Prevention and Early Intervention Component of the Three-Year Expenditure Plan

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES
MENTAL HEALTH SERVICES ACT (MHSA)
JANICE MELTON, LCSW, MENTAL HEALTH DIRECTOR

Enclosure 3

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: Madera	Date:

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

County Mental Health Director	**Project Lead**
Name: Janice Melton	Name: Debby Estes
Telephone Number: (559) 675-7926	Telephone Number: (559) 675-7926
Fax Number: (559) 675-4999	Fax Number: (559) 675-4999
E-mail: jmelton@madera-county.com	E-mail: destes@madera-county.com
Mailing Address: P.O. Box 1288, 126 North B Street Madera, CA 93638	

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 Janice Melton, LCSW — 12-3-08

County Mental Health Director — Date

Executed at Madera, California

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: Madera	Date:12/08/08

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

County Mental Health Director	**Project Lead**
Name: Janice Melton Telephone Number: (559) 675-7926 Fax Number: (559) 675-4999 E-mail: jmelton@madera-county.com	Name: Debby Estes Telephone Number: (559) 675-7926 Fax Number: (559) 675-4999 E-mail: destes@madera-county.com
Mailing Address: P.O. Box 1288, Madera, CA 93639	

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 _____ Director of Behavioral Health 12/3/08

Executed at Madera, California

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form No. 2

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

County: Madera **Date:**

1. The county shall ensure that the Community Program Planning Process is adequately staffed. Describe which positions and/or units assumed the following responsibilities:

a. The overall Community Program Planning Process

The following staff assumed responsibilities for the Community Planning Process

Janice Melton, LCSW, Director, Madera County Department of Behavioral Health
Debby Estes, LCSW, Assistant Director, Madera County Department of Behavioral Health

b. Coordination and management of the Community Program Planning Process

Debbie C. DiNoto, LMFT, Division Manager, Department of Behavioral Health

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

David Weikel, MHSA Coordinator

The Prevention Early Intervention (PEI) Community Planning Process (CPP) included broad general outreach, community forums throughout the county, targeted outreach to ethnic minorities and underserved populations, public stakeholder processes, key informant interviews, existing mental health staff and advisory groups. Madera County is a small, mostly rural county. There are no mental health community based organizations (CBO's) within Madera County. This created special challenges in involving stakeholders in the community planning process. As a result, Madera County Behavioral Health Services (MCBHS) conducted several specialized focus groups and key informant interviews in order to obtain the information and direction of the proposed services in this plan.

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form No. 2

1. Orientation to PEI

All of the following groups received orientation and training to PEI and dedicated time at their regular meetings to identify prevention and early intervention needs and best practices. The orientation included a brief history of the Mental Health Services Act (MHSA) law, the intent of the law, the Five Fundamental Elements and the types of services that could be funded under MHSA. They were also kept informed of the progress of PEI planning and continued to offer input on the process

- Madera County Chief Administrative Office—included the top management of Madera County
- Madera County Health, Behavioral Health Services and Social Service Executive Staff—included the Behavioral Health Services Director and the Director of Department of Social Services,
- Other Madera County Department Directors—included the Madera County Corrections Director, Director of Madera County Department of Public Health, their managers, supervisors, and line staff.
- Madera County Department of Behavioral Health Services Cultural Competency Committee—included the local Behavioral Health Services Director, managers, line staff, clients, mental health board members
- MHSA Steering Committee—included Behavioral Health Services, Social Services, Corrections, service agencies, staff, etc.
- Prevention and Early Intervention Committee – Included clients, family members, staff from county departments, staff from community based non-mental health organizations, school staff and others
- Client and Family Member Committee—included clients and family members who receive or have received behavioral health services from Madera County.
- General public was informed through postings on the MCBHS MHSA website, local fairs, local events, newspaper articles, surveys, key informant interviews, focus groups, etc.

In addition to the above groups, Madera County conducted several focus groups as well as key informant interviews. There was a “training” component in each of those groups to talk about the MHSA. During this time, the following was discussed;

- History of the Mental Health Services Act
- What the Community Services and Supports (CSS) planning and stakeholder process results recommended in regards to the priorities for services to be implemented, and the identified mental health services needs
- The types of services that could be funded with PEI funds; including examples of these services
- Evidence Based Practice (EBP) programs Madera County Behavioral Health Services currently has implemented, which meet PEI program criteria.

2. Outreach—Information on PEI and the PEI CPP as well as announcements to attend local PEI Community Forums was provided through email, mailing lists, newspapers and postings. Announcements were also posted on the Madera County MHSA website.

Madera County Behavioral Health Services learned from the CSS planning process, and the early stages of PEI planning, that large stakeholder meetings and community meetings were not as effective as focus groups and key informant interviews in engaging community stakeholders in the planning process. In addition, due to budget constraints, staffing for the PEI planning was very limited (administrative staff with existing duties were used for the PEI planning). For planning the programs to be developed through PEI, Madera County relied heavily on administrative staff to obtain information and educate the public and stakeholders.

3. Madera County Behavioral Health Services Community Forums—there were a total of five community forums. They were located in various parts of the county (metropolitan Madera, rural and mountain areas) in handicapped accessible locations and on major bus routes. Language interpreters including sign language were available. Forums were not held in behavioral health services buildings/clinics due to concern regarding stigma issues. Meetings were held in health care settings and community buildings. The agenda included opportunities for local residents to participate in setting priority populations to be served, program choices, defining the top issues for Madera County Behavioral Health to address, etc.

4. Stakeholders Group Meetings—PEI was discussed at different Stakeholder Group meetings. These meetings included the MHSA Steering Committee and the PEI Committee Meetings. For a specific list of members of the MHSA PEI Committee and the MHSA Steering Committees, please see Question 2.

There were Client/Family Member meetings as well. They were held at the MHSA Client/Family Member drop-in center, Hope House. During those regularly scheduled meetings, clients and family members learned about the MHSA and provided input on the needs of Madera County and the MHSA plans being developed to address those needs.

5. Focus Group Meetings—Early in the process of planning to implement the various MHSA components, it became apparent that the Madera community stakeholders and partner agencies would not attend regularly scheduled meetings, due to other commitments. Madera County is a small county with limited resources. There are no mental health CBO's within this county. People wear multiple hats and may represent their agency on several boards and committees. It is often difficult to attend the multitude of meetings and still provide appropriate services. It was suggested; that many of the unserved and underserved populations may not feel comfortable attending formal committee meetings with others, e.g., farm workers, Native American community, the Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) community, etc. Therefore, Madera County Behavioral Health Services went to them to provide education regarding the MHSA, seek out their opinions on the needs of the community,

prioritize those needs and develop programs to would address them. A full list of focus groups/key informant interviews is listed in Question 2.

6. Key Informant Interviews — People in Madera County wear multiple hats. There are no mental health CBO's within Madera County. Often, the same person represents an organization at multiple meetings. Therefore Madera County Behavioral Health Services conducted small focus groups and key informant interviews in an attempt to involve the community in the PEI planning process. Some of the most difficult stakeholders to reach were the faith community and the Native American populations. After two years of trying to connect, MCBHS staff was able to hold meetings with representatives from these groups.

7. Health Fairs and other Community Forums—MHSA staff attended several community forums including the local Farmer's Market, Health Fairs, Native American health fairs and events, Latino cultural events, school events, etc. They spoke about the MHSA components, handed out questionnaires, and noted comments from the community on PEI issues and concerns.

8. Surveys—Web based surveys were posted on the Madera County BHSA MHSA website. Surveys were posted in English and Spanish. Those surveys were tallied and their results were included in the development of this plan.

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

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

Madera County established a PEI Committee to assist in the planning process. They included representatives from various community based organizations/agencies serving the community. These organizations serve or represent un-served and/or underserved populations, consumers, youth and family members, and county staff.

Reports of the work group's progress were presented to the MHSA Stakeholder Steering Committee, which was originally developed to oversee the implementation of the CSS programs. The members of the committee are listed below.

1	Janice Melton	Director	Madera County Department of Behavioral Health Services
2	Janet Stutzman	Member	Local Mental Health Board
3	Linda Rosas		Family Member
4	Doug Papagni	Director	Madera County Department of Corrections

5	Claudia Norris	Director	Special Education Local Plan Area
6	Hub Walsh	Director	Madera County Department of Social Services
7	Carol Barney	Director	Madera County Department of Public Health
8	Maria Salas	Department Manager	Housing Authority of the City of Madera
9	Randy Brannon	Pastor	Grace Community Church
10	Jean Robinson	Assistant Director	Fresno Madera Area Agency on Aging
11	Betty Cates	Manager	Madera Community Hospital
12	Debbie DiNoto	Division Manager	Madera County Department of Behavioral Health Services
13	Debby Estes	Assistant Director	Madera County Department of Behavioral Health Services
14	Elizabeth Catanesi	Manager	First 5 of Madera County
15	John Bell	Analyst	Madera County Office of the District Attorney
16	Judy Comer	Analyst	Madera County Department of Behavioral Health Services
17	Jeannie Turpenen	Contractor	Madera County Department of Behavioral Health Services
18	Jeanette Flores	Administrative Assistant	Madera County Department of Corrections
19	Kathy Hayden	Division Manager	Madera County Department of Behavioral Health Services
20	Salvador Cervantes	Analyst	Madera County Department of Behavioral Health Services
21	David Weikel	Program Coordinator	Madera County Department of Behavioral Health Services

In addition to the MHSA Stakeholder Steering Committee, there was a specific PEI Committee. This committee's members included:

1	Kenneth Bernstein	Medical Director	Darin Camarena Health Centers
2	Carol Barney	Director	Madera County Department of Public Health
3	Claudia Norris	Director	Special Education Local Plan Area
4	David Weikel	Program Coordinator	Madera County Department of Behavioral Health Services

5	Julie M. Vlasis	Chief Operations Officer	Darin Camarena Health Centers
6	Tamala Fields	Program Coordinator	Center for Independent Living - Madera
7	Elizabeth Catanesi	Family Resource Center Manager	First 5 of Madera County
8	Hub Walsh	Director	Madera County Department of Social Services
9	Janet Stutzman	Member	Local Mental Health Board
10	Jean Robinson	Assistant Director	Fresno Madera Area Agency on Aging
11	Mary C. Ferrell	Vice-president Patient Care Services	Madera Community Hospital
12	Minnie Aguirre	Member (Family Member)	Local Mental Health Board
13	Linda Rosas		Family Member
14	Randy Brannon	Pastor	Grace Community Church
15	Donna Lutz		Madera County Department of Social Services – Child Welfare
16	Contessa Palermo	Analyst	Madera County Department of Social Services
17	Fern Mills		Madera County Department of Social Services – Child Welfare

The Consumer and Family Member Committee met at the Wellness and Recovery Center (Hope House), which was developed with CSS funds. The Consumer and Family Member Committee received training regarding all of the Mental Health Services Act components and were given multiple opportunities for comments and recommendations regarding the types of services that should be developed with these new funds.

In addition to the Stakeholder Steering Committee and PEI committee, specific focus groups were held. As part of the focus group, an educational forum took place to let the participants know about the MHSA and specifically the PEI component. Specific questions were asked in each of the focus groups about what services they would like to see for PEI activities and which age groups should have the highest priority for those services. Their responses were recorded and included in the development of programs within this Plan. The following is a list of the Focus Groups/Key Informant interviews held during February through November of 2008.

Focus Groups/Key Informant Interviews

The following key informant interviews and focus groups were conducted;

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form No. 2

	Date	Attendee #	Group
1	2/12/08	9	South Madera High School – School of Health Sciences - Curriculum Development Meeting (BHS Introduced Human Services Academy Model)
2	2/12/08	1	Madera Unified Special Education Coordinator
3	4/7/08	8	Early Childhood Initiative Group (Head Start, Madera County Office of Education, Madera County Special Education)
4	6/6/08	7	North Fork Tribal Temporary Aid to Needy Families (TANF)
5	5/19/08	1	California School Mental Health Centers Association
6	6/10/08	2	Nora and Associates (Latina Business Women's Association)
7	7/1/08	15	Migrant Farm Workers (met at the camp)
8	8/6/08	1	Adult Outpatient Supervisor (LPS services, Courts, Intensive Services)
9	8/7/08	7	City of Madera Police Town Hall Meeting - (4) Police Department, (2) District Attorney's Office , (1) Madera Unified School District
10	8/8/08	12	(6) Resource Management Agency, (6) Department of Behavioral Health Services
11	8/13/08	1	Older Adult Full Service Partnership - Senior Clinician
12	8/19/08	1	Center for Independent Living Program Coordinator
13	8/19/08	6	MHSA Children and Youth Full Service Partnership Team (therapists, case workers, supervisor)
14	8/22/08	6	Older Adult Consumer Focus Group
15	8/27/08	1	Madera County District Attorney's Office
16	8/28/08	4	Chowchilla Police Department
17	8/29/08	6	Ready, Set, Go Program (At Risk TAY) and Workforce Development Office (WIB) (All ages)
18	9/3/08	1	Homeless Helping the Community Group
19	9/4/08	10	Chawanakee Unified School District Administration

20	9/5/08	10	Department of Social Services
21	9/5/08	5	Housing Authority of the City of Madera
22	9/9/08	5	Yosemite High School District (Principle and Counseling Staff)
23	9/16/08	16	Madera County Juvenile Probation
24	9/16/08	2	Chowchilla Elementary School District - Special Education Directors
25	9/17/08	10	Fresno Madera Area Agency on Aging
26	9/19/08	2	Centro Binacional Para El Desarrolló Indígena Oaxaqueño
27	9/25/08	16	First 5 of Madera County and Madera County Adult Probation
28	10/1/08	2	Lesbian, Gay, Bisexual, Transgender, Questioning
29	10/2/08	6	Picayune Rancheria of the Chukchansi Indians Tribal Council
30	10/7/08	13	Community Action Partnership of Madera County
31	10/14/08	1	Head Pastor of Believers Church
32	10/15/08	14	Madera County Health Families Taskforce
33	10/16/08	4	Family Members of Transition Age Youth being served in the system (included Spanish speaking Family Members)
34	10/21/08	7	Madera County Behavioral Health Services Management
35	10/23/08	2	Madera Community Hospital
36	10/23/08	11	Adult Consumer Focus Group
37	10/30	3	Madera County Public Health Services (Administration and Direct Services)
38	11/1/08	4	State Center Community College District - North Centers (Administration and Counseling Services)

Total = 302

Madera County Behavioral Health also held Community Forums throughout the County. Meetings were held in the evenings and on weekends so people who worked during the daytime could participate. Language and deaf interpreters were available as necessary. Handicapped accessible buildings were used. Meetings were not held in MCBHS

clinics to reduce stigma. They were held in physical health settings and community centers.

