as needed;
- Care coordination and follow-up to ensure effective intervention and monitor outcomes.

Milestones & Tasks	Estimated Timeline
• Establish providing agency through an RFP process	Dec 2008-Feb 2009
• Establish contract and monitoring agreements to assure effective implementation	Feb-April 2009
• Providing agency will hire additional culturally and linguistically competent mental health staff	June 2009
• Staff will receive training in key evidence-based practices	July-Aug 2009
• Providing agency, with County assistance, will establish referral process and relationships for clients identified as needing further services	July-August 2009
• Establish baseline data necessary to track outcomes	July 2009
• Begin providing assessment and early intervention services	September 2009
• Participate in regular PEI Committee meetings to develop collaborations, problem-solve implementation challenges, and assist in evaluation of PEI projects	Ongoing
• Collect outcome data	Ongoing
• Begin trainings for existing staff in mental health awareness, screening and referral	November 2009
• Review outcome data with PEI Coordination Committee	March 2012
• MHSA Implementation Committee performs program review and reauthorization	April 2012

Our implementation partners for this project will be determined through an RFP process. They will be required to show that they can serve the target populations effectively, such as ability to work with the targeted settings.

The programs identified are expected to achieve the desired outcomes because:

- Community members and current providers have identified the need for these types of services and interest in accessing and implementing them;
- They are provided in a setting already serving the target population and can be offered in a non-stigmatizing way;
- They incorporate evidence-based programs that are shown to be effective with diverse populations.
- Clients will be monitored in order to adjust interventions on an ongoing basis.

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These programs address a number of priorities identified by the community during the planning process:
• Support families and communities to increase their resilience (wellness factor)
• Provide culturally appropriate education and early intervention in the community so it is more accessible
• Increase provider awareness (schools, clinics, etc) so they identify and respond earlier and more effectively
• Parenting education and early intervention for parents (i.e., for substance abuse and depression)
• Increase number of culturally and linguistically competent providers
• Services for unserved clients who do not meet current financial or medical necessity criteria
• Address basic needs first (housing, shelter, employment, medical care) so that mental health services are more effective
• CMHS build effective community partnerships: law enforcement, schools, parent groups, substance abuse services, etc.

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through **June 2010** by type		Number of months in operation through **June 2010**
	Prevention	Early Intervention	
Canal Community-Based Prevention & Early Intervention	Individuals: 300 Families: 100	Individuals: 50 Families: 15	13
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 300 **Families**: 100	**Individuals:** 50 **Families**: 15	

Prevention activities include: provider training, client education, screening
Early intervention activities include: assessment, case management, counseling, services linkages

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

Marin County is a medium sized county (250,000) with extensive relationships among providers. The CSS and PEI planning processes have increased the level of collaboration and linkages. Marin County CMHS will continue to convene the MHSA Implementation Committee and initiate a PEI Implementation Committee. This will be an opportunity for ongoing linkage improvement. Marin County aims to create a network of care that includes CMHS, other Health and Human Services Divisions, CMHS contractors, and many other stakeholders that have participated in the planning process or are identified within the resource map. This network of care will provide a continuum of care in which individuals are effectively linked to the services they need, such as further mental health assessment and treatment, or other needed services.

Clients identified as needing further assessment or treatment than is available through this project will be referred to the most appropriate provider, including primary health care provider, local mental health providers, County mental health clinic, and/or insurance provider. Staff hired by PEI funds will assist with coordinating services for families to ensure successful linkages. PEI staff will maintain an updated list of local providers and maintain relationships with referral sites. Formal referral linkages will be developed among CMHS, other County departments, and CMHS contractors. CMHS contractors include approximately thirty local community-based organizations that provide mental health assessment and treatment, physical health care, substance abuse, domestic violence interventions, housing, and employment services. Linkage relationships will be developed with many of the organizations that participated in the MHSA planning process (see Form 2 for complete lists). In addition, the Marin County Health and Wellness Campus has recently opened in the Canal area, providing accessible health and human services for clients of this PEI program.

The selected program is sufficient to achieve the desired outcomes listed in question 7:
- The screening and intervention tools will be evidence-based practices.
- The service will be provided within an agency that is trusted by the target community.
- Community members and providers in the Canal District participated in the development of this plan and have expressed willingness to participate and support it.

Implementing agencies will be required to show that they can implement with fidelity, develop and maintain the collaborations described below, and provide the expertise and logistical support that will ensure effectiveness leading to positive outcomes.

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6. Collaboration and System Enhancements

Our implementation partners will be determined through an RFP process. They will be required to show that they can serve the target populations effectively, such as having culturally and linguistically appropriate staff, experience serving identified population, and ability to work with the targeted settings. They must also show their ability to implement the project effectively, meet the goals, and meet fiscal, administrative, and evaluation responsibilities.

The PEI Committee and MHSA Implementation Committee will review outcome data and determine reauthorization or adjustments to this and other projects to achieve identified outcomes.

For clients served by this program that are in need of further services, there will be referral processes in place to connect them to a range of services. As described above, linkages will be developed with mental health and other services. Specifically, CMHS has contracts with most of the non-profit mental health providers in the county, and will develop formal referral processes between them and the PEI contractors. In addition, CMHS has formal relationships with health care clinics serving low-income residents, including co-locating mental health providers within County clinics and Federally Qualified Health Centers. Both CSS funds and PEI funds contribute to providing mental health professionals at these sites. Referral processes are in place and will be expanded to include new PEI contractors.

The budget for the program takes into account that supervision, office space and other costs will be leveraged by the community organization contracted to implement the program. In addition, existing provider will conduct initial screenings and referrals. This model of increasing the capacity of existing providers and building upon existing services leverages the infrastructure that already exists, including mechanisms in place for gathering data. Through the RFP process, agencies will be required to demonstrate their ability to fiscally manage and sustain this program. We anticipate that these programs will be ongoing PEI projects, depending on the outcome data, community input, and review by PEI and MHSA Implementation Committees.

7. Intended Outcomes

On the individual and family level, Canal Community-based PEI services will enhance the capacity of current providers to identify clients with mental health concerns; respond to the needs effectively in a coordinated manner; and provide effective referrals for appropriate additional services. This will increase the number of underserved Canal area community members receiving prevention and early intervention services, leading to:

- Reduced substance use (assessment tool)
- Improved mental health status (assessment tool)
- Increased problem solving skills (client reported)

On the system level, these PEI services will coordinate services plans and increase access to services by facilitating linkages and working to develop a better network of services. Providing services that include the family will also increase the effectiveness of services. On the program level, this program is expected to provide services to 300 individuals and 100 families. All of these will receive prevention services, such as screening, and 50 individuals, including 15 families, will receive early intervention services.

8. Coordination with Other MHSA Components

Within the PEI programs, clients identified by Canal Community-based services can have their services coordinated by PEI staff while being referred to Triple P providers and CBO's participating in PEI programs. The PEI Committee will meet regularly to assist with implementation, including ensuring effective referral processes among organizations. In addition, CMHS will likely coordinate evidence based practices trainings that can be useful for multiple PEI providers, such as Problem Solving Therapy.

Protocols for referral from PEI projects to CSS programs will be developed in conjunction with PEI contracts. The MHSA Implementation Committee will include representatives from PEI programs as well as CSS programs to continue working on effective linkages. PEI project needs are being considered in the development of the Workforce Education and Training plan. For example, significant portion of the funds will go to increasing the cultural and linguistic competence of the mental health workforce. The Capital Facilities and Technology plan is in development and will take into consideration the needs of PEI projects.

9. Additional Comments (optional)

PEI PROJECT SUMMARY

Form No. 3

County: **Marin** **PEI Project Name:** **Integrating Behavioral Health in Primary Care** **Date:** **1/29/09**

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

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

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

PEI PROJECT SUMMARY

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

The PEI Committee incorporated many sources of information in developing their recommendations: the data resulting from the pre-MHSA planning process described above (Form 2); prevalence and penetration data from the County; resource mapping; client demographics and needs assessments from relevant organizations; and data from the PEI Community Engagement Process described above (2-3). Data from all of these sources was presented to the PEI Committee at appropriate times throughout the process.

PEI-related Themes from Stakeholder Input from Pre-MHSA and CSS Planning Process:
• Support families and communities to increase their resilience (wellness factor)
• Provide culturally appropriate education and early intervention in the community so it is more accessible
• Increase provider awareness (schools, clinics, etc) so they identify and respond earlier and more effectively
• Increase public awareness about mental health to increase access to resources and reduce stigma
• Parenting education and early intervention for parents (i.e., for substance abuse and depression)
• Increase number of culturally and linguistically competent providers
• Services for unserved clients who do not meet current financial or medical necessity criteria
• Address basic needs first (housing, shelter, employment, medical care) so that mental health services are more effective
• Build effective community partnerships between CMHS and law enforcement, schools, substance abuse services, etc.

The PEI Committee developed 4 workgroups to develop the strategies and program recommendations: Prenatal-5, Youth (6-15), TAY (16-25), and Adult/Older Adult. The Adult/Older Adult workgroup developed the recommendation included in this project. Participants included representatives from CMHS, Commission on Aging of Marin, Marin Community Clinics, Coastal Health Alliance, private mental health practitioners, HHS older adult peer counseling services, and Legal Aid of Marin. Data specific to this age groups that the workgroups considered included:

- CMHS primary diagnoses summary
- County and community clinic client demographics data. For example, one clinic estimates that as many as 50% of their clients are depressed based on current screenings.

Some of the MHSOAC's data points that are most relevant to this population in Marin County include:

- A parent's depression is among the most consistent risk factors for children's anxiety, depression and major behavioral problems. Research shows that a parent's recovery from depression has a major positive impact on children.
- People with lowest levels of income, education and occupation are significantly more likely to have a mental disorder.

- According to the US Surgeon General, the burden and disability in the US from mental disorders is carried disproportionately by children/youth and people of color. They have lower utilization of services, worse quality of care, and more serious consequences from untreated mental illness.

Community engagement meetings, focus groups and key informant meetings were held by the PEI Coordinator to solicit input about community needs, as well as test the appropriateness of the strategies under discussion. For example, 7 focus groups were held with adults and older adults from diverse backgrounds to answer questions such as needs they have, where they are best reached, and what types of services they would like.

As a result of the data and stakeholder input, the Adult/Older Adult workgroup identified the following key community needs: “Disparities in Access to Mental Health Services” and “Psycho-Social Impact of Trauma” and priority populations: “Trauma Exposed Individuals” and “Underserved Cultural Populations.” Specifically, it was recognized that the Latino, African American and Vietnamese communities experience a significant level of trauma resulting in the onset of psychiatric illnesses, especially depression, that can be reduced through early intervention. There are cultural stigmas regarding mental health that make it less likely that individuals will access needed services, as well as significant language barriers and cultural challenges for these communities when they do try to access services.

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

In the early MHSA planning process, community members identified the need to provide services in sites that are accessible, increase provider awareness so they identify and respond earlier and more effectively, and provide early intervention for parents (i.e., for substance abuse and depression). The Adult workgroup considered strategies that met these interests, addressed underserved cultural populations, and focused on the identified community needs and priority populations. In addition, stakeholders not represented in the workgroups were contacted to discus the appropriateness of the strategies under discussion, including past experiences with similar programs and other strategies they would recommend. Using the community input, stakeholder input, data analysis, and desired outcomes, appropriate programs were identified and researched.