The Community Forums included an education component in addition to specific focus group questions. Information was given regarding the website and on-line questionnaires.

There was an ongoing Client/Family Member Group. During this group session, a portion of the MHSA was presented with visual guides and hand-outs. Specific questions were asked of the clients/family members during and after the presentations regarding their opinions, wants and wishes. These were recorded and included in this Plan.

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.

Madera's MHSA planning began in 2005 with the development of the three year plan for Community Services and Supports. Madera County made every effort to ensure comprehensive involvement of local stakeholders: consumers, family members, providers, and key agency/organization representatives. The focus was on trying to reach residents who have not received needed mental health services. Consumer and family member involvement was a crucial element of the MHSA process. However, many consumers and family members were unable or unwilling to participate in traditional committees, community meetings, and task forces. Therefore, a multi-pronged outreach effort was made to obtain input from this often under-represented and underserved population. This effort included specialized focus groups, involvement in ongoing committees, surveys, etc.

Again, due to the reluctance of clients and family members as well as unserved and underserved groups to participate in large meetings, there were small focus groups and key informant interviews held to obtain input and to continue education about the MHSA (See answer to question 2 for specific groups/individuals). In addition, individual key informant interviews were conducted along with community forums and computer surveys. Educational information and educational presentations were included. Educational material was included on the website for each of the surveys posted. Surveys were posted on the internet for the community and service partners as well as clients and family members.

The key informant interviews as well as small focus groups were conducted in areas of the county that clients, family members and the community at large would feel comfortable meeting. Most, if not all were done in places such as community centers, businesses, agency offices, schools, doctor's offices, etc., throughout Madera County. Individuals did not have to come to central Madera to participate; Madera County MHSA staff went to them. This included the mountain communities as well as other cities and unincorporated (rural) areas within Madera County.

Interviews and focus groups were available in Spanish as well as English. Interpreters for deaf and hard of hearing were available as necessary. All forums, stakeholder meetings and committee meetings were held in handicapped accessible buildings. The meeting with farm workers was held at the farm worker's camp. Interviews and education about the Act were also held at homeless shelters, farmer's markets, back to school nights, health fairs, etc.

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

There was a special Client and Family group. This group was conducted at Hope House, Madera County Behavioral Health Service's client Wellness and Recovery Center. In addition to these regularly scheduled meetings, special focus groups were conducted. Please see response to Question 2 for a specific list of types of focus groups and key informant interviews.

Each of the components of the MHSA also had literature and flyers developed. Each had links to the Madera County MHSA website which included information about each of the MHSA components and surveys to address client and family members' desires for programming.

Computers were available at Hope House for clients to participate in the on-line surveys. Clients and family members were encouraged to complete the questionnaires and provide input into the Plan.

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, included but as not limited to:

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

Please see Question 2 for a specific list of all of the individuals/groups and committees that met regarding PEI services through the MHSA.

Clients and family members were part of a specific Client/Family Member group regarding MHSA II and provide input into the Madera County Department of Behavioral Health Services' plan. When necessary, specific clients were sought out for input.

They were clients who may have not been comfortable meeting in a large group setting, e.g., the Lesbian, Gay, Bisexual, Transgender and Questioning clients, farm workers, etc. Special groups were also conducted to obtain input from family members of children seen for services. Again, PEI staff went to the places where clients/community members would feel comfortable talking. Those groups/individuals did not have to come to MCBHS. Meetings were conducted at times that were convenient to the participants.

Providers of physical health and mental health services, educators, representatives of law enforcement as well as other organizations were also part of the PEI committee and again provided input through specialized focus groups and key informant interviews. If those individuals had difficulty attending meetings, Madera County went to them for their input into the plan.

In addition, there were surveys posted on the website, emails sent regarding input and the surveys, advertisements in the local paper about community forums, newspaper articles about the MHSA and the request for input, etc. Staff also attended at local health fairs, back to school nights, farmer's markets, various cultural events where unserved and underserved populations would gather. During this time they spoke about the MHSA II, handed out information, flyers for meetings, surveys, business cards, links to the website, arranged for follow-up meetings, etc.

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

Training was conducted during community forums. Information was also included on the website, including surveys, meetings, etc. This training included an overview of the Mental Health Services Act, the history of the MHSA's development, a description of each of the components of the Act, and the community needs identified in the initial program planning in 2005. All of the participants indicated that the needs identified in the initial planning were still applicable.

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.

Madera County BHS built on the successful strategies of the 2005 Community Program Planning Process. As in the initial planning, the majority of people that BHS sought to engage in planning activities were unwilling and/or unable to participate in large group or public meeting process. In addition, past participants stated they had already made their preferences known in the initial planning process and were reluctant to participate in a new planning process and/or community forums. Therefore, Madera County Department of Behavioral Health Services did extensive focus groups and key informant interviews. These were scheduled to accommodate the stakeholder's schedules, rather

than expecting stakeholders to adjust their schedules to accommodate the Department's schedule. These were done at the informant's place of business, etc., so they didn't have to come to us. Staff was flexible and met on days and times that were convenient for the participants.

In an effort to provide outreach to the Native American population, MHSA staff continued to make regular contact with the various tribes in the community. Staff worked with local citizens who were already accepted by the Native American community. MCBHS worked with members of various boards, North Fork Rancheria of the Mono Indians Tribal TANF, Picayune Rancheria of the Chukchansi Indians Tribal Council, etc., to listen to their concerns and recommendations, while educating them on the MHSA.

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 (TAY).

Listed below from the PEI state guidelines are the PEI Priority Populations and Required and Recommended Sectors and Partner Organizations for Prevention and Early Intervention Planning.

PEI Priority Populations
Underserved Cultural Populations
PEI projects address those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, etc.) and would benefit from Prevention and Early Intervention programs and interventions.
Individuals Experiencing Onset of Serious Psychiatric Illness
Those identified by providers, including but not limited to primary health care, as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service.
Children/Youth in Stressed Families
Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of care giving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.
Trauma-Exposed
Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.
Children/Youth at Risk for School Failure
Due to unaddressed emotional and behavioral problems.

PEI COMMUNITY PROGRAM PLANNING PROCESS

Form No. 2

Children/Youth at Risk of or Experiencing Juvenile Justice Involvement
Those with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through Community Services and Supports (CSS).

Required Sectors for Planning	**Recommended Partner Organizations for Planning**
Underserved Communities	Individuals, families and community-based organizations (administrators and front line staff) representing Native American, African American, Hispanic/Latino, Asian/Pacific Islander, Refugee, Immigrant, Lesbian/Gay/Bisexual/Transgender/ Questioning and other underserved/unserved communities
Education	County offices of education, school districts, parent/teacher associations, Special Education Local Plan Areas, school-based health centers, colleges/universities, community colleges, adult education, First 5 Commissions, early care and education organizations and settings
Individuals with Serious Mental Illness and/or their Families	Client and family member organizations
Providers of Mental Health Services	Mental health provider organizations
Health	Community clinics and health centers, school-based health centers, primary health care clinics, public health, specialist mental health services, specialist older adult care health services, Native American Health Centers, alcohol and drug treatment centers, developmental disabilities regional centers, emergency services, maternal child and adolescent health services
Social Services	Child and family welfare services, CalWORKs, child protective services, home and community care, disability services, adult protective services
Law Enforcement	County criminal justice, courts, juvenile and adult probation offices, judges and public defenders, sheriff/police
Recommended Additional Sectors for Planning	**Recommended Partner Organizations for Planning**

Community Family Resource Centers	Multipurpose family resource centers, spiritual/faith centers, arts, sports, youth clubs/centers, parks and recreation, homeless shelters, senior centers, refugee and immigrant assistance centers
Employment	Public and private sector workplaces, employee unions, occupational rehabilitation settings, employment centers, Work Force Investment Boards
Media	Radio, television, internet sites, print, newspaper, ethnic media

As indicated by the participants in the planning committees, focus groups and key informant interviews, representatives in each category of all required and recommended sectors were engaged in the PEI planning process. Individuals from priority populations were engaged. When it was not possible to engage the individuals directly, members of organizations serving these populations were engaged in the planning activities.

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

a. The date of the public hearing:

The public hearing was held on December 3, 2008 at the Madera County Department of Behavioral Health Services Mental Health Board (MHB) meeting.

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.

Madera County's PEI component or its Executive Summary was circulated to representatives of community stakeholder interests via email, posted on the Madera County MHSA website for thirty days in English and Spanish translation was available. Public notices were posted at all BHS and major county Department sites. In addition, notices were posted in English in local newspapers as well as a notice posted in the Spanish language newspapers.

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

d. The estimated number of participants:

302 Key Informant Interviews and Focus Groups
48 Planning Committees – SSC, PEI and Consumer and Family
55 Surveys

PEI COMMUNITY PROGRAM PLANNING PROCESS
Form No. 2

County: Madera **PEI Project: The Connected Communities Project** **Date:**

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	☒	☒		

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

Stakeholder Input

Madera County's stakeholder input process started with the CSS planning during the first half of 2005. A letter and survey (English and Spanish) were sent to all consumers of public mental health and alcohol/drug services and to over 15,000 individuals who live or work in Madera County. The letter described the intent of the Mental Health Services Act and the establishment of a Leadership Team, Advisory Panel, and Targeted Task Groups (TTGs) to develop the County's Mental Health Services Act Community Services and Supports Three-Year Program and Expenditure Plan. Clients, family members and members of the community were invited to participate in groups/activities and to complete a questionnaire. The questionnaire focused on services needed and concerns with public mental health services.

Clients, family members and the community/stakeholders were asked to identify concerns regarding untreated mental illness. This was done in the four age groups targeted by the Mental Health Services Act. The letter gave a name, e-mail address, and telephone number of the individual who was coordinating the planning process in the event they preferred to talk to someone directly. Clients received training to become distributors of the surveys throughout the County. They performed this service at stores, swap meets, homeless shelters/meal sites, churches, counseling centers, apartment complexes, and by going door-to-door in their communities. Over 500 consumers and family members provided input to the planning process through surveys, forums, Leadership Team, Targeted Task Groups and individual contacts with the MHSA Plan Coordinator. Consumers and family members continued to serve on the Targeted Task Groups to develop procedures for implementing the new CSS programs.

For the second round of MHSA planning, Madera County's community input process took twenty-one months during 2006-08. The PEI planning process took approximately eleven months. Stakeholder participants included clients, family members, low-income communities, ethnic minorities, various age groups, migrant and new immigrant populations, traditionally marginalized populations, community leaders, associated agencies and MCBHS staff. When required, meetings were conducted in both English and Spanish. Interpreters for the deaf and hard of hearing were also available. Meetings were held in handicapped accessible locations. Focus groups and key informant interviews and community forums throughout the Madera County area were conducted (see Form 2, question 2 for the list of participants). Individuals representing diverse ethnic backgrounds such as Latino, Native American, African-American, Caucasian and monolingual Spanish were represented. The MHSA Division Manager and MHSA Coordinator also attended regular meeting held by various community groups. In addition, they took the input and planning process to stakeholders, clients

and family members to ensure that as many individuals as possible had the opportunity to become familiar with the PEI planning process and were able to provide their input.

The statements of need from the 2005 MHSA community input process were reiterated and reconfirmed in the 2007-08 PEI community input process. Input from both efforts were considered and integrated into this plan.

During the initial 2005 planning process for Madera County's CSS Plan, the PEI community issues identified for the mentally ill were:

WECAN (Wellness Empowerment Consumer Action Network)	• More groups and classes for consumers. • A drop-in socialization center in downtown Madera.
Family Member Forums at Madera, Chowchilla, and Oakhurst Counseling Centers	• More groups • Social activities • Education about mental illness • More proactive intervention when a consumer begins to have symptoms develop or return • Take mental health services to the streets • Use community resources to provide training • Train police officers regarding mental illness • Provided information to the public regarding mental illness • Increase school-based services • Provide support for children of mentally ill persons
Boot Camp and Parents of Children/Youth Served by BHS Programs	• More services for youth after school • Classes and groups for parents to teach them how to help their children • More substance abuse counselors
Countywide MHSA Community Letter and Survey	• Provide more information to the public regarding mental health services available.

	• Increase the number of providers available to reduce waiting times and increase the time spent with clients (Psychiatrists, counselors, case managers) • Increase the numbers and types of services available including groups, classes, activities, and drop-in center • Increase services and supports to families • Make services more accessible and affordable to all who need them • Provide more services and supports (including housing) to the homeless • Increase substance abuse counseling for individuals with co-occurring disorders. • Increase services to children and youth in schools and juvenile justice programs. • Hire more bilingual/bicultural staff
Community Forums and Focus Groups in Oakhurst, Madera, and Chowchilla	• More services for Native Americans • Specialist for senior citizens. More outreach to older adults • Nurturing parent program in the community. • Family support groups including grandparents raising their grandchildren • Adult Day Care for adults with severe mental illness. Provide childcare • Drop-in Center • Peer counseling program – especially for older adults • Mental health training for primary health care providers • Brochures regarding mental health service for law enforcement to hand out • Integrated services in one location, e.g. social services, mental health, alcohol and drug counseling, health care • Parenting classes, especially for those in Probation system • Reduce the stigma associated with receiving mental health services • Public education regarding mental health services available in the mountains • Parenting classes for court-ordered clients

	• Classes for older adults in non-clinical settings that deal with mature adult's needs such as depression, grief, alcoholism, understanding dementia, etc. • Periodic column in local newspaper providing information on mental health and substance abuse issues • Clinician time at school sites. • More community education regarding mental illness. • Anger management classes for children. **Spanish Speaking Forum in the City of Madera** • Provide family support group in Spanish. • Re-open the WECAN Canteen. • Provide more educational programs. • Provide more outreach to the community. • Provide home visits. **Seniors Forum at the Frank Bergon Senior Center in Madera** • Primary concern - people in the community do not know how to get mental health services when they need them **Gay, Lesbian, Bi-sexual and Transgender (GLBT) Focus Group** • Develop a service center for GLBT people in Madera **Native American Focus Group at the Sierra Mono Museum** • Provide more support for family members • Provide more services for children with co-occurring substance abuse • Provide more information to Native Americans regarding services available

PEI COMMUNITY PROGRAM PLANNING PROCESS
Form No. 2

The major issues selected by the 2005 CSS community stakeholder process, by age group, to be the focus of the MHSA services over the first three years are indicated by an asterisk (*) placed next to these issues. Many of these issues are common to more than one group.

- Homelessness*
- Isolation*
- Criminal Justice/Juvenile Justice involvement/Incarceration*
- Out of home placements/Institutionalization*
- Inability to obtain education/employment*
- Involuntary Treatment/Hospitalization
- Transportation

During the 2008 PEI planning process, the community continued to state that the above issues continued to be relevant. Specifically, during the PEI planning process, the community was enthusiastic in their response for the Mental Health First Aid program and the Promotores model of services as a program which would accomplish several needs they identified in the current community planning process. Those needs included;

- Obtaining basic education about mental illness
- How to respond to those experiencing mental health issues in a supportive manner
- Reduce stigma against mental illness
- Reduce isolation
- Provide early intervention
- Prevention of mental illness or from the illness progressing
- An entry point to obtain employment in the system
- Utilizing existing persons in the community as a resource for those individuals reluctant to seek services in a traditional setting

It was mentioned over and over that the entire community could benefit from Promotores and Mental Health First Aid training including law enforcement, schools, transportation, etc.

Survey Results

English

- 83% of respondents identified as a member of an agency/organization that works with people with mental health issues or Spanish or a community member interested in improving mental health services.
- 74% of respondents were female
- 78% of respondents were between the ages of 25 and 59 years of age.
- 58% of respondents lived in the City of Madera
- The top three responses for the most important issues to address 1) Gang/school violence, 2) School failure, and 3) Number of undetected mental health problems
- 52% of respondents stated that there is an inadequate amount of prevention and early intervention services in Madera County
- The top three responses for the settings that would be the most effective for identifying person with mental illness were 1) Schools, 2) Doctor's offices or clinics and 3) Social Services (e.g. WIC, CalWORKs)
- The top two responses for the best approaches for addressing mental health prevention and early intervention in Madera County were 1) Provide early and periodic screening, diagnosis and treatment for mental illness (at primary health care, school/college, preschool, child care, and workplace settings and 2) Train educators, law enforcement, emergency responders, church leaders, transportation personnel, retail personnel, volunteers, doctors, nurses and nursing home staff on early recognition and response to mental illness
- The number one response to the priority population by age group was persons between the ages of 11 and 15 years of age
- 58% of respondents stated that persons between the ages of 0 and 24 should be the emphasis of Madera County's PEI services
- The top two responses for the best ways to reach hard to reach populations were 1) Schools and a two way tie for 2) Social Services and 3) Community Events

Spanish

- 57% of respondents identified as a community member interested in improving mental health services
- 68% of respondents were male
- 68% of respondents stated they were between the ages of 16 and 24 years of age

- 71% of respondents stated that they lived in the City of Madera
- 43% or respondents stated that the following community issues were more important to them (a five way tie) 1) Unemployment, 2) Community/domestic violence, 3) Gang/school violence, 4) Lack of resources for Parents of Infants, 4) Education for the public, law enforcement personnel and other about how to deal with mental illness and mental health issues
- 52% of respondents felt that there were inadequate mental health prevention and early intervention services in Madera County
- 57% of respondents stated the most effective setting for early identification of mental illness and early intervention was doctor's office or clinics. The next most frequent response (41%) was a three way tie for Schools, Faith based organizations and Workplace
- The two best approaches for addressing mental health prevention and early intervention were 1) Provide education and support services for parents, grandparents and care givers at community centers, schools, churches and other community settings and 2) Work-based programs (e.g. Employee Assistance Programs, Workplace Health Promotion Programs)
- 43% respondents stated they were between the ages of 11 and 15 years of age or 60 or more years of age
- The top two responses for the best ways to reach hard to reach populations were 1) Medical Clinics and a four way tie for 2) Community Centers, Community Events, Child Care Providers (e.g. Day Care, Head Start), Through radio, television, newspaper, email or internet, and In homes.

Focus Group Results

Priority Populations

The focus groups identified top two priority populations for PEI were the Trauma Exposed and Children/Youth in Stressed Families. The table below indicates the frequency of identification of a population as a priority. Many of the stakeholders felt that these population categories were not discrete; there was significant overlap in all of the categories and the people that were a part of all of the categories were often the same people and/or from the same families. Because of this, they were often reluctant to identify prioritization using the system of categorization provided in the PEI state guidelines.

1. **Trauma-Exposed - 14**
2. **Children/Youth in Stressed Families - 14**

3. Children/Youth at Risk of or Experiencing Juvenile Justice Involvement-12
4. Individuals Experiencing Onset of Serious Psychiatric Illness – 12
5. Underserved Cultural Populations – 4
6. Children Age 0 - 5

The recommendations most frequently given during the focus groups are in **bold** print. The numbers next to the category identify the frequency at which they were given, if they were mentioned more than once.

Type of Services	**Where services should be provided**	**Who should provide the services**
• **Counseling– 14** Drop in counseling services o Family and youth counseling o Family counseling - 3 o More one to one counseling • **Training for community members/stakeholders regarding identifying mental illness and how to address it- 8** o Public awareness o Mental Health First Aid • **Peer counseling/peer support/developing support network- 15** o Children and Family Drop in Center • **Parenting training - 7** o Foster parent education • **Education regarding available mental health resources - 9** • Education for Primary Care, Family, Public Guardian, Housing Providers, and social services regarding developmentally appropriate behavior - 4 o Training regarding signs of emotional distress	• **Schools – 21** • **"Where people are"/where they congregate," On the street," communities -6** o Community sites-1 • **Clinics- 4** • **Churches-5** • **Primary care-6** • **In homes-4** • Not at school • Counseling centers • Central locations - 2 • Parks-2 • Senior centers-2 • Community centers • Community Agencies-2 • Where youth feel most comfortable • Workforce sites • Homeless shelters/homeless-1	• **Education staff/schools - 9** o Teachers • **Community members/community - 9** o Community liaisons o Community leaders • **Clinicians/therapists-7** • Care workers • Consumers • Parent partners • Mental health professionals • Community agencies - 4 • Faith based organizations-4 o Religious leaders • Medical providers/Health - 7 • Public health • Legal system • First responders • Government • Families • Counselors-4 • Case managers • Mental Health Staff-4

PEI COMMUNITY PROGRAM PLANNING PROCESS
Form No. 2

• Education of school staff to identify potential problems early • Education regarding independent living skills/social skill building/life skills – 5 • Physician/psychiatrists evaluation possibly leading to beneficial meds skill assessment to give individual hope of how to constitute normal activities or alternate activities • Case Management Services - 2 • Diagnosis (Understanding?) • Outreach and engagement • Education for families of people with mental illness -2 o Education for families involved in the legal system, children labeled as challenging in schools • Services to address stigma – 5 o (Recovery) success stories given in person/public speaking • Anti-discrimination activities • Early identification through diversion services in court • Follow up services • Group therapy • Rehabilitation - 2 • Services that facilitate access to mental health services and stigma as an issues as a barrier to seeking care - 4 • Resiliency Building for families, as it relates to mental health and school success • AOD education/substance abuse counseling - 4 • Information regarding public assistance	• Access to services in the community; not just clinics • One stop center • Co-location of services and braiding mental health services with social services. • Kaiser/medical • Mental Health Clinic-1 • Family Resource Centers • First 5 - 1 • Libraries • Juvenile detention centers • Everywhere—all areas of the County • California Youth Authority • Hospitals • Parks • Mountain Area • Drop-in-Center • Not at Mental Health • Parent Groups • After School Activities • Madera Oakhurst, Chowchilla • AOD Clinics • Mental Health Clinics • Community Forums	• Interns with Supervision-2 • Student with supervision • Well trained paraprofessionals • Develop partnerships with community partners, agency collaborations, support systems - 1 • Social Services-3 • Hospital • Law enforcement-2 • People trained in assessing needs • Social workers • Caregivers Prevention Services • Others with training • Doctors/Physicians -2 • Volunteers • Multidisciplinary Teams • Probation officers - 2 • Paraprofessionals • Crisis workers • All public agencies-2 • Youth authority (only if it is not using scare tactics) • Qualified Individuals • Community Educators • Trained Licensed Staff • Businesses • Primary Care

• MDT approach for all ages/collaborative teams - 2 • Develop a behavioral health CBO in Madera • Grief Counseling • Trauma counseling (individual and groups) • Anger management - 2 • Psychiatric evaluation • Services for runaway and incorrigible children • Tutoring • After school programs PEI • Translation services/Services in Spanish - 2 • Assessment that includes explanation of mental health services • Interventions • Evidence Based Practices		

Stakeholder Steering Committee

The PEI community needs and barriers to service access identified by this committee are:

1) Services in Oakhurst,
2) Community based services for youth,
3) Working with the faith community,
4) Insufficient funding for prevention and early intervention outreach and engagement activities,
5) Difficulty connecting with the Native American community,
6) Suicide prevention services,
7) Transportation to from the mountain areas to services,
8) What services are currently being provided,
9) Parent education
10) Suicide prevention training

11) Training for consumers to tell their story
12) Supportive services to help SED high school students finish high school; with emphasis on at risk foster youth
13) Independent living skills
14) Cultural competency training; specifically regarding Latinos and LGBT+
15) Youth drop in centers
16) Homeless outreach services

Data Analysis

Madera County is located in the exact center of California, in the heart of the Central Valley and the Sierra Nevada mountain range. It is one of the fastest growing counties in California. With rich fertile farmlands, Madera County has a vibrant agribusiness economy which employs 30% of its 146,300 residents. Madera is projected to have a population of 224,600 by 2020.

Between 2005 and 2006, the Madera County population grew by 9%, from 134,200 to 146,300. The number of persons per square mile in Madera County is 57. Almost 45% of the documented population is Latino/Hispanic. In 2005, 20% of the population in Madera was foreign born, 30,000 of which were migrant and seasonal farm workers.

In 2000, 31% of residents were unemployed. 58% of students receive free/reduced price lunches and 1,610 people are homeless (2006). Nearly 17% of residents live in poverty (2005). The median household income is $46,800. The County has, on average, 300 youth in foster care or group homes each month. About 16% of the population is disabled. The County is twelfth in the state for adults arrested for drug violations and thirty-ninth for alcohol violations. The 11-13% of the county population is over age 65; 8%-13% of these individuals are Latino and 72%-81% are White Non-Latinos. Of the 65 and older population, 29%-33% has an income below 200% of the federal poverty level. The California Health Interview Survey indicated that almost 80% of the teens that were at risk for depression and could have benefited from counseling services in 2003 and 2005, did not receive these services. Most community services are located in the County seat, but many residents are unable to access needed services due to limited public transportation. More than 11,000 residents need mental health services.