PEI funds will be used to start or expand integrated behavioral health in physical health care settings. This builds on existing services accessed by priority populations, incorporates evidence-based practices, and incorporates existing staff within primary care settings. Implementation partners will be chosen through an RFP process. Representatives from eligible clinics have participated in the PEI Committee or community engagement process. They all serve a high

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proportion of underserved cultural populations. All of the clinics experience a higher need for mental health services than they are able to meet. To increase the capacity for providing mental health services and increase the effectiveness of services, PEI would fund implementation of an evidence-based model of integrated behavioral health in primary care settings, such as IMPACT depression care, that included the following key elements:

- training of primary care staff to identify, screen and make referrals to mental health services;
- on-site, evidence-based brief mental health services;
- collaboration between mental health and primary care providers;
- coordination with and linkage to other services, including more extensive mental health services;
- consulting psychiatrist;
- client monitoring, stepped care, and outcome measurement.

Milestones & Tasks	Estimated Timeline
• Establish providing agency through an RFP process	Dec 2008-Feb 2009
• Establish contract and monitoring agreements to assure effective implementation	Feb-April 2009
• Hire additional clinic mental health staff	June-July 2009
• Clinic, with County assistance, will establish referral process and relationships necessary for clients identified as needing further services	July-August 2009
• Establish baseline data necessary to track outcomes	July 2009
• Develop clinic procedures necessary for effective implementation	Aug-Sept 2009
• Implement integrated mental health services	November 2009
• Participate in regular PEI Committee meetings to develop collaborations, problem-solve implementation challenges, and assist in evaluation of PEI projects	Ongoing
• Collect outcome data	Ongoing
• Review outcome data with PEI Coordination Committee	March 2012
• MHSA Implementation Committee performs program review and reauthorization	April 2012

This program meets a number of needs identified in the planning process:

- Provide culturally appropriate education and early intervention in the community so it is more accessible
- Increase provider awareness (schools, clinics, etc) so they identify and respond earlier and more effectively
- Parenting education and early intervention for parents (i.e., for substance abuse and depression)
- Increase number of culturally and linguistically competent providers
- Services for unserved clients who do not meet current financial or medical necessity criteria
- Address basic needs first (housing, shelter, employment, medical care) so that mental health services are more effective

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• Build effective community partnerships between CMHS and law enforcement, schools, substance abuse services, etc.

The program identified is expected to achieve the desired outcomes because:

- Community members and providers have identified the need for these types of services and interest in accessing and implementing them
- The sites eligible for providing these services are accessed and trusted by the target populations
- The strategy of integrating behavioral health into primary care settings has been shown successful with low income and underserved cultural populations.

Our implementation partners for this project will be determined through an RFP process. They will be required to show that they can serve the target populations effectively, such as having culturally and linguistically competent staff.

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through **June 2010** by type		Number of months in operation through **June 2010**
	Prevention	Early Intervention	
Integrating Behavioral Health in Primary Care	Individuals: 500 Families:	Individuals: 150 Families:	13
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 500 **Families**:	**Individuals:** 150 **Families**:	

Prevention activities include: provider education, client education, and screening
Early intervention activities include: assessment and intervention for identified individuals, which may include family interventions

PEI PROJECT SUMMARY

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

Marin County is a medium sized county (250,000) with extensive relationships among providers. The CSS and PEI planning processes have increased the level of collaboration and linkages. Marin County CMHS will continue to convene the MHSA Implementation Committee and initiate a PEI Implementation Committee. This will be an opportunity for ongoing linkage improvement. Marin County aims to create a network of care that includes CMHS, other Health and Human Services Divisions, CMHS contractors, and many other stakeholders that have participated in the planning process or are identified within the resource map. This network of care will provide a continuum of care in which individuals are effectively linked to the services they need, such as further mental health assessment and treatment, or other needed services.

Clients identified as needing further assessment or treatment than is available through this project will be referred to the most appropriate provider, including primary health care provider, local mental health providers, County mental health clinic, and/or insurance provider. Staff hired by PEI funds will assist with coordinating services for families to ensure successful linkages. PEI staff will maintain an updated list of local providers and maintain relationships with referral sites. Formal referral linkages will be developed among CMHS, other County departments, and CMHS contractors. CMHS contractors include approximately thirty local community-based organizations that provide mental health assessment and treatment, physical health care, substance abuse, domestic violence interventions, housing, and employment services. Linkage relationships will be developed with many of the organizations that participated in the MHSA planning process (see Form 2 for complete lists).

The selected program is sufficient to achieve the desired outcomes listed in question 7 by:
- providing services in settings that already serve target populations in a non-stigmatizing manner;
- providing evidence-based screening and intervention within an evidence-based services model;
- identifying issues early and adjusting interventions based on outcomes.

Implementing agencies will be required to show that they can implement with fidelity, develop and maintain the collaborations described below, and provide the expertise and logistical support that will ensure effectiveness leading to positive outcomes. Integrating behavioral health into primary care settings is well evaluated. There are core components that are important for successful outcomes, which will be required. There are a number of programs a clinic setting can choose from that will meet these requirements.

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6. Collaboration and System Enhancements

Our implementation partners will be determined through an RFP process. They will be required to show that they can serve the target populations effectively, such as having culturally and linguistically appropriate staff and experience serving these populations. They must also show their ability to implement the project effectively, meet the goals, and meet fiscal, administrative, and evaluation responsibilities. Sites applying for funding will be encouraged to collaborate to most effectively meet the goals of the project.

The PEI Committee and MHSA Implementation Committee will review outcome data and determine reauthorization or adjustments to this and other projects to achieve identified outcomes.

For individuals and families served by these programs that are in need of further services, there will be referral processes in place to connect them to a range of services. As described above, linkages will be developed with mental health and other services. Specifically, CMHS has contracts with most of the non-profit mental health providers in the county, and will develop formal referral processes that include PEI contractors.

The staff requirements, and therefore the program budget, takes into account that existing staff will provide initial client education and screening, as well as primary care provider time for case coordination. In addition, most of the eligible sites already have some integrated behavioral healthcare in place that can be built upon, including mechanisms for data collection. This model of increasing provider capacity, building on existing infrastructure, and developing referral processes helps to multiply and sustain the PEI efforts. In addition, most of the sites are able to bill Medi-Cal and Medi-Care for the cost of eligible client visits. Contracting agencies will be expected to contribute office space/expenses and primary care provider time. Through the RFP process, agencies will be required to demonstrate their ability to fiscally manage and sustain this program. We anticipate that these programs will be ongoing PEI projects, depending on the outcome data, community input, and review by the PEI and MHSA Implementation Committees.

7. Intended Outcomes

Integrated behavioral health is a model that has been shown to be a successful for serving low-income and culturally diverse populations. This population-based approach improves the health of the population by providing prevention, primarily in the form of screening and increased primary care provider skills, and early/brief intervention for those in need. The fact that the services are provided within a setting that priority populations already access reduces the stigma of receiving mental health services and increases compliance.

On the individual and family level, integrating behavioral health will enhance the capacity of primary care settings to identify individuals and families with mental health issues, provide client education, and link them to evidence based early intervention in a non-stigmatizing manner. In addition, primary and mental health care will be integrated, improving the effectiveness of both services.

- Increased mental health knowledge (client survey)
- Increased resiliency skills (assessment tool)
- Improved mental status (assessment tool)

On the system level, clinics will develop their capacity to identify, provide intervention, and manage clients with mental health needs. By implementing evidence-based practices, the integrated services will be more cost-effective than current practices and significantly expand the number of clients receiving appropriate services. On the program level, in 2009-10, clinics are expected to screen approximately 500 clients, of which approximately 150 individuals will receive early intervention services. Numbers served will significantly increase in 2010-11 once the program is fully operational.

8. Coordination with Other MHSA Components

Within the PEI programs, clients identified by clinic services can be referred as appropriate to Triple P providers and CBO's participating in PEI programs. Primary care-givers identified through ECMH depression screening can be referred to health care clinics. The clinics participating in this program will also coordinate as needed to manage clients that may access more than one health care site. The PEI Committee will meet regularly to assist with implementation, including ensuring effective referral processes among organizations. In addition, CMHS will coordinate evidence based practices trainings that can be useful for multiple PEI providers, such as Problem Solving Therapy.

Protocols for referral from PEI projects to CSS programs will be developed in conjunction with PEI contracts. The MHSA Implementation Committee will include representatives from PEI programs as well as CSS programs to continue working on effective linkages. PEI project needs are being considered in the development of the Workforce Education and Training plan. For example, significant funds will go to increasing the cultural and linguistic competence of mental health workers. The Capital Facilities and Technology plan is in development and will take into consideration the needs of PEI projects.

9. Additional Comments (optional)

Marin County
PEI PROJECT SUMMARY

Form No. 3

County: Marin **PEI Project Name: Home Delivered Meals Prevention & Early Intervention** **Date: 1/29/09**

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

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

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

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

The PEI Committee incorporated many sources of information in developing their recommendations: the data resulting from the pre-MHSA planning process described above (Form 2); prevalence and penetration data from the County; resource mapping; client demographics and needs assessments from relevant organizations; and data from the PEI Community Engagement Process described above (2-3). Data from all of these sources was presented to the PEI Committee at appropriate times throughout the process.

PEI-related Themes from Stakeholder Input from Pre-MHSA and CSS Planning Process:
• Support families and communities to increase their resilience (wellness factor)
• Provide culturally appropriate education and early intervention in the community so it is more accessible
• Increase provider awareness (schools, clinics, etc) so they identify and respond earlier and more effectively
• Increase public awareness about mental health to increase access to resources and reduce stigma
• Parenting education and early intervention for parents (i.e., for substance abuse and depression)
• Increase number of culturally and linguistically competent providers
• Services for unserved clients who do not meet current financial or medical necessity criteria
• Address basic needs first (housing, shelter, employment, medical care) so that mental health services are more effective
• Build effective community partnerships between CMHS and law enforcement, schools, substance abuse services, etc.

The PEI Committee developed 4 workgroups to develop the strategies and program recommendations: Prenatal-5, Youth (6-15), TAY (16-25), and Adult/Older Adult. The Adult/Older Adult workgroup developed the recommendation included in this project. Participants included representatives from CMHS, Commission on Aging of Marin, Marin Community Clinics, Coastal Health Alliance, private mental health practitioners, HHS older adult peer counseling services, and Legal Aid of Marin. Data specific to these age groups that the workgroups considered included:

- Suicide rates by age
- Demographics of older adult clients served by health care settings, senior specific services, etc.

Community engagement meetings, focus groups and key informant meetings were held by the PEI Coordinator to solicit input about community needs, as well as test the appropriateness of the strategies under discussion. For example, one focus group was held specifically with older adults, and older adults participated in 3 of the other focus groups, to answer questions such as needs they have, where they are best reached, and what types of services they would like. Specifically, it was recognized that isolated older adults are at high risk for depression, suicide and other serious psychiatric illnesses. At the same time, they are not accessing services where they are likely to receive mental health services.