Generally, the most underserved groups in Madera are Latinos, Native Americans, Older Adults, TAY and LGBT+.

PEI COMMUNITY PROGRAM PLANNING PROCESS
Form No. 2

CY2006 Medi-Cal Approved Claims Data

Element	Madera	Small MHPs	Statewide
Penetration rate	4.85%	8.10%	6.28%
Penetration rate – Hispanic	2.67%	3.92%	3.24%

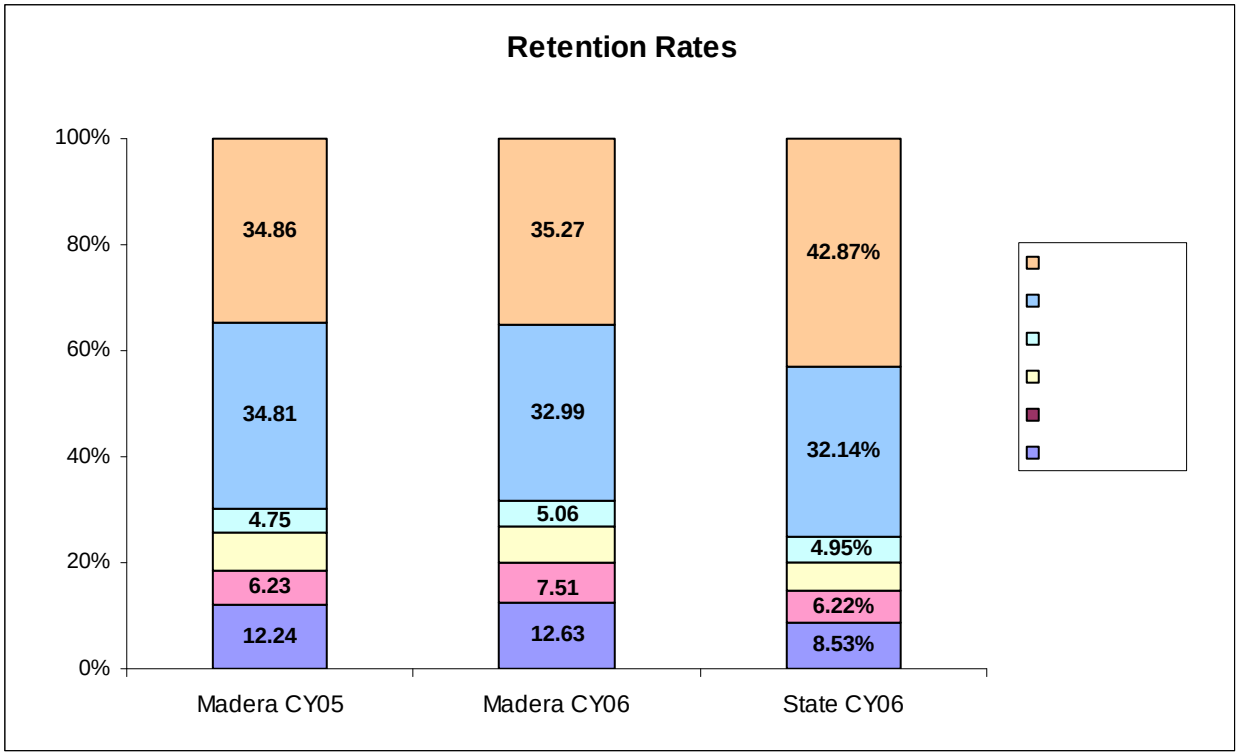
This information in the table above is current information from Medi-Cal approved claims data system. Madera County wants to provide better access to services for its Latino and Native American as well as other minority populations. While the overall statistics of people being served through "traditional" mental health services reflects the overall population of Madera County, Madera County BHS still needs to improve access and services to increase its Medi-Cal penetration rate. MCBHS believes that it can do this through the prevention, early intervention programs described below. Madera has first generation Latinos who would not traditionally seek mental health services. The Native American community would also not traditionally seek services through a mental health clinic location. Therefore, Madera County BHS proposed the following programs to address these issues and provide prevention and early intervention services in the communities and by community partners. In addition, a significant number of clients only attend a one to fours service contacts before discontinuing treatment. Not completing the course of indicated treatment tends to have negative outcomes. The Promotores model has been shown to be an effective services engagement model in recruiting underserved populations into services and supporting them to remain engaged in service and completes the course of treatment.

Retention Rates

Figure 1 displays the MHP's CY05 and CY06 Medi-Cal approved claims data showing retention rates – the percentage of beneficiaries who received the specified number of services during each annual period. Statewide data for CY06 is also presented for comparison. Figure 7 follows, depicting the raw numbers of beneficiaries who received the specified number of services, as well as the average amount of approved claims for each category for the MHP and the state.

PEI COMMUNITY PROGRAM PLANNING PROCESS
Form No. 2

Figure 1



General Access Disparities and PEI Related Services Needs for Latinos and Native Americans

The information below was taken from a 2005 fact sheet that was revised by Yvette G. Flores, PhD, clinical psychologist, and Professor of Chicana/o Studies, UC Davis. The information presented in this fact sheet was assembled by Xóchitl Castañeda, California-Mexico Health Initiative Director, with the support of the CMHI staff. This information is available at the Binational Week website sponsored by UC Berkeley at: http://hia.berkeley.edu/binational.shtml

General Population

- Suicide is the eighth-leading cause of death in the United States, and 80% to 90% of people who die by suicide are suffering from a diagnosable mental illness.

- Almost one-third of Americans have had one or more serious mental disorders during their lifetime. At any one moment, major mental disorders affect almost 15% of the nation's population.
- Studies have consistently shown that rates of substance abuse are positively linked with rates of mental disorders.

Latinos and Access to Care

- Among Latino Americans with a mental disorder, less than 1 in 11 contact mental-health specialists, and less than 1 in 5 contact general health-care providers. Among Latino immigrants with mental disorders, less than 1 in 20 use services from mental-health specialists, and less than 1 in 10 use services from general health-care providers.
- While the percentage of mental-health professionals who speak Spanish is not known, only about 1% of licensed psychologists who are also members of the American Psychological Association identify themselves as Latino. There are only 29 Latino mental health professionals for every 100,000 Latinos in the United States, compared to 173 non-Latino white providers per 100,000 non-Latino whites.
- Adult Mexican immigrants who have lived in the United States less than 13 years have lower rates of mental disorders than Mexican Americans born in the United States, and adult Puerto Ricans living on the island tend to have lower rates of depression than Puerto Ricans living on the mainland. This information suggests that factors associated with living in the United States are related to an increased risk of mental disorders.
- The incarcerated are at high risk for mental disorders compared to those who are not, and Latino men are nearly four times as likely as white men to be imprisoned at some point during their lifetimes.

Latinos and Insurance

- The lack of health insurance is a significant barrier to mental health care for many Latinos. Although Latinos constitute 12% of the U.S. population, they represent nearly 1 out of every 4 uninsured Americans. Nationally, 37% of Latinos are uninsured—more than double the percentage for whites.
- Studies have consistently shown that people in the lowest strata of income, education, and occupation have higher levels of psychological distress and are about 2 to 3 times more likely than those in the highest strata to have a mental disorder. Latinos are almost 3 times as likely to live in poverty as whites.
- In 1999, the per capita income of Latinos was less than half that of whites ($11,621 compared with $24,109).
- The low rate of health insurance enrollment among Latinos is driven mostly by Latinos' lack of employer-based coverage—43% compared to 73% for non-Latino whites. Medicaid and other public coverage reach 18% of Latinos.8

Culturally Bound Symptoms

- Non-Latino providers may have trouble diagnosing certain symptoms among Latinos as a result of cultural differences.
- Latinos often report symptoms differently than non-Latinos, such as *susto* (fright), *nervios* (nerves), *mal de ojo* (evil eye), and *ataque de nervios* (an attack of nerves).
- Latinos tend to experience depression as bodily aches and pains (like stomachaches, backaches, or headaches) that persist despite medical treatment. Latinos often describe their depression as feeling nervous or tired for a prolonged period.

Latino Adolescents

- Latino youth experience or engage in proportionately more anxiety-related and delinquency problem behaviors, depression, and drug use than do non-Latino white youth.
- The current cost of treating children and adolescents for mental illness is estimated at nearly $12 billion, significantly more than expected based on previous estimates. Despite these annual expenditures, nearly three-quarters of psychologically troubled youth do not get the care they need. Latino and African-American children are the most likely to go without needed care.

Latinas

- Depression is an illness that affects the body, mood, and thoughts. The rate of depression in American or other Latinas is about twice that of men. Among the various causes for depression are changes in brain chemistry, living through painful and difficult events, and even taking medications for other illnesses.
- One study found that Latinas who immigrate to the United States without their children were 1.52 times more likely to experience depression than Latinas who immigrated with their children or who had none.
- According to the 2003 Youth Risk Behavior Survey, Latina adolescents are more likely to feel sad or hopeless, seriously consider attempting suicide, and make a suicide plan than non-Latina white or African-American adolescents. Of the three groups, Latina adolescents in grades 9-12 have the highest attempted suicide rate in the United States, almost 1.5 times that of non-Latina white and African-American females of the same age.

Native Americans and Mental Health Services

The information below regarding the American Indian and Alaskan Native Communities was taken from a 2006 fact sheet prepared by the National Alliance on Mental Illness (NAMI). This is available at NAMI website at http://www.nami.org

Cultural differences exist in seeking mental health services and in reporting distress.

- An historical distrust of the outside population exists among many American Indian communities. Individuals tend to have negative opinions of non-Indian health service providers, and traditional healing is used by a majority of Native Americans.
- Compared to the general population, AI/AN individuals tend to underutilize mental health services, have higher therapy dropout rates, are less likely to respond to treatment.
- A study of adult American Indians of a Northwest Coast Tribe demonstrated little differentiation between physical and emotional distress.
- The words “depressed” and “anxious” are absent from some American Indian and Alaska Native languages. Different expression of illness, such as *ghost sickness* and *heartbreak syndrome,* do not correspond to DSM diagnoses.

Living in a stressful environment has potentially negative mental health consequences.

- Approximately 26% of AI/AN live in poverty, as compared to 13% of the general population and 10% of white Americans.
- In the Northern Plains study, 61% of the children had experienced a traumatic event.
- The American Indian and Alaska Native population reports higher rates of frequent distress than the general population.

High prevalence of substance abuse and alcohol dependence is tied to a high risk for concurrent mental health problems.

- Alcohol abuse is a problem for a substantial portion of the American Indian adult population, but widely varies among different tribes.
- The Great Smoky Mountain study found that though prevalence of psychotic disorders is similar among American Indian and Caucasian American youth in the same geographic area, there are significantly higher rates of substance abuse in American Indian children.
- A study of Alaska Natives in a community mental health center found substance abuse was the reason for 85% of men and 65% of women to seek mental health care.
- In a study of Northern Plains youth, of those diagnosed with any depressive disorder 60% also had substance disorders.

The prevalence of suicide is a strong indication of the necessity of mental health services in the AI/AN community.

- Alaska Native males have had one of the highest documented suicide rates in the world.
- Suicide rates are particularly high among Native American males ages 15-24, who account for 64% of all suicides by AI/AN individuals.
- A study of Eskimo children in Nome, Alaska found previous suicide attempts to be one of the most common problems for those seeking mental health care.

Mental health services are available for the AI/AN community, but are in need of improvement.

- The Indian Health Service funds 34 urban Indian health organizations, which operate at 41 sites located in cites throughout the United States offering a variety of care including mental health services and alcohol and drug abuse prevention. Approximately 605,000 American Indians and Alaska Natives are eligible to utilize this program. However, only 1 in 5 American Indians reported access to this care in 2000.
- Because Native tribes are not defined by state boundaries and many Native families have inadequately addressed dual-nationality issues, many tribal and intertribal family-run organizations face difficulty in obtaining critical funds through Federal grants.
- Grassroots organizations such as Intertribal Voices of Children and Families create a network to connect Native families across tribes to influence the improvement of mental health services.

<u>Depression and Suicide in the San Joaquin Valley</u>

The information below was taken from the Centrally Valley Health Policy Institute report titled HEALTHY PEOPLE 2010 A 2007 Profile of Health Status in the San Joaquin Valley.

"The 2005 California Health Information Survey CHIS found only 5.6% of San Joaquin Valley adults age 18 and older who reported feeling downhearted and sad all or most of the time (an indicator for major depression), saw a health professional. This was slightly lower than the state percentage of 8.3%. The percentage has drastically decreased since the 2001 CHIS. In 2001, 17.6% of San Joaquin Valley adults and 20.2% of California adults who reported depression were seeing a health professional. According to 2005 CHIS, San Joaquin County indicated the highest percentage (8.6%) among the eight Valley counties, yet still well below the HP 2010 objective. Results from a national telephone survey conducted in 1997-98 showed that 17.0% of adults with a probable depressive or anxiety disorder saw a health care

provider (Young, Klap, Sherbourne, & Wells, 2001). The rates in the Valley, state and nation for this indicator were all well below the HP 2010 objective of 50%.

Suicide is the most dreaded complication of major depressive disorders. A review of psychological autopsies conducted by Angst, Angst, and Stassen (1999) estimated that approximately 10-15% of patients formerly hospitalized with depression committed suicide. When looking at all deaths by suicide, approximately 20-35% of deaths were among individuals who had been diagnosed with a major depressive disorder and received treatment at some point (Angst et al., 1999). In 2002, 132,353 individuals in the U.S. were hospitalized following a suicide attempt. An additional 116,639 individuals were treated in emergency departments following a suicide attempt and then released (CDC, National Center for Injury Prevention and Control, 2004). In 2004, 1.4% of the total number of deaths in California was the result of suicide (RAND California, 2004).

An increase in the suicide rate is evidence of the lack of access to mental health care. There has been an increase in the rates, per 100,000 persons, of deaths from suicide in six of the eight San Joaquin Valley counties between 2001 and 2004. However, rates have decreased since 2003. Suicide rates in California as a whole remained stable at 9.3 in 2001 and 9.4 in 2004 (Rand California, 2004). In 2004, only one of the San Joaquin Valley counties (Madera) met the HP 2010 objective of reducing the suicide rate to 5.0 suicides per 100,000 persons."

PEI PROJECT SUMMARY

Form No. 3

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

(Briefly describe the PEI project)

THE CONNECTED COMMUNITY PROJECT

Populations Served;

- **Services to Trauma Exposed,**
- **Services To Children And Youth In Stressed Families,**
- **Services to Individuals Experiencing the Onset of Psychiatric Illness**

Madera County plans on using a multi-pronged approach to providing services to the trauma exposed, children and youth in stressed families and services to individuals experiencing the onset of psychiatric illness. The approach includes the following services which will be under the umbrella of the program called the Connected Community Project. Since one approach may not be appropriate for all, given the cultural diversity of Madera County, several approaches are described that will incorporate best practice and evidence based services to the children, youth and families of Madera County. This approach addresses the priority needs identified in the PEI planning process including focus groups, key informant interviews, surveys, etc.

As previously noted in this plan, there were consistent themes noted in the planning process. One of those themes was for parenting classes for the community at large, not just MCBHS clients. Another strong theme was training about mental illness for specific organizations in the community, law enforcement, schools and the community at large. Clients and family members wanted the MCBHS Wellness and Recovery Center services (Hope House) expanded. In response to these requests, MCBHS will be initiating the Connected Community Project.

The Connected Community Project will have several components. One of those will be the client directed wellness/empowerment center also known as Hope House. Hope House will expand to the mountain region as well as the rural community of Chowchilla. Another will be an outreach component offered to the community with an emphasis on underserved and unserved individuals. That component will consist of Promotores/Community Workers who will be paid/volunteer staff through Hope House. These Promotores/Community Workers will be clients/family members.

PEI PROJECT SUMMARY

Form No. 3

Another component will be an expansion of training/consultation for educators, law enforcement, organizations, faith based communities and the public. There will be oversight for these components through a Division which will house the MHSA II components. There will be oversight of the programs through administration and a special unit. That unit will consist of a Mental Health Services Supervisor, a Licensed Mental Health Clinician, a Health Educator and various administrative support staff necessary for the day-to-day functioning of the programs.

MCBHS is requesting a Supervising Mental Health Clinician and Licensed Mental Health Clinician to supervise the ongoing community education and cultural competency component of its programs. These staff will supervise the training received through Mental Health First Aid (MHFA), CASRA, and the various parenting programs (Love and Logic, Incredible Years, Center for the Improvement of Child Caring, etc.). They will act as a resource for Hope House, the community and schools. Additional administrative support and Quality Improvement/Assurance staff is also being requested. There will be a Division Manager and a MHSA Program Manager provided through these funds.

Transfer of Position from CSS Funds to PEI Funds

Currently, an approved Health Education Coordinator position is currently being paid out of MHSA CSS funds. Originally, this position was created using CSS funds as that was the only MHSA funding component available although this position provided prevention/early intervention and outreach services. This position will be transferred from CSS to PEI funding upon approval of this plan. This position currently provides educational information and training to clients, family members and the community. The topics include prevention information in regards to mental health and health issues. This staff person would continue in this role and provide consultation to the Hope House Promotores/Community Worker staff that would provide prevention services to the community.

PEI PROJECT SUMMARY

Form No. 3

The Connected Communities Project

Hope House Expansion and Transfer of CSS to PEI Funds

- **Services to Trauma Exposed—expansion of services to Oakhurst for adults, youth and families**

- **Services to Children and Youth in Stressed Families—expansion of services to TAY and families**

- **Services to Individuals Experiencing the Onset of Psychiatric Illness—expansion of Wellness/Recovery Hope House services to Mountain Area and if funds allow, the Chowchilla area, expansion of services to TAY and families, expansion of services to Older Adults**

(Briefly describe the PEI project)

During the initial MHSA planning process, the stakeholders and community indicated they wanted a client socialization center located within downtown Madera. As a result, Hope House was developed utilizing MHSA CSS funds. Hope House is the MCBHS drop-in client empowerment/socialization center. Since its inception, it has been extremely successful. Clients have enjoyed the camaraderie with other clients. They have been involved in the day-to-day operations of the program.

Since the opening, services have expanded from a drop-in/socialization center to a Wellness/Recovery Center at the direction of the clients who participate in the program. Wellness Recovery Action Plan Training has been realized. Clients have been hired as staff for the program. Peer support groups are currently operating at the facility. Town Hall meetings are held at least once a month to give additional client input on the day-to-day operation of the program along with planned activities. Culturally appropriate activities have been an active part of the program. These comprise many of the services offered to individuals experiencing the onset of serious psychiatric illness. All of these are prevention

activities in that they help to stabilize the client from needing higher level services. As a result of the expansion of services offered through Hope House, MCBHS is requesting the funding will transfer from CSS dollars to PEI.

Since many of the activities offered at Hope House are preventative in nature, the transition to the PEI funding stream is appropriate given the work that this program does to assist clients and families with the onset of their mental illness through education, support and specialized client driven activities. These services are preventative because they empower individuals to continue on their path to wellness and recovery. They help to increase capacity and decrease mental health disparities among unserved and underserved cultural populations. Additional funding would allow Hope House to also outreach into the community on a more frequent basis as well as prepare clients and family members to work within the mental health system. Currently there are clients who are full and part time staff members of Hope House. They have gone through CASRA training as one of the preparations for employment (see the Connected Community Project for a description of CASRA training).

MCBHS is looking to expand the roles of clients/family members by having them perform as Promotores/Community Workers in the community (see Promotores/Community Worker description below). Special outreach and prevention services would be developed for family members and unserved/underserved populations. Those populations include outreach to the Latino and Native American populations. Hope House would be developing client/family member positions to act as Promotores/Community Workers. These paid and volunteer positions will provide outreach as well as training on mental health issues, parenting issues, vocational issues, etc. As necessary, they would link clients to existing services and programs within MCBHS. MCBHS Clinical staff would also be available to consult with the Promotores/Community Workers on an individual basis regarding mental health issues/concerns.

Clients have indicated they would like to have the program expanded to Chowchilla and the mountain region of Madera County. Currently MCBHS transports clients to Hope House from these areas on a daily basis. Older Adults have requested their own programming geared toward their age group. There have been numerous requests to expand services to Transition Age Youth (TAY). MCBHS is requesting additional PEI funds to allow Hope House to expand to the mountain area and to develop special services for older adults and TAY. Through the proposed expansion of Hope House, special programming for these populations and areas of Madera County would be implemented. Once the expansion of services to Oakhurst proves successful, MCBHS will consider further expansion of services into Chowchilla.

Hope House will continue to be consumer-directed and operated through a contract with Turning Point of Central California, Inc. Programming is designed in direct relation to input of the participants. Hope House's mission is to end isolation and promote wellness through its activities such as peer support and education as well as self healing activities.

PEI PROJECT SUMMARY

Form No. 3

All programs are focused on empowerment and alternative approaches to healing. Services are delivered by client staff (both paid and volunteers) with oversight from Turning Point of Central California, Inc.; a nonprofit community based behavioral health services organization. Hope House conducts outreach and engagement activities in both Spanish and English and in an inclusive and culturally relevant manner.

They will serve at least 15 additional individuals on an annual basis, starting with FY 09-10, with the additional prevention and early intervention activities and expanded services.

(Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.)

The two key community needs were Trauma Exposed individuals and Children and Youth in Stressed Families. By expanding the scope and capacity of this program by adding youth and additional geographic areas, Hope House will better be able to meet the prevention needs of these populations. In addition, peer counseling, drop in services, undetected mental health problems, education regarding independent living skills, and community members as providers were identified as service needs. With its expanded capacity, Hope House will be able to expand its existing services to Individuals Experiencing the Onset of Serious Psychiatric Illness. These services fall into the full range of Prevention and Early Intervention Services, through the three areas of Prevention, Treatment and Maintenance. It would also be able to do all three Prevention and Early Intervention interventions of Universal, Selective and Indicated.

Because Hope House is not a mental health clinic, people are more likely to access its services. This helps to reduce stigma. It allows the general public to see and interact with persons experiencing mental health conditions, when they are functioning well as well as when they have been newly diagnosed. Hope House regularly has community events where mental health issues are discussed. It serves populations which experience higher rates of mental illness, such as the homeless. Because of the nature of the program, it is well positioned and designed to engage people before the onset of mental illness or before it becomes disabling. It is also able to support people to remaining in care, once they have entered services. Finally, through its volunteer and employment opportunities it supports sustained recovery and wellness.

(Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.)

PEI PROJECT SUMMARY

Form No. 3

Turning Point of Central California, Inc. is a contracted agency of MCBHS. MCBHS will work with Turning Point staff to implement the prevention, early intervention program proposed. The Madera site for services is a Wellness/Recovery Center. It is not in a traditional mental health treatment site. MCBHS, upon approval of this plan, will work with Turning Point to locate space in the mountain area of Madera County to provide the expanded Wellness and Recovery Center (Hope House) services. By providing the expanded services to this area, the community will have easier access to the prevention/early intervention services rather than being transported or having to find transportation to the city of Madera. Public transportation within Madera County is limited. It is difficult for our clients to access services because of transportation issues. The Hope House expansion to these areas will increase services to our clients, especially the Latino and Native American populations residing there. Older adults and TAY will also have easier access to the Center. Again, during the community/stakeholder process, having Wellness and Recovery Services within the mountain areas and Chowchilla was a priority that was mentioned. We will initially focus the development of expansion services in the mountain area and if successful, a similar expansion will occur in Chowchilla.

(Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served)

By expanding its services to youth, older adults and a strong emphasis on targeting Latinos and Native Americans through the expansion of its services to the mountain area, Hope House will address some of the needs identified in both the 2005 and 2007-08 CPPP. In addition, increasing services outside the city of Madera has been a consistent theme throughout all MHSA planning activities since 2005. Further Hope House will target unserved and underserved populations (Latino and Native American) through the proposed Promotores program.

(Highlights of new or expanded programs)

1. Expansion of program services to Transition Age Youth and Older Adult Services
   - Development of TAY peer counseling program
   - Development of a Senior Peer Counseling program
2. Services in the mountain area of Madera County
3. Outreach to rural areas of the county which currently do not have easy access to client directed services
   - Outreach to rural populations for development of Prevention/Early Intervention activities such as Wellness, Recovery Action Plan (WRAP) services, education about their mental illness, recovery and resiliency

4. Services specifically targeting Latinos and Native Americans
5. Services to individuals experiencing the onset of serious psychiatric illness
   - Education and support to clients and family members about mental illness and recovery

(Actions to be performed to carryout the PEI project, including frequency or duration of key activities. Key milestones and anticipated timeline for each milestone)

1. Obtain approval from Oversight and Accountability Commission on PEI plan.
2. Obtain approval from State DMH on PEI plan
3. Upon approval of the PEI plan, transfer funding from CSS dollars to PEI and expand programs
   - Within three months after approval develop contract to expand services
   - Within six months after approval, Turning Point will hire staff into position(s) to expand program
   - Services will be expanded to include activities for older adults and senior peer counseling by the fall of 2009
   - Services will be expanded to include activities for transition age youth by the fall of 2010.
6. Work with Hope House and the communities in the mountain region to set up the expansion of the program
   - Program will be set up for implementation in the fall of 2009, with at least one site located in the mountain region
   - Dependent on the successfulness of the expansion in the mountain area, MCBHS will consider establishing a site in Chowchilla.
7. Work with community members and organizations to implement program
   - Program will serve 15 additional clients June 30, 2009 for prevention services
   - Program will serve 15 clients by June 30, 2009 for early intervention services
8. Monitor and track progress of program and its goals/objectives

Promotores/Community Worker Program

(Briefly describe the PEI project)

Promotores/Community Workers are a liaison between the mental health system and community residents. They are known as guides to the public behavioral health care system. They can work in a variety of setting, such as clinics, hospitals, community-based organizations, faith-based organizations academic settings, etc. Their outreach activities take them into community centers, homes, the streets, etc. As paid staff or volunteers through the Hope House expansion, they can perform the following tasks;

PEI PROJECT SUMMARY

Form No. 3

- Provide cultural mediation between communities, health and human service systems,
- Provide informal counseling and support,
- Teach culturally and linguistically appropriate behavioral health education,
- Help clients and families navigate through mental health and other systems,
- Supporting clients and families through the service enrollment process,
- Promote self-directed change and community development
- Provide cultural mediation between communities and behavioral health service systems,
- Perform referral and follow-up services,
- Advocate for individual and community behavioral health needs,
- Be an active member of multidisciplinary treatment teams and services,
- Assure people get the services they need, and
- Build individual and community capacity.