As a result of the data and stakeholder input, the Adult/Older Adult workgroup identified the following key community needs for Older Adults: “Disparities in Access to Mental Health Services” and “Psycho-Social Impact of Trauma” and priority populations: “Trauma Exposed Individuals,” recognizing this would also address some individuals with risk of suicide and/or onset of serious psychiatric illness. Home delivered meal programs reach older adults who have multiple risk factors, targeting low-income populations.

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

In the early MHSA planning process, community members identified the need to provide services in sites that are accessible and increase provider awareness so they identify and respond earlier and more effectively. The Adult workgroup considered strategies that met these interests, addressed underserved cultural populations, and focused on the identified community needs and priority populations. In addition, stakeholders not represented in the workgroups were contacted to discus the appropriateness of the strategies under discussion, including past experiences with similar programs and other strategies they would recommend. Using the community input, stakeholder input, data analysis, and desired outcomes, appropriate programs were identified and researched.

The Home Delivered Meals Prevention and Early Intervention Program will provide mental health screening, education, and early intervention to older adults, age 60 and over, who participate in a home delivered meals program. These participants have multiple risk factors for mental health concerns, especially depression and suicide, including isolation, illness, disability, low-income, nutritional risk, and risk for substance use/abuse. The Home Delivered Meals PEI Programs can reduce risk of depression and suicide among at-risk older adults and improve their access to and utilization of mental health services by providing:

- Training for current home delivered meals program staff to integrate mental health into their current work. For example, drivers are trained to determine and report if there are any changes in the clients’ physical or emotional status.
- Mental health screenings will be provided regularly by the social workers performing home delivered meal eligibility screenings. The social worker currently conducts eligibility screenings in the home within 2 weeks of the start of meal services and at least every other quarter while on the program. Screening results will be provided to the mental health worker.
- The mental health worker will provide in home assessment and early intervention for clients identified by the screening. The mental health worker will be a master’s level licensed mental health clinician with a specialization in geriatric mental health.

The mental health worker would be responsible for the following:

- Clinical oversight of the Home Delivered Meal PEI program, including supervision of home delivered meal staff regarding mental health service interventions;
- Education and training of home delivered meal staff regarding PEI including training on recognizing signs and symptoms of depression, suicide risk, and co-occurring alcohol abuse/medication misuse;
- Review and interpretation of all mental health screening results;
- Mental health assessment, education and brief intervention/short term counseling for clients and caregivers who are identified by mental health screenings;
- Linking clients and caregivers to additional services as needed;
- Care coordination and follow-up to ensure effective intervention and monitor outcomes.

The social worker will be responsible for the following:
- Providing education about mental health during their initial eligibility assessment;
- Conducting an evidence-based mental health screening tool (to be determined by the providing agency);
- Working with the mental health worker to assist with the implementation and follow-up for intervention plans.

Potential evidence-based screening tools include:
- Depression: Geriatric Depression Scale (short form), Patient Health Questionnaire (PHQ-9)
- Alcohol: Michigan Alcohol Screening Test (short MAST-G) and the Complaint-Annoyed-Guilty-Eye-Opener (CAGE)

Potential evidence-based brief interventions include:
- Problem Solving Therapy and Behavioral Activation Therapy.

Milestones & Tasks	Estimated Timeline
• Establish providing agency through an RFP process	Dec 2008-Feb 2009
• Establish contract and monitoring agreements to assure effective implementation	Feb-April 2009
• Hire mental health worker	June 2009
• Provider, with County assistance, will establish referral process and relationships necessary for clients identified as needing further services	July-August 2009
• Establish baseline data necessary to track outcomes	July 2009
• Develop procedures necessary for effective implementation	Aug-Sept 2009
• Train home delivered meal staff	October 2009
• Begin integrating mental health education and screening at all in-home eligibility screenings	October 2009
• Participate in regular PEI Committee meetings to develop collaborations, problem-solve implementation challenges, and assist in evaluation of PEI projects	Ongoing

• Collect outcome data	Ongoing
• Review outcome data with PEI Coordination Committee	March 2012
• MHSA Implementation Committee performs program review and reauthorization	April 2012

The program identified is expected to achieve the desired outcomes because:

- Community members and providers have identified the need for these types of services and interest in accessing and implementing them
- The screening and intervention tools will be evidence-based for older adults
- This strategy has been shown to be effective by the Meals on Wheels Mental Health Outreach Program of Redwood Coast Seniors, Inc.

Our implementation partners for this project will be determined through an RFP process. They will be required to show that they can serve the target populations effectively, such as having culturally and linguistically competent staff.

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through **June 2010** by type		Number of months in operation through **June 2010**
	Prevention	Early Intervention	
Home Delivered Meals Prevention & Early Intervention	Individuals: 400 Families:	Individuals: 100 Families:	13
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 400 **Families**:	**Individuals:** 100 **Families**:	

Prevention activities include: provider training, client education and screening
Early intervention activities include: case management, counseling, and linkages to services

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

Marin County is a medium sized county (250,000) with extensive relationships among providers. The CSS and PEI planning processes have increased the level of collaboration and linkages. Marin County CMHS will continue to convene the MHSA Implementation Committee and initiate a PEI Implementation Committee. This will be an opportunity for ongoing linkage improvement. Marin County aims to create a network of care that includes CMHS, other Health and Human Services Divisions, CMHS contractors, and many other stakeholders that have participated in the planning process or are identified within the resource map. This network of care will provide a continuum of care in which individuals are effectively linked to the services they need, such as further mental health assessment and treatment, or other needed services.

Clients identified as needing further assessment or treatment than is available through this project will be referred to the most appropriate provider, including primary health care provider, local mental health providers, County mental health clinic, and/or insurance provider. Staff hired by PEI funds will assist with coordinating services for families to ensure successful linkages. PEI staff will maintain an updated list of local providers and maintain relationships with referral sites. Formal referral linkages will be developed among CMHS, other County departments, and CMHS contractors. CMHS contractors include approximately thirty local community-based organizations that provide mental health assessment and treatment, physical health care, substance abuse, domestic violence interventions, housing, and employment services. Linkage relationships will be developed with many of the organizations that participated in the MHSA planning process (see Form 2 for complete lists). In particular, CMHS provides HOPE, a Full Services Partnership for older adults, and a senior peer counseling program that clients of this PEI program can be linked to as needed.

The selected program is sufficient to achieve the desired outcomes listed in question 7 by:
- providing services in settings that already serve target populations;
- providing evidence-based screening and intervention within a promising practice services model;
- providing services that community members and providers recommend and have expressed interest in participating in.

Implementing agencies will be required to show that they can implement with fidelity, develop and maintain the collaborations described below, and provide the expertise and logistical support that will ensure effectiveness leading to positive outcomes. Integrating behavioral health into primary care settings is well evaluated. There are core components that are important for successful outcomes, which will be required. There are a number of programs a clinic setting can choose from that will meet these requirements.

6. Collaboration and System Enhancements

Our implementation partners will be determined through an RFP process. They will be required to show that they can serve the target populations effectively, such as having culturally and linguistically appropriate staff and experience serving these populations. They must also show their ability to implement the project effectively, meet the goals, and meet fiscal, administrative, and evaluation responsibilities. Sites applying for funding will be encouraged to collaborate to most effectively meet the goals of the project.

The PEI Committee and MHSA Implementation Committee will review outcome data and determine reauthorization or adjustments to this and other projects to achieve identified outcomes.

For clients served by this program that are in need of further services, there will be referral processes in place to connect them to a range of services. As described above, linkages will be developed with mental health and other services. CMHS has contracts with most of the non-prfit mental health providers in the county, and will develop formal referral processes that include PEI contractors. Specifically, this PEI program will collaborate with the Full Service Partnership for older adults, HOPE, and the senior peer counseling program.

The program budget takes into account that general client education and screening will be conducted by existing staff. This model of increasing provider capacity and developing referral processes helps to multiply and sustain the PEI efforts. In addition, some of the services provided will be Medi-Care billable. The infrastructure for the program, including mechanisms for data collection and reporting, are already in place. Contracting agencies will be expected to contribute office space/expenses. Through the RFP process, agencies will be required to demonstrate their ability to fiscally manage and sustain this program. We anticipate that these programs will be ongoing PEI projects, depending on the outcome data, community input, and review by the PEI and MHSA Implementation Committees.

7. Intended Outcomes

The Meals on Wheels Mental Health Outreach Program of Redwood Coast Seniors, Inc. has been shown to be a promising practice. In addition to the components of the Redwood Coast program, this PEI program will incorporate provision of evidence-based brief intervention and more extensive case management by a licensed mental health worker. This population-based approach improves the health of the population by providing prevention, primarily in the form of

education, screening and increased provider skills, and early intervention for those in need. The fact that the services are provided within a setting that priority populations already access reduces the stigma of receiving mental health services.

On the individual and family level, integrating mental health will enhance the capacity of home delivered meal services to identify individuals and families with mental health issues and link then to early intervention in a non-stigmatizing manner. Specific outcomes expected include:
• Increased mental health knowledge and resiliency skills (client survey)
• Decreased substance abuse (assessment tool)
• Improved mental status (assessment tool)

On the system level, the integration of mental health services into the home delivered meal service will result in:
• All clients receiving information about mental health issues, including depression and suicide;
• All clients will be screened for mental health problems at least once each year;
• All clients who screen positive for mental health problems will receive assessment and brief intervention;
• All home delivered meal staff will receive mental health training;
• Cross referrals between the home delivered meal program and mental health and/or primary care providers will increase.

On the program level, this program is expected to screen approximately 400 clients, of which approximately 100 will receive early intervention services.

8. Coordination with Other MHSA Components

Within the PEI programs, clients identified by home delivered meal services can have their services coordinated by PEI staff while being referred to clinics participating in PEI “Integrating Behavioral Health in Primary Care” program. The PEI Committee will meet regularly to assist with implementation, including ensuring effective referral processes among organizations. In addition, CMHS will likely coordinate evidence based practices trainings that can be useful for multiple PEI providers, such as Problem Solving Therapy.

Protocols for referral from PEI projects to CSS programs will be developed in conjunction with PEI contracts. This PEI program will be coordinated with the Hope Program, the MHSA CSS Older Adults full service partnership. In particular, some older adults identified through the PEI program may benefit from the peer counseling program and the HOPE Program (the full services partnership for older adults). The MHSA Implementation Committee will include representatives

from PEI programs as well as CSS programs to continue working on effective linkages. PEI project needs are being considered in the development of the Workforce Education and Training plan. For example, co-occurring disorder training is being considered by WET, a service older adults often need. The Capital Facilities and Technology plan is in development and will take into consideration the needs of PEI projects.

9. Additional Comments (optional)

Marin County
PEI PROJECT SUMMARY

Form No. 3

County: **Marin** **PEI Project Name:** **Suicide Prevention** **Date:** **1/29/09**

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

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

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

Form No. 3

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

The PEI Committee incorporated many sources of information in developing their recommendations: the data resulting from the pre-MHSA planning process described above (Form 2); prevalence and penetration data from the County; resource mapping; client demographics and needs assessments from relevant organizations; and data from the PEI Community Engagement Process described above (Form 2, Questions 2-3). Data from all of these sources was presented to the PEI Committee at appropriate times throughout the process.