Promotores/Community Workers are unique in certain ways:

- They may be neighbors to their clients and can relate from first-hand knowledge,
- There established relationships with community members can overcome distrust of the behavioral health care system and use their rapport bridge relationship gaps,
- Since they live in the community, they have a stake in eliminating barriers to care
- They have been shown to be an effective tool in greatly reducing services access disparities
- They are in a position to link behavioral health services directly to community residents.

Strength for this group lies mostly in its versatility. They may provide a variety of services, such as language translation, benefit information, and guidance in completing applications. They may take the lead in organizing and motivating their neighbors, or provide education to their clients on preventing illnesses and managing chronic diseases. They are a viable force in ensuring their neighbors' participation in social programs for which they qualify. One of the most important factors that make this service delivery approach effective is that fact that these individuals are already culturally competent with the people they seek to serve.

(Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.)

PEI PROJECT SUMMARY

Form No. 3

The Promotores/Community Worker program with its various training components supports the recommendations of our county stakeholders. It allows the community to obtain basic education about mental illness. It allows those in the community to respond to those experiencing mental health issues in a supportive manner. It reduces stigma against mental illness. It provides early intervention.

The proposed Promotores/Community Worker program will be provided training and certification in core competencies to develop the following skills: communication, interpersonal skills, service coordination, capacity-building, advocacy, teaching, organizational and knowledge base. These skills can be used in a variety of settings. While Promotores/Community Workers are best known in the Latino community, similar models have been used in African-American communities as well as both urban and rural settings. Madera County intends to purchase training for the Promotores/Community Workers (through WET funds). MCBHS would directly provide or contract with an agency to provide the Mental Health First Aid and the CASRA training. The training could be provided at one of the clinics or at an outside agency/location from treatment services. The number of people attending, dates, time of day and area in the county where the training would take place, would determine the location of the training. It is hoped that eventually, through the outreach of Hope House services to the Latino/Native American populations as well as TAY and the older adult expansion services, there will be Promotores/Community Workers in the Latino, African American and Native American communities as well as services to clients/family members living throughout Madera County.

The Promotores/Community Worker model provides opportunities for clients, family members and the community, to obtain employment in the mental health system, especially those that are from our underserved populations. The model helps promote cultural competence for those members of the minority cultures, who would be reluctant to seek services in a traditional outpatient setting, because it utilizes existing resources such as elders, natural healers. These are individuals the community would already turn to for information and support.

The services provided through Promotores/Community Workers would serve the priority populations identified in the planning process, children, adolescents, minority populations (Latinos, Native Americans), etc. The desired outcomes would include increased awareness of mental illness, reducing stigma, train members of the community, clients and family members to provide prevention/early intervention services, create a career pathway for clients and family members to enter the mental health work force.

Prevention/Early Intervention Activities Potential Outcomes

- Increased knowledge of social, emotional and behavioral issues

PEI PROJECT SUMMARY

Form No. 3

- Increased knowledge of risk and resilience/protective factors
- Improved mental health status
- Reduced isolation
- Increased social support
- Increased number of individuals/families who receive prevention programs and early intervention services
- Reduced stigma
- Earlier access to mental health treatment
- Reduced wait time to see mental health staff
- Increased completion of services

(Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.)

Turning Point of Central California, Inc. is a contracted agency of MCBHS. MCBHS will work with Turning Point staff to implement the prevention, early intervention program proposed. The Madera site for services is a Wellness/Recovery Center currently being operated by Turning Point called Hope House. It is not in a traditional mental health treatment site. MCBHS, upon approval of this plan, will work with Turning Point to locate space in the mountain area of Madera County to provide the expanded Wellness and Recovery Center (Hope House) services. By providing the expanded services to this area, the community will have easier access to the prevention/early intervention services rather than being transported or having to find transportation to the city of Madera. Public transportation within Madera County is limited. It is difficult for our clients to access services because of transportation issues. The Hope House expansion to this area will increase services to our clients, especially the Latino and Native American populations residing there. Older adults and TAY will also have easier access to the Center. Again, during the community/stakeholder process, having Wellness and Recovery Services within the mountain area was a priority that was mentioned.

(Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served)

By expanding its services to youth, older adults and a strong emphasis on targeting Latinos and Native Americans through the expansion of its services to the mountain areas , Hope House will address some of the needs identified in

both the 2005 and 2007-08 CPPP. In addition, increasing services outside the city of Madera has been a consistent theme throughout all MHSA planning activities since 2005. Further they will target unserved and underserved populations (Latino and Native American) through the Promotores program to be initiated through Hope House.

Madera County has a low penetration rate for the Latino and Native American population. The Promotores/Community Worker model of services has been shown to be an effective way to outreach to and engage the Latino community in services. These are two of the minority populations the proposed plan will attempt to reach.

The Native American representatives involved in the PEI CPPP indicated the Promotores/Community Worker model would be effective in working with the Native American community. Madera County has two reservations located within its boundaries. It has been extremely difficult to engage this community in services. It is hoped that by training members of the tribes as Promotores, Madera County Behavioral Health Services will be able to provide prevention services and linkage and brokerage through the Promotores for access to behavioral health services as necessary.

The Promotores/Community Workers would provide services within the community. They could be located on tribal land, at health/medical clinics, behavioral health clinics, MCBHS peer support and recovery program, at schools, etc., throughout Madera County. Having the Promotores/Community Workers located in the community where they live and work would provide will increase access to mental health services for Madera County residents. This would help provide services to our underserved Latino and Native American populations and increase our penetration rate into these underserved populations.

(Highlights of new or expanded programs)

1. Expansion of program Wellness and Recovery Services to provide Promotores/Community Worker positions
   - Increase information about mental health issues to the community as act as a resource for information, thus reducing stigma
   - Provide support for individuals and assist them in obtaining services as necessary
2. Services in the mountain area of Madera County
   - Outreach to rural areas of the county which currently do not have easy access to client directed services
   - Outreach to rural populations for development of Prevention/Early Intervention activities such as Wellness, Recovery Action Plan services, education about their mental illness, recovery and resiliency
3. Services specifically targeting Latinos and Native Americans

PEI PROJECT SUMMARY

Form No. 3

4. Services to individuals experiencing the onset of serious psychiatric illness
   - Education and support to clients and family members about mental illness and recovery
   - Neighborhood/community organization—Promotores/Community Workers sees and interacts with families on a regular basis through a formal and informal contact
   - In-Culture services—staff and volunteers who are culturally competent to address diverse needs of families and communities. Both staff and volunteers share the cultural background and language of the participating families.
   - Lack of existing ongoing relationship with target populations is a barrier to access. Promotores/Community Workers will be familiar to the target populations so will likely bypass this service access barrier.
   - Increased access to care
   - Increased culturally competent care
   - As needed/drop-in-care
   - Increase duration of service engagement that would, ideally reduce acute care needs by addressing mental health conditions early

(Actions to be performed to carryout the PEI project, including frequency or duration of key activities. Key milestones and anticipated timeline for each milestone)

1. Obtain approval from Oversight and Accountability Commission on PEI plan.
2. Obtain approval from State DMH on PEI plan
3. Within three months after approval, State contracts signed and funds received by Madera County, additional training for staff will be developed and a plan developed for implementation.
4. Within six months after approval, Turning Point will hire staff into position(s) to expand program
5. Hired staff will participate in Mental Health First Aid and CASRA training within six months after contract for training has been approved by Madera County.
6. Hired staff will provide Wellness and Recovery Action Plan training to at least 20 additional clients/family members by FY 2009--2010.

Training for Promotores/Community Workers

<u>Mental Health First Aid</u>

PEI PROJECT SUMMARY

Form No. 3

Training for the Promotores/Community Workers will be purchased through the MHSA Workforce, Education and Training (WET) funds. They will include Mental Health First Aid (MHFA) and CASRA psychosocial rehabilitation training. Mental Health First Aid is an award winning training program for members of the public in how to support someone in a mental health crisis situation or who is developing a mental disorder. It is an established Evidence Based Practice in several counties. The program has solid evidence for its effectiveness from randomized controlled trials and qualitative studies. It increases knowledge, reduces stigma and, most importantly, increases supportive actions. Research has shown it has improved the mental health of those provided the services that have been trained.

Mental Health First Aid training can assist in early intervention and in the on-going community support of people with mental illnesses. It is useful for people employed in areas which involve increased contact with mental health issues and for the family of people with mental illness. It has been recommended that Mental Health First Aid training becomes a prerequisite for practice in certain occupations which involved increased contact with people having mental health problems, such as teachers and police.

The MHFA course is a four session 12-hour course. At the end of the course, participants receive a Mental Health First Aid certificate. The course can be taken by any member of the public. The course does not teach therapy. It is not a substitute for getting professional help. However, it is useful for people who may have experienced a mental health problem but are currently functioning reasonably well. The course does not qualify them to be a counselor, just as a conventional first aid course does not qualify someone to be a doctor or a nurse. Its role is to promote first aid—the initial help that is given before professional help is sought.

The course teaches the symptoms, causes and evidence-based treatments for: depression, anxiety disorders, psychosis and substance use disorder. It also addresses the possible crisis situations arising from these mental health problems and steps to help. The crisis situations include a person who is feeling suicidal; a person having a panic attack; a person who has had a recent traumatic experience; a person who is acutely psychotic and perceived to be threatening violence; and a person who has overdosed.

Although crises are dramatic consequences of mental health problems, it is better to intervene early before such crises develop. The course emphasizes the need for early intervention for mental disorders as they are developing. Mental Health “first-aiders” are taught to assess the risk of suicide or harm, listen non-judgmentally, give reassurance and information, and encourage the person to get appropriate professional help in addition to encouraging self–help strategies. Trainees learn to apply this strategy in a variety of situations, such as helping someone through a panic attack, engaging with someone who may be suicidal, supporting a person experiencing psychosis and helping an

individual who has overdosed. An important component of the Mental Health First Aid training is that trainees practice the intervention strategy rather than just learn about it. This simple experience can make it easier to actually apply the knowledge in a real-life situation.

The most critical time for early intervention is when people are first developing a mental disorder. Often this occurs during adolescence and early adulthood. To cover this crucial period of life adequately, a Youth Mental Health First Aid Program was developed. It is aimed at adults who have frequent contact with young people. It emphasizes the mental disorders and the crisis situations that are most common in this age group and includes additional modules on eating disorders and deliberate self-harm.

The Mental Health First Aid program has core elements that translate across various cultural groups. However, there is always a need for some cultural modification and translations. The course was developed to suit mainstream society, but it is recognized this is not suitable for cultural minority groups. Cultural adaptations of the course have also been developed for a number of groups with non-English speaking backgrounds. Lastly, it was developed in Australia, which is primarily rural, to address the chronic and acute shortage of mental health professionals in that area. This is very relevant to Madera County, as a small rural county.

The National Council for Community Behavioral Healthcare is in the process of culturally adapting the program for the Latino culture. Currently, the program has been implemented for the Latino population in Texas. Madera County will be working with the National Council for Community Behavioral Healthcare to develop a culturally appropriate program for the Native American population within Madera County.

Mental Health First Aid is an established Evidence Based Practice in several counties. The program has solid evidence for its effectiveness from randomized controlled trials and qualitative studies. It increases knowledge, reduces stigma and, most importantly, increases supportive actions. Research has shown it has improved the mental health of those provided the services that have been trained. Mental Health First Aid has been replicated in England, Scotland, Canada, Hong Kong, Ireland, and Singapore. The National Council of Behavioral Healthcare values the supporting evidence and strives to achieve fidelity to the original Mental Health First Aid program developed in Australia. It has the potential to reduce stigma, improve mental health literacy, and empower individuals.

The National Council for Community Behavioral Healthcare chose to help bring Mental Health First Aid to the U.S. due to the strong evidence supporting the program. Four detailed studies have been completed in Australia and nearly a dozen journal articles published on Mental Health First Aid's impact on mental health literacy. One trial of 301 randomized

participants found that those who trained in Mental Health First Aid have greater confidence in providing help to others, greater likelihood of advising people to seek professional help, improved concordance with health professionals about treatments, and decreased stigmatizing attitudes. Unexpectedly, the study also found that Mental Health First Aid improved the mental health of the participants themselves. Findings from the other studies have echoed these outcomes.

During the community input process, every time MHFA program was described, there was great enthusiasm for it. This was the top requested program for services to be implemented. Law Enforcement, service organizations, transportation departments, schools are among many of the agencies requesting this training for their staff. This program fulfills the publics and stakeholders request to learn more about mental illness and how to respond to someone who may have mental health issues. It reduces stigma.

The desired PEI outcome this program addresses is to provide services to children and youth in stressed families, trauma exposed children/youth and people with onset of serious psychiatric illnesses. This priority population was the ones most addressed during MCBHS' planning process. Again, the public, family members, schools, transportation personnel, law enforcement as well as stakeholders wanted to learn more about mental illness and how to respond to someone who may have mental health issues. This was one of the top requests we received during the planning process. This program answers this request.