PEI-related Themes from Stakeholder Input from Pre-MHSA and CSS Planning Process:
• Support families and communities to increase their resilience (wellness factor)
• Provide culturally appropriate education and early intervention in the community so it is more accessible
• Increase provider awareness (schools, clinics, etc) so they identify and respond earlier and more effectively
• Increase public awareness about mental health to increase access to resources and reduce stigma
• Parenting education and early intervention for parents (i.e., for substance abuse and depression)
• Increase number of culturally and linguistically competent providers
• Services for unserved clients who do not meet current financial or medical necessity criteria
• Address basic needs first (housing, shelter, employment, medical care) so that mental health services are more effective
• Build effective community partnerships between CMHS and law enforcement, schools, substance abuse services, etc.

The PEI Committee developed 4 workgroups to develop the strategies and program recommendations: Prenatal-5, Youth (6-15), TAY (16-25), and Adult/Older Adult. As the plans for the State administered projects developed, a workgroup was formed to address developing a local component recommendation. Community engagement meetings, focus groups and key informant meetings were held by the PEI Coordinator to solicit input about community needs, as well as test the appropriateness of the strategies under discussion. In addition, stakeholders not represented in the workgroups were contacted to discus the appropriateness of the strategies under discussion, including past experiences with similar programs and other strategies they would recommend.

As a result of the data, community input, and stakeholder input, the following key community needs were identified: “Suicide Risk” and priority populations: “Underserved Cultural Populations.” Specifically it was recognized that there has been a recent increase in suicides, the current suicide crisis line is mono-lingual, and that expanded mental health PEI services will likely increase the number of people aware of and calling local resources, such as the suicide hotline.

Marin County has a 24/7 suicide prevention hotline center that:
• is accredited by the American Association of Suicidology and a member of National Lifeline;

- has a local suicide prevention advisory council;
- conducted a capacity assessment of the hotline that identified the lack of linguistic capacity to be the most significant problem;
- conducts training and provides ongoing clinical supervision for hotline staff and volunteers;
- conducts community education;
- convenes support meetings for friends and family who have lost a loved one to suicide;
- gathers data from the Coroner's Office on completed suicides;
- sends a representative to Bay Area meetings of suicide hotlines.

In addition, death reviews are conducted by CMHS for clients who have committed suicide.

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

In the early MHSA planning process, community members identified the need to increase public awareness about mental health to increase access to resources and increase the number of culturally and linguistically competent providers. The Suicide Prevention and Stigma Reduction workgroup considered strategies that met these interests, addressed underserved cultural populations, and focused on the identified community needs and priority populations. Using the community input, stakeholder input, data analysis, and desired outcomes, appropriate programs were identified and researched.

Suicide Prevention Hotline Expansion

Marin County currently has a 24/7, accredited suicide prevention and crisis hotline call center. Various components of the PEI plan will expand awareness of local resources and appropriate accessing of resources. The suicide prevention hotline plays a key role in responding to people in crisis, preventing suicide attempts, and helping to link callers to appropriate services. The hotline is currently in English only. To assist in meeting the goals of MHSA PEI, the suicide call center will implement the following key elements:

- Conduct a county-wide assessment of existing suicide prevention services and supports and major gaps;
- Develop a local suicide action plan through an inclusive community process;
- Expand the cultural competence of the hotline service through staff and volunteer training;
- Research and implement an effective method for providing crisis hotline services in multiple languages;
- Conduct extensive marketing campaign to educate the media and inform the community about the availability of the hotline, with special outreach efforts to diverse populations. This marketing campaign will work in collaboration with other PEI components, such as the Stigma Reduction Campaign and the educational efforts within other projects;

- Appoint a liaison to the statewide Office of Suicide Prevention.

Milestones & Tasks	Estimated Timeline
• Establish providing agency through an RFP process	Dec 2008-Feb 2009
• Appoint a liaison to the statewide Office of Suicide Prevention	January 2009
• Establish contract and monitoring agreements to assure effective implementation	Feb-April 2009
• Hire additional staff	June 2009
• Provider with County assistance, will establish referral process and relationships necessary for clients identified as needing further services	July-August 2009
• Develop marketing and outreach campaign in conjunction with needs assessment and local action plan	Aug 2009-May 2010
• Conduct county-wide assessment of services and gaps	Sept 2009-Feb 2010
• Implement cultural competency training for staff and volunteers	November 2009
• Develop action plan through inclusive community process	March-June 2010
• Research effective method for providing hotline services in multiple languages	March-June 2010
• Establish baseline data necessary to track outcomes	June 2010
• Implement effective method for providing hotline services in multiple languages	July 2010-ongoing
• Implement marketing campaign	July 2010-ongoing
• Implement local action plan	July 2010-ongoing
• Participate in regular PEI Committee meetings to develop collaborations, problem-solve implementation challenges, and assist in evaluation of PEI projects	Ongoing
• Collect outcome data	Ongoing
• Review outcome data with PEI Coordination Committee	March 2011
• MHSA Implementation Committee performs program review	April 2011

<u>Follow-up and Support for Suicide Attempts and Ideation</u>

A highly targeted suicide prevention program will be implemented that provides phone follow-up for people who have been discharged after serious suicidal ideation or suicide attempts in collaboration with hospital Emergency Rooms, County Psychiatric Emergency Services, and in-patient psychiatric hospitals. Key elements include:

- Developing MOUs and referral protocols with emergency departments and psychiatric emergency services;
- Establishing a follow-up protocol for contacting clients;

- Evaluating the impact of the services and making changes as needed.

Milestones & Tasks	Estimated Timeline
• Establish providing agency through an RFP process	Dec 2008-Feb 2009
• Establish contract and monitoring agreements to assure effective implementation	Feb-April 2009
• Provider with County assistance, will establish referral process and relationships necessary for clients identified as needing further services	July-August 2009
• Establish baseline data necessary to track outcomes	July 2009
• Develop MOUS with hospitals, Emergency Departments, Psychiatric Emergency Services	Aug 2009-May 2010
• Develop protocols for identifying and following up with clients	Aug 2009-May 2010
• Train participating staff in protocols	June 2010
• Implement new protocols	July 2010
• Participate in regular PEI Committee meetings to develop collaborations, problem-solve implementation challenges, and assist in evaluation of PEI projects	Ongoing
• Collect outcome data	Ongoing
• Review outcome data with PEI Coordination Committee	March 2011
• MHSA Implementation Committee performs program review and reauthorization	April 2011

The programs identified are expected to achieve the desired outcomes because:

- Suicide prevention hotlines are an effective service that reduce stigma of accessing mental health services due to their confidentiality. In one of the Spanish speaking focus groups, participants were reluctant to discuss mental health service needs, but when given a phone number to call for confidential assistance, almost half of the 27 participants wrote the number down.
- 41% of suicides among those who received inpatient psychiatric care occur within one year of discharge (9% within one day). A study has shown that those who received follow-up calls after being discharged from emergency departments were 45% less likely to repeat a suicide attempt during the following year than those who did not receive such a contact.

Our implementation partners for this project will be determined through an RFP process. They will be required to show that they can serve the target populations effectively, such as having culturally and linguistically competent staff.

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through **June 2010** by type		Number of months in operation through **June 2010**
	Prevention	Early Intervention	
Suicide Prevention Hotline Expansion	Individuals: Families:	Individuals: Families:	0*
Follow-up and Support for Suicide Attempts and Ideation	Individuals: Families:	Individuals: Families:	0*
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** **Families**:	**Individuals:** **Families**:	

* These programs require extensive planning and are expected to begin providing services July 2010.

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

Marin County is a medium sized county (250,000) with extensive relationships among providers. The CSS and PEI planning processes have increased the level of collaboration and linkages. Marin County CMHS will continue to convene stakeholder meetings to oversee MHSA implementation. This will be an opportunity for ongoing linkage improvement. Marin County aims to create a network of care that includes CMHS, other Health and Human Services Divisions, CMHS contractors, and many other stakeholders that have participated in the planning process or are identified within the resource map. This network of care will provide a continuum of care in which individuals are effectively linked to the services they need, such as further mental health assessment and treatment, or other needed services.

Clients identified as needing further assessment or treatment than is available through this project will be referred to the most appropriate provider, including primary health care provider, local mental health providers, County mental health clinic, and/or insurance provider. Staff hired by PEI funds will assist with coordinating services for families to ensure successful linkages. PEI staff will maintain an updated list of local providers and maintain relationships with referral sites.

Formal referral linkages will be developed among CMHS, other County departments, and CMHS contractors. CMHS contractors include approximately thirty local community-based organizations that provide mental health assessment and treatment, physical health care, substance abuse, domestic violence interventions, housing, and employment services. Linkage relationships will be developed with many of the organizations that participated in the MHSA planning process (see Form 2 for complete lists).

The selected programs are sufficient to achieve the desired outcomes listed in question 7 by building on an extensive infrastructure already in place. Implementing agencies will be required to show that they can implement with fidelity, develop and maintain the collaborations described below, and provide the expertise and logistical support that will ensure effectiveness leading to positive outcomes.

6. Collaboration and System Enhancements

Our implementation partners will be determined through an RFP process. They will be required to show that they can serve the target populations effectively, such as having culturally and linguistically appropriate staff and experience serving specific populations. They must also show their ability to implement the project effectively, meet the goals, and meet fiscal, administrative, and evaluation responsibilities. Sites applying for funding will be encouraged to collaborate to most effectively meet the goals of the project.

The PEI Committee and MHSA Implementation Committee will review outcome data and determine reauthorization or adjustments to this and other projects to achieve identified outcomes.

For clients served by this program that are in need of further services, there will be referral processes in place to connect them to a range of services. As described above, linkages will be developed with mental health and other services. Specifically, CMHS has contracts with most of the non-profit mental health providers in the county, and will develop formal referral processes that include PEI contractors.

The program budget takes into account that the infrastructure for the suicide hotline, including mechanisms for data collection and reporting, are already in place. Contracting agencies will be expected to contribute office space/expenses. Through the RFP process, agencies will be required to demonstrate their ability to fiscally manage and sustain this program. We anticipate that these programs will be funded by PEI for not more than 3 years, depending on the outcome data, community input, and review by the PEI and MHSA Implementation Committees. This is a one-time funding project which does not have a continuous funding stream. Collaboration with other local, regional and statewide suicide prevention efforts is recommended to ensure increase efficiency and ensure economies of scale.

7. Intended Outcomes

Currently Marin County suicide prevention services fulfill many of the key elements identified in the "California Strategic Plan on Suicide Prevention: Every Californian Is a Part of the Solution." This program will address additional components that are considered the next highest priority locally.

On the individual and family level, more individuals will be aware of the hotline services, non-English speakers will be able to access the services, and high-risk individuals will receive targeted follow-up support. Specific outcomes expected include:
• Increased knowledge about suicide risks, signs, and resources (client/community survey)
• Increase help-seeking behaviors by clients (i.e., calling the hotline) (provider records)
• Reduced number of suicide attempts among those receiving follow-up support (provider records)

On the system level, the increase in suicide prevention activities will lead to:
• Underserved communities receiving information about wellness, stress reduction, and suicide prevention resources;
• An increase in the capacity of the suicide hotline to serve non-English speakers;
• Collaboration among agencies serving high risk individuals, resulting in improved referrals and follow-up services.

July 2009 through June 2010 will be dedicated to assessment and planning. This process will result in the implementation of services and an estimate of the number expected to be served.

8. Coordination with Other MHSA Components

The PEI Committee will meet regularly to assist with implementation, including ensuring effective referral processes among organizations. Protocols for referral from PEI projects to CSS programs will be developed in conjunction with PEI contracts. The MHSA Implementation Committee will include representatives from PEI programs as well as CSS programs to continue working on effective linkages. PEI project needs are being considered in the development of the Workforce Education and Training plan. For example, co-occurring disorder training is being considered by WET. The Capital Facilities and Technology plan is in development and will take into consideration the needs of PEI projects.

9. Additional Comments (optional)

Marin County
PEI PROJECT SUMMARY

Form No. 3

County: **Marin** **PEI Project Name:** **Mental Health Awareness and Stigma Reduction** **Date:** **1/29/09**

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

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

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

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

The PEI Committee incorporated many sources of information in developing their recommendations: the data resulting from the pre-MHSA planning process described above (Form 2); prevalence and penetration data from the County; resource mapping; client demographics and needs assessments from relevant organizations; and data from the PEI Community Engagement Process described above (Form 2, Questions 2-3). Data from all of these sources was presented to the PEI Committee at appropriate times throughout the process.

PEI-related Themes from Stakeholder Input from Pre-MHSA and CSS Planning Process:
• Support families and communities to increase their resilience (wellness factor)
• Provide culturally appropriate education and early intervention in the community so it is more accessible
• Increase provider awareness (schools, clinics, etc) so they identify and respond earlier and more effectively
• Increase public awareness about mental health to increase access to resources and reduce stigma
• Parenting education and early intervention for parents (i.e., for substance abuse and depression)
• Increase number of culturally and linguistically competent providers
• Services for unserved clients who do not meet current financial or medical necessity criteria
• Address basic needs first (housing, shelter, employment, medical care) so that mental health services are more effective
• Build effective community partnerships between CMHS and law enforcement, schools, substance abuse services, etc.

The PEI Committee developed 4 workgroups to develop the strategies and program recommendations: Prenatal-5, Youth (6-15), TAY (16-25), and Adult/Older Adult. As the plans for the State administered projects developed, a workgroup was formed to address developing a local component recommendation. Community engagement meetings, focus groups and key informant meetings were held by the PEI Coordinator to solicit input about community needs, as well as test the appropriateness of the strategies under discussion. In addition, stakeholders not represented in the workgroups were contacted to discus the appropriateness of the strategies under discussion, including past experiences with similar programs and other strategies they would recommend. In particular, families with mentally ill members placed a high priority on providing education about mental illness and resources to a broad population. Ideas for doing this included media, websites, written materials, gatekeeper trainings and educational presentations. Some of these ideas are integrated into the other PEI projects.

As a result of the data, community input, and stakeholder input, the following key community needs were identified: “Stigma and Discrimination” and priority populations: “Underserved Cultural Populations.”

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

In the early MHSA planning process, community members identified the need to increase public awareness about mental health and resources in order to reduce the stigma of accessing services and increase knowledge of services. The Suicide Prevention and Stigma Reduction workgroup considered strategies that met these interests, addressed underserved cultural populations, and focused on the identified community needs and priority populations. Using the community input, stakeholder input, data analysis, and desired outcomes, appropriate programs were identified and researched.

Based on the other programs that already exist in the community, such as NAMI's Parent-to-Parent program and the suicide prevention center's community education program, as well as additional services included in the PEI plan, such as the suicide center's outreach campaign and extensive provider education components, it was decided that an appropriate complement would be a media-based mental health awareness and stigma reduction campaign. This will help to inform providers, family members, and others about mental health, signs and symptoms, personal stories, resources available and other information that will reduce the stigma and increase the ability to access services when needed.

Milestones & Tasks	Estimated Timeline
• Establish providing agency through an RFP process	Dec 2008-Feb 2009
• Establish contract and monitoring agreements to assure effective implementation	Feb-April 2009
• Develop campaign plan including mediums and messages	June-Aug 2009
• Establish baseline data necessary to track outcomes	August 2009
• Implement campaign plan	September 2009
• Participate in regular PEI Committee meetings to develop collaborations, problem-solve implementation challenges, and assist in evaluation of PEI projects	Ongoing
• Collect outcome data	Ongoing
• Review outcome data with PEI Coordination Committee	March 2011
• MHSA Implementation Committee performs program review and reauthorization	April 2011

The program identified are expected to achieve the desired outcomes because:

- Many family members of mentally ill indicated this would have been an effective way to reach them;
- County Alcohol, Drug and Tobacco Division has been successful at getting favorable media coverage and changing community attitudes about substance use;

- It will consider integrating evidence-based components, such as Triple P's Level 1, which is a media based intervention;
- It will build on the State administered Stigma and Discrimination Reduction efforts;
- It is a prevention efforts that can reach the entire county.
- It will reduce disparities in access to mental health services by better informing underserved cultural populations about available services, as well as reducing the stigma of accessing such services. CMHS will work with the contractor for the Stigma Reduction Project to identify effective ways to outreach to underserved cultural populations. Strategies would include:
  - Providing culturally competent information in Spanish (a threshold language in Marin) and Vietnamese.
  - Providing culturally competent information to the African American community where their youth, many which have mental health problems, are overrepresented in the Juvenile Justice system.
  - Identifying and providing information through venues that reach underserved populations in Marin, such as local newspapers, radio, bus-stop advertising, flyers/pamphlets at trusted community agencies, etc.
  - Researching methods and messages that have been found effective with similar populations.

Our implementation partners for this project will be determined through an RFP process.

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through **June 2010** by type		Number of months in operation through **June 2010**
	Prevention	Early Intervention	
Mental Health Awareness and Stigma Reduction	Individuals: 50,000 Families:	Individuals: NA* Families: NA	13
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 50,000 **Families**:	**Individuals:** NA **Families**: NA	

* This program includes exclusively prevention activities.

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

Marin County is a medium sized county (250,000) with extensive relationships among providers. The CSS and PEI planning processes have increased the level of collaboration and linkages. Marin County CMHS will continue to convene stakeholder meetings to oversee MHSA implementation. This will be an opportunity for ongoing linkage improvement. Marin County aims to create a network of care that includes CMHS, other Health and Human Services Divisions, CMHS contractors, and many other stakeholders that have participated in the planning process or are identified within the resource map. This network of care will provide a continuum of care in which individuals are effectively linked to the services they need, such as further mental health assessment and treatment, or other needed services as resources are available.

The purpose of the campaign would be to educate community members about:
- mental health issues and when to consider accessing services;
- the variety of services and prevention activities available;
- a few key services that can provide education and referrals, such as the suicide and crisis hotline. These services will maintain updated referral databases to assist callers in accessing the most appropriate services;
- the Marin.NetworkofCare.org website which contains service, legislative, advocacy and recovery messages;
- mental illness in order to increase social inclusion, decrease stigma, and decrease discrimination in employment and housing opportunities.

6. Collaboration and System Enhancements

Our implementation partners will be determined through an RFP process. They must show their ability to implement the project effectively, meet the goals, and meet fiscal, administrative, and evaluation responsibilities. Through the RFP process, agencies will be required to demonstrate their ability to fiscally manage this program. We anticipate that this program will be funded by PEI for up to 3 years, depending on the outcome data, community input, and review by the PEI and MHSA Implementation Committees. The PEI Committee and MHSA Implementation Committee will review outcome data and determine adjustments to this and other projects to achieve identified outcomes. This is funded on a one-time basis and has no on-going funding stream.

7. Intended Outcomes

The Mental Health Awareness and Stigma Reduction campaign is a complement to both the Statewide Projects and the local MHSA projects. Triple P parenting program is one example of an evidence-based program that includes a media component aimed at reducing the stigma of and increasing the knowledge to seek parenting support. Many parents of seriously emotional disturbed children or mentally ill adult children indicated that local coverage of mental health issues and resources would have assisted them in seeking assistance sooner and more effectively.

The other PEI programs support the media-based component by providing a community of more informed providers to respond to inquiries by individuals or families and mental health specialists accessible in a variety of settings.

Expected outcomes for individuals/families include:
• Increased knowledge about mental illness, signs, and resources (client/community survey)
• Reduced negative attitudes about mental illness (client/community survey)
• Increased number of individuals/families engaging in help-seeking behaviors (provider records)

On the system level:
• Increased number of Marin County residents receiving information about mental illness and resources;
• Reduced discrimination in employment and housing based on mental illness;
• Increased number of Marin County residents appropriately seeking mental health services.

July through December 2009 will be dedicated to developing the media campaign plan. The media campaign is expected to reach 50,000 individuals in FY 2009-10 and more individuals in following years.

8. Coordination with Other MHSA Components

The PEI Committee will meet regularly to assist with implementation, including ensuring that providers are aware of available resources and effective referral processes among organizations. Protocols for referral from PEI projects to CSS programs will be developed in conjunction with PEI contracts. The MHSA Implementation Committee will include representatives from PEI programs as well as CSS programs to continue working on effective linkages. PEI project needs are being considered in the development of the Workforce Education and Training plan. For example, co-occurring disorder training is being considered by WET. The Capital Facilities and Technology plan is in development and will take into consideration the needs of PEI projects.

9. Additional Comments (optional)

Marin County

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

County Name: Marin Date: 1/29/09

PEI Project Name: **Early Childhood Mental Health Consultation**

Provider Name (if known): Not known

Intended Provider Category: CBO

Proposed Total Number of Individuals to be served:	FY 08-09		FY 09-10	1050
Total Number of Individuals currently being served:	FY 08-09		FY 09-10	
Total Number of Individuals to be served through PEI Expansion:	FY 08-09		FY 09-10	1050
Months of Operation:	FY 08-09	1	FY 09-10	12

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
2 FTE - ECMH Consultants	10,000	120,000	$130,000
			$0
			$0
b. Benefits and Taxes @ 25 %	2,500	30,000	$32,500
c. Total Personnel Expenditures	$12,500	$150,000	$162,500
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	2,500	30,000	$32,500
c. Total Operating Expenses	$2,500	$30,000	$32,500
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Evaluation Plan Development	2,000	$0	$2,000
Evaluation Data Analysis	$0	2,500	$2,500
	$0	$0	$0
a. Total Subcontracts	$2,000	$2,500	$4,500
4. Total Proposed PEI Project Budget	$17,000	$182,500	$199,500
B. Revenues (list/itemize by fund source)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$17,000	$182,500	$199,500
6. Total In-Kind Contributions	$0	$0	$0

Marin County
PEI Revenue and Expenditure Budget Worksheet

Marin County
Early Childhood Mental Health Consultation
Budget Narrative

The budget worksheet represents a one-month estimated budget for fiscal year **08-09** and a 12-month estimated budget for **09-10**. The project budget is based on State approval of the Prevention and Early Intervention Plan in time to begin implementation by June 1, 2009. The provider selection process is taking place concurrently with the State approval process through a Request for Proposals process. The RFP process will provide more detailed budget information. The expenses described in the PEI line items are for allowable expenses under PEI guidelines.

Number of Individuals Served
The existing ECMH Consultation program currently serves approximately 1000 individuals and their families. PEI funds will provide additional services to these same 1000 individuals and a full complement of services to an additional 50 individuals and their families. Therefore, the PEI expansion serves 1050 individuals and their families.