For sites that participate in the Instructor Certification Program, the National Council of Behavioral Healthcare will provide ongoing technical assistance in program planning and implementation, marketing, funding and other core components critical to the sustainability of Mental Health First Aid in communities. In addition, the National Council of Behavioral Healthcare will provide trained sites with new research and updated materials, module supplements targeted to a variety of audiences, and best practices from other Mental Health First Aid sites across the country and around the world. Perhaps most importantly, the National Council of Behavioral Healthcare is also developing an evaluation processes to allow sites to benchmark and track program outcomes.

CASRA

PEI PROJECT SUMMARY

Form No. 3

In addition to MHFA, Madera County plans on using the CASRA psychosocial rehabilitation training for its clients, family members, staff and Promotores. CASRA is dedicated to improving services and social conditions for people with psychiatric disabilities by promoting their recovery, rehabilitation and rights. CASRA's purposes are:

- To promote and support the development of community-based systems of services which provide choices for consumers and which are based upon the promise of growth and recovery.
- To encourage the development and implementation of community-based mental health programs consistent with the philosophy and practice of social rehabilitation.
- To provide leadership and consultation to enhance the development of effective community services which promote self-help and rehabilitation, and
- To offer educational and training opportunities which address and evaluate the effective use of the social rehabilitation approach to meet human needs.

Through the training received from MHFA, CASRA and other culturally appropriate workshops, the Promotores will be able to provide supportive services within their various communities and reduce the stigma of mental illness. When these programs have been presented to the community, several stakeholders indicated strong interest in being trained. These stakeholders included law enforcement, schools, social service agencies, clients, family members, citizens, etc. Specific cultural groups also wanted this training. They felt it was an appropriate way to provide prevention services to their communities through the Promotores model. These included the Native American population, the Latino population and the African American populations. These trainings are also excellent ways for Madera County clients and family members to enter the Behavioral Health workforce.

<u>Support from MCBHS staff</u>

As previously stated, there will be MCBHS staff available to answer questions, concerns, provide consultation and expedite referrals into the mental health system as appropriate for the Promotores/Community Workers. All Hope House staff is welcome to engage in any MCBHS ongoing training including cultural competency training. Any additional training needs will be assessed and implemented for the Promotores/Community Worker staff as necessary.

PEI PROJECT SUMMARY

Form No. 3

The Connected Communities Project

Parent Training, Teacher Training, Child Social Skills (Expansion and New)

Services to Trauma Exposed
Services to Children and Youth in Stressed Families

(Briefly describe the PEI project)

Expansion of existing parenting and child social skills programs to the community including teachers, parents, etc. Currently these programs are only offered to parents of MCBHS clients.

(Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.)

The priority populations identified in the PEI CPPP focus groups were Trauma-Exposed and Children/Youth in Stressed Families. Amongst the top recommendations for the types of services to develop with PEI funds were training for community members/stakeholders regarding identifying mental illness and how to address it (e.g. public awareness, Mental Health First Aid) and parent training (including foster parent education) and education regarding available mental health resources.

A theme mentioned over and over during the 2008 MHSA community/stakeholder process was the need for additional parent and teacher training programs on mental illness and how to deal with difficult behavior issues for the community. As part of the response to this request, MCBHS plans to build on its existing parent training, teacher training and child social skills programs. Currently some MCBHS staff is trained in the Love and Logic Parenting Program as well as in Incredible Years. Madera County Department of Social Services has staff crossed trained in Love and Logic as well as in Incredible Years. MCBHS will work with the Madera County Department of Social Services and Madera County First Five to expand the parent training classes available for the public (not just MCBHS clients).

Another frequently requested service was a clinician to act as a resource to schools and to provide training for school based personnel on appropriate responses to children who exhibit difficult behaviors. This training was specifically

requested for those who work in the pre-school and Head Start programs. However, we received requests for training from all of the schools on how to deal with difficult behaviors regardless of the age of the students.

Schools also requested training for their personnel on mental illness, signs and symptoms. They also wanted training on where and how to refer students for services. When the Mental Health First Aid training was explained to them, schools indicated they wanted their personnel to go through this training.

As part of the training curriculum offered through the Connected Communities Project, MCBHS will also focus on training personnel in schools, law enforcement, faith-based community, transportation, Head Start/Preschool personnel, First Five, etc. All of the above mentioned institutions have requested training in Mental Health First Aid, parenting programs and training for their instructors to assist with children who exhibit difficult behaviors. Below are some of the training programs that will be utilized.

Center for the Improvement of Child Caring, Los Niño's Bien Educados Program and Effective Black Parenting Program

During the planning process, parent training was mentioned as a community need. While the County has Love and Logic and Incredible Years parent training programs, the stakeholders indicated they wanted more. MCBHS is hoping to implement the following parent training programs specifically for Latino and African American parents.

The Los Niño's Bien Educados program is respectful of the traditions and customs of Latino families. It is sensitive to the variety of adjustments that are made as to acculturate to life in a multicultural society. Program teaches parenting skills within a Latino cultural frame of reference. The program uses Latino proverbs or "dichos." Parents learn effective skills and strategies which promote and maintain child behaviors. They are reflective of a child who is "bien educados" (well educated in a social and academic sense). The program can be taught in either English or Spanish.

The Los Niño's Bien Educados program has been used in variety of programs serving Latino-American as an effort to combat

- Child abuse
- Drug abuse
- Juvenile delinquency
- Gangs and
- Crime

PEI PROJECT SUMMARY

Form No. 3

One of the requested services for PEI was how to reduce the number of youth entering gang related activities. One of the results of this program is the reduction of youth entering gangs and reducing delinquency behaviors.

The Effective Black Parenting Program teaches parenting strategies unique to parents of African American children. It is the same Confident Parenting Program but from African American frame of reference. The program uses African American proverbs to teach parenting skills.

The Effective Black Parenting Program classes can be taught in schools, churches, mosques, agencies, community centers, etc. This program has been shown to aid in preventing;

- Child abuse
- School failure
- Substance abuse
- Delinquency and
- Gang involvement

Again, one of the requested services for PEI was how to reduce the number of youth entering gang related activities. One of the results of this program is the reduction of youth entering gangs and reducing delinquency behaviors.

<u>Expansion of Existing Love and Logic Parenting Programs</u>

MCBHS is looking at implementing a component of the Love and Logic Parenting Program. This component would be aimed at teachers and educators. The Love and Logic program for teachers helps to;

- Minimize student misbehavior
- Maximize teaching time
- Cure discipline problems immediately
- Build positive relationships with kids
- No longer be manipulated by students
- Strategies for building strong, emotionally healthy children
- How to “bully proof” children, diffuse power struggles & handle difficult people
- Proactive classroom management ideas that lower stress for students and teachers

PEI PROJECT SUMMARY

Form No. 3

School districts have indicated they would like to have staff trained on how to deal with difficult children/youth in their classrooms. The Love and Logic model for the classroom is an evidenced based program which accomplishes this goal. Through PEI funds, there would be mental health staff, Promotores/Community Workers who would be a resource to teachers for implementing and maintaining this education program.

Expansion of Existing Incredible Years Program

Currently, the Madera County Department of Social Services and MCBHS have staff co-trained in the Incredible Years program. The Incredible Years is an evidenced based program. MCBHS would expand the services offered to include training for teachers of pre-school children. This was a highly requested service from those who deal with the pre-school populations. This curriculum is designed to promote children's emotional literacy, problem-solving and anger management skills during conflict situations that occur during unstructured play interactions. The program teaches effective classroom management strategies for reducing aggressive and oppositional behavior and strengthening young children's social competence.

(Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.)

Implementation partners will include Madera County Department of Social Services, Madera County First Five, schools and eventually the faith-based community. The setting that will deliver the PEI program and interventions will be schools, community organizations, First Five, etc. MCBHS will seek to provide these prevention services in places where the public is used to going, e.g., schools, churches, etc. MCBHS will also seek to provide these services during hours and days that are convenient for the community to participate. It is hoped that by attending these services in non-traditional mental health settings, sigma can be reduced and services be more accessible to the community.

(Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served)

PEI PROJECT SUMMARY

Form No. 3

Target community regions include all of Madera County, including rural, mountain and metropolitan areas. There will be special emphasis to the Latino, Native American, African American and other unserved, underserved populations.

(Highlights of new or expanded programs)

- Increase information about mental health issues to the community as act as a resource for information, thus reducing stigma
- Provide support for individuals and assist them in obtaining services as necessary
- Outreach to rural areas of the county which currently do not have easy access to services
- Services specifically targeting Latinos, Native Americans and African Americans

(Actions to be performed to carryout the PEI project, including frequency or duration of key activities. Key milestones and anticipated timeline for each milestone)

- Within three months after approval, State contracts have been signed and funds received with Madera County, additional training for staff will be set up to be implemented.
- Within three months after approval, State contracts signed and funds received, Madera County will work with school districts within Madera County to set up training program for teachers and other personnel for Incredible Years and Love and Logic to be implemented during FY 2009—10.
- Within six months after approval, State contracts have been signed and funds received, 20 school personnel and/or community members will have received the training.
- Within twelve months after approval, State contracts signed and funds received, 50 school personnel and/or community members will have received the training.

PEI PROJECT SUMMARY

Form No. 3

The Connected Communities Project

Human Services Academy Primary Intervention Program/Primary Intervention Program

- **Services to Trauma Exposed**
- **Services to Children and Youth in Stressed Families**

(Briefly describe the PEI project. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

Through WET funds, MCBHS is working with South Madera High School to develop a program that acquaints students in secondary education to a career in the mental health workforce. Staff from the Chowchilla School District has also expressed interest in developing this type of program.

The Human Services Academy curriculum/program has been shown to help At Risk Youth stay in school and move onto higher education, as well as recruit entry level staff that is oriented and trained for work in public mental health. The Human Services Academy developed by Mental Health America of Great Los Angeles and Los Angeles Unified has been presented to South Madera High School staff and they are amenable to implementing this track in their existing Health Science Academy. Special effort will be made to involve youth from diverse ethnic communities, where access to knowledge about mental health careers is limited and stigma regarding mental illness is strong.

This Action would include a combination of curriculum developed in partnership with this high school and supervised field placements providing mental health supportive services. It will provide Public Mental Health occupation orientation to senior high school students. The students from the Human Services Academy will provide the workforce and for the Primary Intervention Program services on elementary school campuses.

The Primary Intervention Program (PIP) is a school-based program designed for the early intervention and prevention of mild to moderate school adjustment difficulties in primary (K-3) grade students. Each student is seen individually for weekly sessions in a specially designed and equipped activity room at the school.

PEI PROJECT SUMMARY

Form No. 3

Through the use of a systematic selection process, the program identifies students who are experiencing adjustment problems and who could benefit from early intervention. Once identified, these elementary school students participate in self directed play with the students who are part of the Human Services Academy. MCBHS, South Madera High School and Chowchilla High School anticipate using student's field placements to work with the kindergarten through third grade students who have been identified for PIP services. The Human Services Academy students will provide the "personnel" for this program as part of their field placements. These students will be supervised by school professionals. Referrals for appropriate services will be provided for the elementary school students whose needs are beyond scope of the PIP.

Student selection would be through a mental health professional, teacher, principal, etc. They would select the students who would be most appropriate for program services. Systematic screening procedures using a team approach would identify students for program placement. These screeners would include MCBHS and school personnel.

Kindergarten through third grade students who will be receiving the PIP services will be selected using the Walker Screening Instrument (WSI). This is a screening tool designed to identify young children experiencing school adjustment difficulties. Participation will be based on the WSI score (i.e. rating of teacher-preferred social behavior, peer-preferred social behavior and social adjustment required for success in classroom settings) and other pertinent information (i.e. out-of-home placement, changes in family/home situation, behavioral/discipline referrals).

Elementary school children selected to participate in the PIP program will receive one-to-one, non-directive play experience from a specially trained Human Services Academy student, once a week, for 30 to 40 minutes in a specially designated and equipped activity room. Identified children will follow a twelve to fifteen sessions timeline for program participation. Through non-directive play experience and support of their choice of activities in a nurturing environment, children will gain confidence in expressing their feelings and work out their own problems related to school adjustment, adult and peer relations, social behavior, etc.

The Human Services Academy student would be a supportive listener helping the child deal with issues that may interfere with learning at school. The Academy students would be trained to be culturally and ethnically sensitive. The Academy students will receive specific ongoing supervision and training from a mental health professional and the school. The non-directive play sessions for children are designed to establish a positive, meaningful relationship to reduce school adjustment difficulties.

PEI PROJECT SUMMARY

Form No. 3

During the FY 08-09, and FY 09—10, MCBHS will continue to work with South Madera High School and Chowchilla High School to develop a Health and Human Services Academy and implement this program as part of the field placement for its students.

Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

Community demographics include the South Madera High School at risk youth participating in the Human Services Academy program providing Primary Intervention Program services to an elementary school within Madera County. Madera County has a large Latino population and is a small, primarily rural county. Unemployment is high and youth are at risk for gang activities. This program targets the at-risk adolescent youth and elementary school age youth experiencing problems with school adjustment.

Highlights of new or expanded programs.