Expenditures

1. Personnel Expenditures

Budget for positions in projects to be contracted to Community Based Organizations are based on salaries and benefits for similar positions in existing community based programs. ECMH Consultants will be highly skilled in child development, early childhood mental health, parenting, screening and assessment, and communication with diverse populations. Additional training will be provided in specific evidence-based methods, community resources, and other skills as needed.

2. Operating Expenditures

Budget for operating expenses is an estimate based on expenses for the existing ECMH consultation program in Marin County, including:
- training in evidence-based screening, childcare/parenting curriculum
- travel to and materials for participating childcare/education sites
- office expenses

Facility costs are expected to be provided in-kind by contracting agency.

3. Subcontracts

An evaluation consultant will be contracted to assist with developing program evaluations for all programs and evaluating the resulting data in order to inform ongoing program improvement and future funding decisions.

Revenues

Revenues will be determined through the RFP process. Revenues beyond PEI funding will offset the cost of serving additional individuals and families.

In-Kind Contributions

In-kind contributions will be determined through the RFP process. Office space, supervision, and readiness to implement are expected contributions.

Marin County

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

County Name: Marin Date: 1/29/09

PEI Project Name: **Triple P: Provider Training & Support**

Provider Name (if known): Not known

Intended Provider Category: CBO

Proposed Total Number of Individuals to be served:	FY 08-09		FY 09-10	100
Total Number of Individuals currently being served:	FY 08-09		FY 09-10	
Total Number of Individuals to be served through PEI Expansion:	FY 08-09		FY 09-10	100
Months of Operation:	FY 08-09	1	FY 09-10	12

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
1 FTE – Triple P Coordinator	5,000	60,000	$65,000
.25 FTE – Admin Asst	800	10,000	$10,800
			$0
b. Benefits and Taxes @ 25 %	1,450	17,500	$18,950
c. Total Personnel Expenditures	$7,250	$87,500	$94,750
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	2,700	82,500	$85,200
c. Total Operating Expenses	$2,700	$82,500	$85,200
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Evaluation Plan Development	2,000	$0	$2,000
Evaluation Data Analysis	$0	2,500	$2,500
	$0	$0	$0
a. Total Subcontracts	$2,000	$2,500	$4,500
4. Total Proposed PEI Project Budget	$11,950	$172,500	$184,450
B. Revenues (list/itemize by fund source)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$11,950	$172,500	$184,450
6. Total In-Kind Contributions	$0	$0	$0

Marin County
PEI Revenue and Expenditure Budget Worksheet

Marin County
Triple P: Provider Training & Support
Budget Narrative

The budget worksheet represents a one-month estimated budget for fiscal year **08-09** and a 12-month estimated budget for **09-10**. The project budget is based on State approval of the Prevention and Early Intervention Plan in time to begin implementation by June 1, 2009. The provider selection process is taking place concurrently with the State approval process through a Request for Proposals process. The RFP process will provide more detailed budget information. The expenses described in the PEI line items are for allowable expenses under PEI guidelines.

Number of Individuals Served

In fiscal year 09-10, training of providers will most likely focus on training appropriate providers in Triple P Level 4. Level 4 provides intervention for identified families. Therefore the number of individuals/families served is much lower than in future years when Levels 2-4 are operational.

Expenditures

1. Personnel Expenditures

Budget for positions in projects to be contracted to Community Based Organizations are based on salaries and benefits for similar positions in existing community based programs. The Triple P Coordinator will be highly skilled in planning, coordination, public speaking, and working with diverse providers. Additional training will be provided in Triple P and other skills as needed.

2. Operating Expenditures

Budget for operating expenses is an estimate of costs including:
- Triple P Training and Technical Assistance
  - $50,000 one time funding is allocated for 09-10
  - approximately $15-20,000 is available yearly for training
  - training per person is approximately $1500
- Triple P materials
- office expenses

Facility costs are expected to be provided in-kind by contracting agency.

3. Subcontracts

An evaluation consultant will be contracted to assist with developing program evaluations for all programs and evaluating the resulting data in order to inform ongoing program improvement and future funding decisions.

Revenues

Revenues will be determined through the RFP process. Revenues beyond PEI funding will offset the cost of serving additional individuals and families.

In-Kind Contributions

In-kind contributions will be determined through the RFP process. Office space, supervision, and readiness to implement are expected contributions.

Marin County

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

County Name: Marin Date: 1/29/09

PEI Project Name: **Student Assistance Program – MLK Middle School**

Provider Name (if known): Not known

Intended Provider Category: CBO

Proposed Total Number of Individuals to be served:	FY 08-09		FY 09-10	60
Total Number of Individuals currently being served:	FY 08-09		FY 09-10	
Total Number of Individuals to be served through PEI Expansion:	FY 08-09		FY 09-10	60
Months of Operation:	FY 08-09	1	FY 09-10	12

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
.8 FTE – SAP Coordinator	3,750	45,000	$48,750
			$0
			$0
b. Benefits and Taxes @ 25 %	938	11,250	$12,188
c. Total Personnel Expenditures	$4,688	$56,250	$60,938
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	312	3,750	4,062
c. Total Operating Expenses	$312	$3,750	$4,062
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Evaluation Plan Development	2,000	$0	$2,000
Evaluation Data Analysis	$0	2,500	$2,500
	$0	$0	$0
a. Total Subcontracts	$2,000	$2,500	$4,500
4. Total Proposed PEI Project Budget	$7,000	$62,500	$69,500
B. Revenues (list/itemize by fund source)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$7,000	$62,500	$69,500
6. Total In-Kind Contributions	$0	$0	$0

PEI Revenue and Expenditure Budget Worksheet

Marin County
Student Assistance Program – Martin Luther King Middle School
Budget Narrative

The budget worksheet represents a one-month estimated budget for fiscal year **08-09** and a 12-month estimated budget for **09-10**. The project budget is based on State approval of the Prevention and Early Intervention Plan in time to begin implementation by June 1, 2009. The provider selection process is taking place concurrently with the State approval process through a Request for Proposals process. The RFP process will provide more detailed budget information. The expenses described in the PEI line items are for allowable expenses under PEI guidelines.

Number of Individuals Served

The Student Assistance Program will be located in Martin Luther King Middle School and serve 60 individuals, and their families, attending Martin Luther King or transitioning into or out of MLK Middle School.

Expenditures

1. Personnel Expenditures

Budget for positions in projects to be contracted to Community Based Organizations are based on salaries and benefits for similar positions in existing community based programs. The SAP Coordinator will be skilled in planning, coordination, mental health screening and assessment, and working with underserved youth and their families. Additional training will be provided in specific evidence-based methods, community resources, and other skills as needed.

2. Operating Expenditures

Budget for operating expenses is an estimate of costs including:
- materials
- travel
- office expenses

Facility costs are expected to be provided in-kind by contracting agency and/or MLK School.

3. Subcontracts

An evaluation consultant will be contracted to assist with developing program evaluations for all programs and evaluating the resulting data in order to inform ongoing program improvement and future funding decisions.

Revenues

Revenues will be determined through the RFP process. Revenues beyond PEI funding will offset the cost of serving additional individuals and families.

In-Kind Contributions

In-kind contributions will be determined through the RFP process. Office space, supervision, and readiness to implement are expected contributions. The Masonic SAP project provides free training for teams from schools.

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

County Name: Marin Date: 1/29/09

PEI Project Name: **Transition Age Youth PEI**

Provider Name (if known): Not known

Intended Provider Category: CBO

Proposed Total Number of Individuals to be served:	FY 08-09		FY 09-10	150
Total Number of Individuals currently being served:	FY 08-09		FY 09-10	
Total Number of Individuals to be served through PEI Expansion:	FY 08-09		FY 09-10	150
Months of Operation:	FY 08-09	1	FY 09-10	12

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
1 FTE – TAY PEI MH Worker	4,667	56,000	$60,667
			$0
			$0
b. Benefits and Taxes @ 25 %	1,167	14,000	$15,167
c. Total Personnel Expenditures	$5,834	$70,000	$75,834
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	$833	$10,000	$10,833
c. Total Operating Expenses	$833	$10,000	$10,833
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Evaluation Plan Development	2,000	$0	$2,000
Evaluation Data Analysis	$0	2,500	$2,500
	$0	$0	$0
a. Total Subcontracts	$2,000	$2,500	$4.500
4. Total Proposed PEI Project Budget	$8,667	$82,500	$91,167
B. Revenues (list/itemize by fund source)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$8,667	$82,500	$91,167
6. Total In-Kind Contributions	$0	$0	$0

Marin County
Transition Age Youth Prevention and Early Intervention
Budget Narrative

The budget worksheet represents a one-month estimated budget for fiscal year **08-09** and a 12-month estimated budget for **09-10**. The project budget is based on State approval of the Prevention and Early Intervention Plan in time to begin implementation by June 1, 2009. The provider selection process is taking place concurrently with the State approval process through a Request for Proposals process. The RFP process will provide more detailed budget information. The expenses described in the PEI line items are for allowable expenses under PEI guidelines.

Number of Individuals Served

The TAY PEI project expects to serve 150 transition age youth in 09-10.

Expenditures

1. Personnel Expenditures

Budget for positions in projects to be contracted to Community Based Organizations are based on salaries and benefits for similar positions in existing community based programs. The TAY PEI Coordinator will be skilled in planning, coordination, mental health, and working with underserved transition age youth. Additional training will be provided in specific evidence-based methods, community resources, and other skills as needed.

2. Operating Expenditures

Budget for operating expenses is an estimate of costs including:
- training in evidence based methods as needed
- materials
- travel (the program expects to serve more than one site)
- office expenses

Facility costs are expected to be provided in-kind by contracting agency.

3. Subcontracts

An evaluation consultant will be contracted to assist with developing program evaluations for all programs and evaluating the resulting data in order to inform ongoing program improvement and future funding decisions.

Revenues

Revenues will be determined through the RFP process. Revenues beyond PEI funding will offset the cost of serving additional individuals and families.

In-Kind Contributions

In-kind contributions will be determined through the RFP process. Office space, supervision, and readiness to implement are expected contributions.

Marin County

Form No. 4

County Name: Marin Date: 1/29/09

PEI Project Name: **Canal Community-Based PEI**

Provider Name (if known): Not known

Intended Provider Category: CBO

Proposed Total Number of Individuals to be served:	FY 08-09		FY 09-10	300
Total Number of Individuals currently being served:	FY 08-09		FY 09-10	
Total Number of Individuals to be served through PEI Expansion:	FY 08-09		FY 09-10	300
Months of Operation:	FY 08-09	1	FY 09-10	12

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
.8 FTE – Mental Health Worker	3,750	45,000	$48,750
			$0
			$0
b. Benefits and Taxes @ 25 %	938	11,250	$12,188
c. Total Personnel Expenditures	$4,688	$56,250	$60,938
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	312	3,750	$4,062
c. Total Operating Expenses	$312	$3,750	$4,062
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Evaluation Plan Development	2,000	$0	$2,000
Evaluation Data Analysis	$0	2,500	$2,500
	$0	$0	$0
a. Total Subcontracts	$2,000	$2,500	$4,500
4. Total Proposed PEI Project Budget	$7,000	$62,500	$69,500
B. Revenues (list/itemize by fund source)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$7,000	$62,500	$69,500
6. Total In-Kind Contributions	$0	$0	$0

Marin County
Canal Community-Based Prevention and Early Intervention
Budget Narrative

The budget worksheet represents a one-month estimated budget for fiscal year **08-09** and a 12-month estimated budget for **09-10**. The project budget is based on State approval of the Prevention and Early Intervention Plan in time to begin implementation by June 1, 2009. The provider selection process is taking place concurrently with the State approval process through a Request for Proposals process. The RFP process will provide more detailed budget information. The expenses described in the PEI line items are for allowable expenses under PEI guidelines.

Number of Individuals Served

The Canal Community-Based PEI project expects to serve 300 individuals in 09-10.

Expenditures

1. Personnel Expenditures

Budget for positions in projects to be contracted to Community Based Organizations are based on salaries and benefits for similar positions in existing community based programs. The Mental Health Worker will be bi-lingual in Spanish and skilled in mental health screening, assessment and intervention for diverse communities. Additional training will be provided in specific evidence-based methods, community resources, and other skills as needed.

2. Operating Expenditures

Budget for operating expenses is an estimate of costs including:
- training in evidence based methods as needed
- materials
- office expenses

Facility costs are expected to be provided in-kind by contracting agency.

3. Subcontracts

An evaluation consultant will be contracted to assist with developing program evaluations for all programs and evaluating the resulting data in order to inform ongoing program improvement and future funding decisions.

Revenues

Revenues will be determined through the RFP process. Revenues beyond PEI funding will offset the cost of serving additional individuals and families.

In-Kind Contributions

In-kind contributions will be determined through the RFP process. Office space, supervision, and readiness to implement are expected contributions.

Form No. 4

County Name: Marin Date: 1/29/09

PEI Project Name: **Integrating Behavioral Health in Primary Care**

Provider Name (if known): Not known

Intended Provider Category: Primary Health Care

Proposed Total Number of Individuals to be served:	FY 08-09		FY 09-10	500
Total Number of Individuals currently being served:	FY 08-09		FY 09-10	
Total Number of Individuals to be served through PEI Expansion:	FY 08-09		FY 09-10	500
Months of Operation:	FY 08-09	1	FY 09-10	12

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
3 FTE – Mental Health Worker	22,500	270,000	$292,500
1 FTE – Medical Assistant	3,467	41,600	$45,067
.25 FTE - Psychiatrist	4,767	57,200	$61,967
b. Benefits and Taxes @ 25 %	7,683	92,200	$99,883
c. Total Personnel Expenditures	$38,417	$461,000	$499,417
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	1,250	15,000	$16,250
c. Total Operating Expenses	$1,250	$15,000	$16,250
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Evaluation Plan Development	14,000	$0	$14,000
Evaluation Implementation	$0	20,000	$20,000
	$0	$0	$0
a. Total Subcontracts	$14,000	$20,000	$34,000
4. Total Proposed PEI Project Budget	$53,667	$496,000	$549,667
B. Revenues (list/itemize by fund source)			
	$0	$0	$0
Medi-Cal/Medi-Care (24%)	$9,667	$116,000	$125,667
	$0	$00	$0
1. Total Revenue	$9,667	$116,00	$125,667
5. Total Funding Requested for PEI Project	$44,000	$380,000	$424,000
6. Total In-Kind Contributions	$0	$0	$0

Marin County
Integrating Behavioral Health in Primary Care
Budget Narrative

The budget worksheet represents a one-month estimated budget for fiscal year **08-09** and a 12-month estimated budget for **09-10**. The project budget is based on State approval of the Prevention and Early Intervention Plan in time to begin implementation by June 1, 2009. The provider selection process is taking place concurrently with the State approval process through a Request for Proposals process. The RFP process will provide more detailed budget information. The expenses described in the PEI line items are for allowable expenses under PEI guidelines.

Number of Individuals Served

The Integrating Behavioral Health in Primary Care project expects to serve 500 individuals in 09-10. That assumes approximately 7 months to become operational and that approximately 1000 will be served each following year.

Expenditures

1. Personnel Expenditures

Budget for positions in projects to be contracted to primary care sites are based on salaries and benefits for similar positions in comparable settings. The Mental Health Workers will be LCSW/MFTs with experience with diverse communities and appropriate language skills. Additional training will be provided in specific evidence-based methods, community resources, and other skills as needed.

2. Operating Expenditures

Budget for operating expenses is an estimate of costs including:
- training in evidence based methods as needed
- technical assistance
- materials
- office expenses

Facility costs are expected to be provided in-kind by contracting agency.

3. Subcontracts

This project is selected for the local evaluation. An evaluation consultant will be contracted to develop and implement the program evaluation in conjunction with CMHS and the providing agency(ies).

Revenues

Revenues will be determined through the RFP process. Medi-Cal and Medi-Care billings are expected to provide a portion of the revenue.

In-Kind Contributions

In-kind contributions will be determined through the RFP process. Office space, supervision, and readiness to implement are expected contributions.

Marin County

Form No. 4

County Name: Marin Date: 1/29/09

PEI Project Name: **Home Delivered Meals PEI**

Provider Name (if known): Not known

Intended Provider Category: CBO

Proposed Total Number of Individuals to be served:	FY 08-09		FY 09-10	400
Total Number of Individuals currently being served:	FY 08-09		FY 09-10	
Total Number of Individuals to be served through PEI Expansion:	FY 08-09		FY 09-10	400
Months of Operation:	FY 08-09	1	FY 09-10	12

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
.5 FTE – Mental Health Worker	2,500	30,000	$32,500
			$0
			$0
b. Benefits and Taxes @ 25 %	625	7,500	$8,125
c. Total Personnel Expenditures	$3,125	$37,500	$40,625
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	208	2,500	$2,708
c. Total Operating Expenses	$208	$2,500	$2,708
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Evaluation Plan Development	2,000	$0	$2,000
Evaluation Data Analysis	$0	2,500	$2,500
	$0	$0	$0
a. Total Subcontracts	$2,000	$2,500	$4,500
4. Total Proposed PEI Project Budget	$5,333	$42,500	$47,833
B. Revenues (list/itemize by fund source)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$5,333	$42,500	$47,833
6. Total In-Kind Contributions	$0	$0	$0

Marin County
Home Delivered Meals Prevention & Early Intervention
Budget Narrative

The budget worksheet represents a one-month estimated budget for fiscal year **08-09** and a 12-month estimated budget for **09-10**. The project budget is based on State approval of the Prevention and Early Intervention Plan in time to begin implementation by June 1, 2009. The provider selection process is taking place concurrently with the State approval process through a Request for Proposals process. The RFP process will provide more detailed budget information. The expenses described in the PEI line items are for allowable expenses under PEI guidelines.

Number of Individuals Served

The Home Delivered Meals Prevention & Early Intervention project expects to serve 400 individuals in 09-10.

Expenditures

1. Personnel Expenditures

Budget for positions in projects to be contracted to community-based organizations are based on salaries and benefits for similar positions in comparable settings. The mental health worker will be a master's level licensed mental health clinician with a specialization in geriatric mental health. Additional training will be provided in specific evidence-based methods, community resources, and other skills as needed.

2. Operating Expenditures

Budget for operating expenses is an estimate of costs including:
- training in evidence based methods as needed
- materials
- office expenses
- travel for home visits

Facility costs are expected to be provided in-kind by contracting agency.

3. Subcontracts

An evaluation consultant will be contracted to assist with developing program evaluations for all programs and evaluating the resulting data in order to inform ongoing program improvement and future funding decisions.

Revenues

Revenues will be determined through the RFP process. Medi-Care billings are expected to provide revenue that can expand the number of clients receiving early intervention.

In-Kind Contributions

In-kind contributions will be determined through the RFP process. Office space, supervision, and readiness to implement are expected contributions.

Marin County

Form No. 4

County Name: Marin Date: 1/29/09

PEI Project Name: **Suicide Prevention**

Provider Name (if known): Not known

Intended Provider Category: CBO

Proposed Total Number of Individuals to be served:	FY 08-09	0	FY 09-10	0
Total Number of Individuals currently being served:	FY 08-09		FY 09-10	
Total Number of Individuals to be served through PEI Expansion:	FY 08-09		FY 09-10	
Months of Operation:	FY 08-09	1	FY 09-10	12

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
.5 FTE – Program Coordinator	1,833	22,000	$23,833
			$0
			$0
b. Benefits and Taxes @ 25 %	459	5,500	$5,959
c. Total Personnel Expenditures	$2,292	$27,500	$29,792
2. Operating Expenditures			
a. Facility Cost	$0	$0	$0
b. Other Operating Expenses	375	4,500	4,875
c. Total Operating Expenses	$375	$4,500	$4,875
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Evaluation Plan Development	2,000	$0	$2,000
Evaluation Data Analysis	$0	2,500	$2,500
	$0	$0	$0
a. Total Subcontracts	$2,000	$2,500	$4,500
4. Total Proposed PEI Project Budget	$4,667	$34,500	$39,167
B. Revenues (list/itemize by fund source)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$4,667	$34,500	$39,167
6. Total In-Kind Contributions	$0	$0	$0

Marin County
Suicide Prevention
Budget Narrative

The budget worksheet represents a one-month estimated budget for fiscal year **08-09** and a 12-month estimated budget for **09-10**. The project budget is based on State approval of the Prevention and Early Intervention Plan in time to begin implementation by June 1, 2009. The provider selection process is taking place concurrently with the State approval process through a Request for Proposals process. The RFP process will provide more detailed budget information. The expenses described in the PEI line items are for allowable expenses under PEI guidelines.

Number of Individuals Served

The Suicide Prevention project requires extensive planning and outreach and does not expect to provide direct services until FY 10-11.

Expenditures

1. Personnel Expenditures

Budget for positions in projects to be contracted to community-based organizations are based on salaries and benefits for similar positions in comparable settings. The Project Coordinator will be skilled in program planning and development, as well as have experience in suicide prevention. Additional training will be provided in other skills as needed.

2. Operating Expenditures

Budget for operating expenses is an estimate of costs including:
- materials
- office expenses
- travel to local, regional and statewide meetings

Facility costs are expected to be provided in-kind by contracting agency.

3. Subcontracts

An evaluation consultant will be contracted to assist with developing program evaluations for all programs and evaluating the resulting data in order to inform ongoing program improvement and future funding decisions.

Revenues

Revenues will be determined through the RFP process.

In-Kind Contributions

In-kind contributions will be determined through the RFP process. Office space, supervision, and readiness to implement are expected contributions.

Form No. 4

County Name: Marin Date: 1/29/09

PEI Project Name: **Mental Health Awareness and Stigma Reduction**

Provider Name (if known): Not known

Intended Provider Category: CBO

Proposed Total Number of Individuals to be served:	FY 08-09		FY 09-10	50,000
Total Number of Individuals currently being served:	FY 08-09		FY 09-10	
Total Number of Individuals to be served through PEI Expansion:	FY 08-09		FY 09-10	50,000
Months of Operation:	FY 08-09	1	FY 09-10	12

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
			$0
			$0
			$0
b. Benefits and Taxes @ 25 %			$0
c. Total Personnel Expenditures	$0	$0	$0
2. Operating Expenditures			
a. Facility Cost			$0
b. Other Operating Expenses			$0
c. Total Operating Expenses	$0	$0	$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Media agency	2,667	32,000	$34,667
Evaluation Plan Development	2,000	$0	$2,000
Evaluation Data Analysis	$0	$2,500	$2,500
a. Total Subcontracts	$4,667	$34,500	$39,167
4. Total Proposed PEI Project Budget	$4,667	$34,500	$39,167
B. Revenues (list/itemize by fund source)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$4,667	$34,500	$39,167
6. Total In-Kind Contributions	$0	$0	$0

Marin County
Mental Health Awareness and Stigma Reduction
Budget Narrative

The budget worksheet represents a one-month estimated budget for fiscal year **08-09** and a 12-month estimated budget for **09-10**. The project budget is based on State approval of the Prevention and Early Intervention Plan in time to begin implementation by June 1, 2009. The provider selection process is taking place concurrently with the State approval process through a Request for Proposals process. The RFP process will provide more detailed budget information. The expenses described in the PEI line items are for allowable expenses under PEI guidelines.

Number of Individuals Served

The media generated by the Mental Health Awareness and Stigma Reduction project is expected to reach approximately 50,000 people in 09-10.

Expenditures

1. Personnel Expenditures

The County staff time spent to oversee this contract is included in the Administration Budget.

2. Operating Expenditures

Costs incurred outside of this contract are included in the Administration Budget.

3. Subcontracts

- A media agency will be contracted to develop a campaign the goals of the PEI Plan.
- An evaluation consultant will be contracted to assist with developing program evaluations for all programs and evaluating the resulting data in order to inform ongoing program improvement and future funding decisions.

Revenues

Additional revenues are not expected for this project.

In-Kind Contributions

Once the media campaign is designed, in kind contributions will be sought as appropriate. Most likely these will include free or reduced cost PSA venues.

Marin County

Form No.5

County: Marin Date: 1/29/09

	Client & Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2008-09	Budgeted Expenditure FY 2009-10	Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator - Contract				55,000	$55,000
b. PEI Support Staff			5,162	32,171	$37,333
c. Other Personnel (list all classifications)					$0
					$0
					$0
					$0
					$0
d. Employee Benefits			2,212	13,787	$15,999
e. Total Personnel Expenditures			$7,374	$100,958	$108,332
2. Operating Expenditures					
a. Facility Costs			$0	$0	$0
b. Other Operating Expenditures			2,532	15,777	18,309
c. Total Operating Expenditures			$2,532	$15,777	$18,309
3.County Allocated Administration					
a. Total County Administration Cost			$6,637	$41,365	$48,002
4. Total PEI Funding Request for County Administration Budget			$16,543	$158,100	$174,643
B. Revenue					
1. Total Revenue					$0
C. Total Funding Requirements			$16,543	$158,100	$174,643
D. Total In-Kind Contributions			$0	$0	$0

Marin County
PEI Administration Budget Narrative

1. Personnel Expenditures

a. PEI Coordinator – Contract

Kristen Gardner was hired in March 2008 to coordinate the completion of the PEI planning process. Her responsibilities during implementation include:

- Manage all PEI provider contracts
- Provide implementation assistance for providers, especially regarding evidence-based practice selection, training and adaptation; evaluation plans; and reporting
- Coordinate PEI Committee (PEI providers and other stakeholders), including:
  - the PEI project evaluation process
  - coordination and collaboration among participants
  - training in PEI requirements
- Fulfill PEI state reporting requirements
- Participate in regional and statewide PEI activities as they pertain to Marin County
- Coordinate with other prevention activities within the Health and Human Services
- Coordinate PEI component with other MHSA components

b. PEI Support Staff

The Administration budget includes salary and benefit expenditures for the following staff to manage MHSA PEI requirements: Mental Health Director, Special Projects Coordinator, Assistant CFO, Youth and Family Program Manager, H&HS Fiscal Supervisor, Tech Systems Specialist 1 and Accountant 1.

2. Operating Expenditures

The following operating expenditures are also included in the PEI Admin budget: Maintenance of the Marin CMHS Network of Care website, as well as other administrative operating expenses related to contacts, accounting, billing, information technology, and payroll to administer MHSA PEI requirements.

3. County Allocated Administration

County Allocated Administration is distributed as follows: $3,960 (fy 08-09) and $24,682 (fy09-10) in County indirect costs (A-87); and $2,677 (fy 08-09) and $16,683 (fy 09-10) in other administrative costs including general insurance malpractice insurance, telephones, and H&HS departmental admin overhead.

PREVENTION AND EARLY INTERVENTION BUDGET SUMMARY

Form No. 6

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

County:	Marin
Date:	1/29/09

		Fiscal Year			Funds Requested by Age Group			
#	List each PEI Project	**FY 08/09**	**FY 09/10**	**Total**	*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
1	Early Childhood Mental Health Consultation	$17,000	$182,500	$199,500	$199,500			
2	Triple P: Provider Training and Support	$11,950	$172,500	$184,450	$184,450			
3	Student Assistance Program at MLK	$7,000	$62,500	$69,500	$69,500			
4	Transition Age Youth PEI	$8,667	$82,500	$91,167		$91,167		
5	Canal Community-Based PEI	$7,000	$62,500	$69,500		$13,900	$55,600	
6	Integrating Behavioral Health in Primary Care	$44,000	$380,00	$424,000		$84,800	$296,800	$42,400
7	Home Delivered Meals PEI	$5,333	$42,500	$47,833				$47,833
8	Suicide Prevention	$4,667	$34,500	$39,167		$11,750	$18,409	$9,008
9	Mental Health Awareness & Stigma Reduction	$4,667	$34,500	$39,167		$11,750	$18,409	$9,008
	Administration	$16,543	$158,100	$174,643	$68,110	$31,960	$58,331	$16,242
	Total PEI Funds Requested:	$126,827	$1,212,100	$1,338,927	$521,560	$245,327	$447,549	$124,491

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

LOCAL EVALUATION OF A PEI PROJECT

County: Marin **Date: 1/29/09**

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

PEI Project Name: Integrating Behavioral Health in Primary Care

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

Marin County will evaluate the "Integrating Behavioral Health in Primary Care" project.

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

This project was selected because:

- Stakeholders have a significant interest in this program due to the level of resources allocated, the high level of support for implementing it, and the concerns raised about adequate access to the programs services, It will be important to ensure that this program has the impact that stakeholders are expecting.
- It is the largest PEI project with the largest sample size which increases the validity of the findings.
- There are a number of well-researched models for integrating behavioral health, which have developed clear outcomes and methods for measuring them.
- Primary health care sites are currently required to collect and report on extensive data, and therefore have the capacity to implement successful data collection systems.

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

These are the minimum expected outcomes. The complete set of outcomes and tracking methods will be determined during the provider contracting process in conjunction with an independent evaluator to ensure validity and that it meets State requirements.

<u>Person/Family Level Outcomes</u>:

- Increased client knowledge about their mental health status and self-management skills
- Improved mental health status
- Satisfaction with mental health prevention and brief intervention services by clients, including whether services were provided with ethnic/cultural sensitivity and competency

LOCAL EVALUATION OF A PEI PROJECT

Program/System Level Outcomes:

- Increase in knowledge about mental health among primary care providers
- Increase in clients receiving mental health assessment and early intervention
- Services will be accessible to underserved populations

LOCAL EVALUATION OF A PEI PROJECT

Form No. 7

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

PERSONS TO RECEIVE INTERVENTION

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/ DISCRIMINATION
ETHNICITY/ CULTURE							
African American	40						
Asian Pacific Islander	40						
Latino	560						
Native American	20						
Caucasian	340						
Other (Indicate if possible)							
AGE GROUPS							
Children & Youth (0-17)							
Transition Age Youth (16-25)	200						
Adult (18-59)	700						
Older Adult (>60)	100						
TOTAL	1000						

Total PEI project estimated ***unduplicated*** count of individuals to be served ____1000__*

* 500 are expected to be served in 09-10, with 1000 served per year after that.

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

The specific data collection tools and intervals for data collection will be determined during the provider contracting process with the assistance of an independent evaluator. The provider agencies will be expected to review mental health status data on an ongoing basis to improve individual treatment plans. Complete evaluation data reports will be provided to CMHS on at least an annual basis to improve program implementation.

Person/Family Level Outcomes:

- Increased client knowledge about their mental health status and self-management skills

Client surveys at the beginning of intervention services and at regular intervals.

- Improved mental health status

Providing agencies will select validated screening tools to administer at regular intervals to clients receiving early intervention in order to monitor and adjust interventions. The results of these screenings will provide mental health status data. For example, a client identified as depressed and receiving brief intervention for depression will be given a depression screening at the start of treatment and at regular intervals to assess changes over time.

- Client satisfaction with mental health prevention and brief intervention services, including whether services were provided with ethnic/cultural sensitivity and competency

Client satisfaction surveys at regular intervals. Data collection tools considered will include the California DMH survey, surveys currently used by implementing agencies, and surveys developed for similar programs.

Program/System Level Outcomes:

- Increase in knowledge about mental health among primary care providers

Pre/post surveys of providers before training and between 2-6 months after training.

- Increase in clients receiving mental health assessment and services

Numbers and demographics of clients receiving screening, assessment, brief intervention, and referrals from the primary health care provider agency will be tracked by the contracting agencies on an ongoing basis.

- Services will be accessible to underserved populations

Client satisfaction surveys that inquire about barriers to services. Tracking demographics of clients who do and do not complete indicated interventions.

5. How will data be collected and analyzed?

Community Mental Health, provider agencies, and a contracted evaluator will work together to determine data collection tools and design data collection processes. Some evidence-based practices already have well researched methods that may be used. The provider agencies will be responsible for conducting client surveys and screenings, tracking client demographic data, conducting provider surveys, and tracking numbers of referrals. The evaluator will analyze the data.

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

- Screening, assessment and brief interventions implemented will have validity with diverse populations (Latino, African American and Asian specifically).
- Client satisfaction surveys and tracking demographics of clients who do not complete indicated interventions will be used to improve program accessibility.
- Provider contracts require the following:

A. All program staff shall receive at least one (1) in-service training per year on some aspect of providing culturally and linguistically appropriate services. At least once per year and upon request, Contractor shall provide County with a schedule of in-service training(s) and a list of participants at each such training.

B. Contractor shall translate health-related materials in a culturally and linguistically appropriate manner. Materials shall be translated into Spanish. At least once per year and upon request, Contractor shall provide to County copies of Contractor's health-related materials in English and as translated.

C. Contractor shall hire clinical staff members who can communicate with clients in a culturally and linguistically appropriate manner. At least once per year and upon request, Contractor shall submit to County the cultural composition and linguistic fluencies of Contractor's staff.

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

Providing agencies will select an evidence-based model (such as IMPACT) and prepare an implementation plan that ensures fidelity. Any necessary changes or adaptation will be reported, along with reasons for the changes, in the initial implementation plan and following progress reports.

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

- Evaluation results will be discussed with project staff, including consideration of changes to the program as indicated.

- The PEI Committee will include PEI contractors and other stakeholders. They will participate in reviewing and making recommendations regarding all evaluation reports.
- Evaluation reports will be posted on the CMHS website. An announcement will be sent-out to relevant stakeholders when reports are posted.