Program has high-risk youth providing prevention/early intervention services to youth also at risk. These programs, Human Services Academy and the Primary Intervention Program have both been shown to be effective with their respective populations. This will be the first time such a program utilizing at risk youth as providers to at risk youth in elementary schools will be implemented within Madera County.

Actions to be performed to carry out the PEI project, including frequency or duration of key activities. Key milestones and anticipated timeline for each milestone.

- MCBHS continues to work with South Madera High School and the Chowchilla School District in developing these programs. It is anticipated these programs would be implemented during FY 09-10 and FY 10-11 as additional funds become available. MCBHS is seeking overall approval of the program for continued program development and future implementation.

PEI PROJECT SUMMARY

Form No. 3

The Connected Communities Project

Responding in Peaceful and Positive Ways Program

- **Services to Trauma Exposed**
- **Services to Children and Youth in Stressed Families**

Briefly describe the PEI project. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

The Responding in Peaceful and Positive Ways Program (RIPP) is for ages 6—12 and 13—17. It is a best practice school-based violence prevention program. It contains a peer mediation program. Students learn to practice problem-solving to identify and choose nonviolent strategies for dealing with conflicts. The program emphasizes social-cognitive problem-solving techniques for dealing with conflict.

RIPP sessions are taught in the classroom by a school-based prevention specialist. This is typically incorporated into existing social studies, health or science class. The full-time violence prevention specialist also supervises and coordinates the peer medication program.

The RIPP program does the following;

- Develop norms and expectations for non-violent means of conflict resolution and achievement.
- Create opportunities for conflict resolution and positive risk-taking.
- Provide adult and peer models for conflict resolution and positive risk taking.
- Provide institutional and peer support for conflict resolution and positive risk taking.
- Provide knowledge to support the value of non-violent conflict resolution and achievement.
- Develop values that sustain non-violent conflict resolution and achievement.
- Diminish stereotypes, beliefs, attributions, and cognitive scripts that support violence.
- Develop cognitive scripts for pro-social behavior.
- Enlarge skills repertoire for non-violent conflict resolution and positive risk-taking.

PEI PROJECT SUMMARY

Form No. 3

- Provide opportunities for mentally rehearsing non-violent means for conflict resolution and achievement.
- Promote self-management through repeated use of problem-solving models.
- Enable participants to identify the optimal violence prevention strategy in a given situation and given personal skills

Madera County Department of Behavioral Health Services will have staff trained in the RIPP program and act as the resource for a school district to provide RIPP services. This school district would be located in a rural or mountain area of Madera County. As the program's successes are reported and as additional dollars become available for services, this program could be expanded to other schools and school districts within Madera County. Chowchilla school personnel and North Fork School personnel have expressed interest in having this program located within their schools.

(Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.)

In the 2005 CPPP indicated a need for increased services for children and youth. The 2008 surveys identified gang/school violence and community/domestic violence as a priority mental health services needs. Schools were consistently identified as priority sites for PEI service delivery.

Madera County BHS surveys for the PEI component were translated into Spanish. All of the respondents to the PEI Latino survey listed on the Madera County PEI website were transition age youth. In listing the community issues they thought were most important for mental illness prevention and early intervention services was gang/school violence. Gang/school violence also rated as one of the top choices for the surveys completed in English.

Key informant interviews with school district personnel as well as specific focus groups also echoed the survey's results. Madera's population was interested in programs that would reduce school violence. They wanted to create positive problem solving opportunities for students. They stated interest in programs that taught mediation skills to students.

Desired outcomes include;

- Reduced school drop-out, expulsion and suspensions
- Improved school performance
- Reduced involvement with law enforcement and courts

PEI PROJECT SUMMARY

Form No. 3

- Reduced incarceration in Juvenile Justice facilities
- Reduced violence
- Increased social support
- Increased appropriate help-seeking

Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

Implementation partners would be the school districts. Services would be provided on school campuses. The Chowchilla and North Fork School districts which have expressed an interest in the development of this program has a large Latino and Native American population attending their schools.

(Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served)

The top priority populations as indicated by the focus groups were Trauma-Exposed and Children and Youth in Stressed Families. In addition, school sites were the number one top priority for service delivery sites. Addressing violent behavior and anger management were listed as key mental health services needs in both the 2005 and 2007-08 CPPPs. The Native American community was listed as one of the main underserved groups in both the 2005 and 2007-08 CPPPs. As indicated in the data section of this proposal, the Latino population and Native American population experience a high rate of poverty and trauma. This trauma is due to experiences such a genocide and immigration issues that have multi-generational and intergenerational impacts on interpersonal behavior that can lead to increased violent behavior. In addition, both populations consistently underutilize mental health services which could address these issues. Both tend to not access public mental health services even though they are eligible for services. However, children and youth from both populations regularly attend schools.

Madera County BHS would partner with a school district in the rural or mountain area of the county. The Chowchilla school district has expressed interest as has the Chawanakee Unified School District in North Fork. The Chowchilla Unified School District serves a large Latino population. The Chawanakee School District has a reservation located within its district.

PEI PROJECT SUMMARY

Form No. 3

(Highlights of new or expanded programs)

1. Provides a strong basis or support for the development of youth peer support
2. Teaches wellness skills that are essential independent living skills
3. Development of an alternative to school and gang violence

(Actions to be performed to carryout the PEI project, including frequency or duration of key activities. Key milestones and anticipated timeline for each milestone)

- MCBHS continues to work with South Madera High School and the Chowchilla School District in developing this program. It is anticipated this program would be implemented during FY 09-10 and FY 10-11 as additional funds become available. MCBHS is seeking overall approval of the program for continued program development and future implementation.

PEI PROJECT SUMMARY

Form No. 3

The Connected Communities Project

Co-location of BHS staff with Physical Health Services

- **Services to Trauma Exposed**
- **Services to Children and Youth in Stressed Families**
- **Services to Individuals Experiencing the Onset of Psychiatric Illness**

(Briefly describe the PEI project. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.)

National reports recommend an integrated and coordinated model of care;

- President's New Freedom Commission, 2003
- IOM: Improving the Quality of Health Care for Mental and Substance-Use Conditions, 2006
- The Surgeon General's report on Mental Health, 1999
- SAMHSA: Transforming Mental Health Care in America, 2006

Collaborative MH/Physical healthcare helps bridge gaps in Mental Health care. Effective Mental Health treatment strategies can be effectively delivered in primary care settings. Co-location embraces the fundamental "understanding that mental health is essential to overall health."

The primary approach for services would be brief treatment/referral. Modalities would include:

- Assessment
- Brief individual therapy
- Brief group therapy
- Medication evaluation and monitoring
- Collateral consultation to primary care providers
- Referrals for those clients with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED)

PEI PROJECT SUMMARY

Form No. 3

The mental health staff would work with service coordinators as well as Promotores. In addition to the services above, they would provide mental health screening and services. The service coordinators, Promotores and clinical staff would provide Depression screening and services. They would act in a team approach and provide;

- Brief intervention,
- Case management and
- Support primary care MD's who provide psychotropic meds

Services would be provided in a similar model to the IMPACT program only it would serve other age groups besides the senior population and other diagnosis including depression.

When the population of Madera County was asked either in key informant interviews, focus groups or on questionnaires, repeatedly, they stated they wanted services to be co-located with primary care. Being co-located made it easier to obtain treatment for services. It also helped to reduce stigma.

(Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served)

It has been stated in several reports and during MHSA CPPP activities that Latinos are much more likely to access mental health care when it is co-located with primary care services. In addition, due to the high rate of co-morbidity between mental health and physical health conditions, locating mental health services in the primary care setting well positions these services to identify these conditions in the earliest stages.

(Highlights of new or expanded programs)

The local FQHC had brief mental health care until 2007, when it lost its funding to continue the services. There has been ongoing discussion regarding integrating mental health into either the FQHC, Madera Community Hospital outpatient clinics or the Madera County Public Health Department. Funding has always been a barrier.

Madera County would use clinical staff and Promotores/Community Workers to provide ongoing education and coordination services. In particular, there would be an outreach to the senior population who needs coordination of care for depression. This would reduce stigma as Mental Health services are provided as part of routine medical care. It

provides improved client access to care. It recognizes the client's identified "Medical Home." Physical health care is often where the client will seek help first for symptoms. Staff would also be able to educate primary health personnel on mental health issues and resources in the community.

The primary approach would be brief intervention and referral. Modalities include;

- Assessment of symptoms,
- Issues and barriers to treatment,
- Brief supportive services in an individual or group situation,
- Medication evaluation and monitoring,
- Collateral consultation to primary care providers and
- Referrals for those clients with Serious Mental Illness (SMI)

The mental health clinical staff would assist with depression screening and services. The Promotores/Community Workers would act as Care Coordinators and provide brief intervention services and care management. Mental Health staff would provide support to the primary care staff providing medication and other health related services. Madera County is still in discussion with its health and primary care providers. It anticipates implementing this program in FY 2009—10 through FY 2010—11.

(Actions to be performed to carryout the PEI project, including frequency or duration of key activities. Key milestones and anticipated timeline for each milestone)

- MCBHS continues to work with health services providers located within Madera County in developing this program. It is anticipated this program would be implemented during FY 09-10 and FY 10-11 as additional funds become available. MCBHS is seeking overall approval of the program for continued program development and future implementation.

PEI PROJECT SUMMARY

Form No. 3

4. Programs

Program Title **The Connected Communities Project**	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation July 2009 through June 2010
	Prevention	Early Intervention	
Expansion of Wellness/Recovery Center Services program (Hope House) • Expansion to mountain area • Promotores Model/Community Worker incorporating a. CASRA training, (curriculum paid through WET plan) b. Mental Health First Aid Training, (curriculum paid through WET plan)	Individuals: Families: 90 individuals 10 families 25 individuals 20 individuals	Individuals: Families: 90 individuals 10 families 25individuals 20 individuals	To be started July 1, 2009
Parent Training, Teacher Training and Child Social Skills Training; • Incredible Years (curriculum paid through WET plan) • Love and Logic (curriculum paid through WET plan) • Effective Black Parenting (curriculum paid through WET plan) • Los Niños Bien Educados (curriculum paid through WET plan)	Individuals: Families: 15	Individuals: Families: 15	To be started July 1, 2009

PEI PROJECT SUMMARY

Form No. 3

Responding in Peaceful and Positive Ways (RIPP)	Individuals:25 Families:	Individuals:25 Families:	To be developed during FY 09-10, possibly implemented FY 10-11 if we obtain sufficient funds
Human Services Academy/Primary Intervention Program (PIP)	Individuals:20 Families:	Individuals:20 Families:	To be developed during FY 09-10, possibly implemented FY 10-11 if we obtain sufficient funds
Co-location of staff with Physical Health Care Services	Individuals:15 Families:5	Individuals:15 Families:5	To be developed during FY 09-10, possibly implemented during FY 10-11 if we obtain sufficient funds
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 195** **Families**:**30**	**Individuals: 195** **Families**:**30**	To be started July 1, 2009

PEI PROJECT SUMMARY

Form No. 3

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

(Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.)

The Connected Communities Project will link individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to MCBHS, the primary care provider or other appropriate mental health professional through providing direct referrals to agencies. The Promotores/Community Worker will also follow-up to ensure that the individual receives treatment or further assignment. This person will interface with the community partners and service providers.

Through the variety of training (CASRA, Mental Health First Aid, etc.) for the Promotores/Community Worker, they will be able to identify those individuals who need referrals into the behavioral health system for further evaluation and possible services. They will work closely with the MCBHS program supervisors and clinical staff to link people to services. The PEI programs will be readily available to serve individuals who would traditionally refrain from accessing services, overcoming cultural and language barriers as well as reducing stigma about mental health. As a result of service availability in non-traditional settings there would be a positive community impact with more individuals leading healthy and thriving lives.

MCBHS staff that will be working with the school districts, Madera County First Five, community organizations, faith-based organizations, etc., to provide parent training, training for school personnel and child social skills training will also be able to link individuals to needed services. They will be able to work with these organizations to make sure appropriate follow-up care and services are provided.

(Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.)

Madera County is a small county. There are no mental health CBO's within its county limits. Alternative resources for services are scarce. However, as the need dictates, the Promotores/Community Worker will be able to link individuals

and family members to appropriate health care providers, Madera County Department of Social Services, domestic violence programs, and other community resources, e.g., food banks, thrift stores, emergency housing, etc.
Again, the MCBHS staff that will be working with the school districts, Madera County First Five, community organizations, faith-based organizations, Hope House, etc., to provide parent training, training for school personnel and child social skills training will also be able to refer individuals to needed services such as appropriate health care providers, domestic violence programs, etc. They will be able to work with these organizations to make sure appropriate follow-up care and services are provided.

(Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.)

The PEI staff and the Promotores/Community Workers will be able to provide services in any location including churches, the Rescue Mission, primary health care clinics, etc. Space within these organizations will be leveraged for the services provided.

The trainings and workshops will be open to all community agencies, organizations and the public. Local media will advertise the trainings/workshops for free.

Both Madera County Department of Social Services and MCBHS have been crossed trained on the Incredible Years and Love and Logic. That cross training will continue. MCBHS will continue to work with Madera County First Five for all of the training/workshops and for program services.

The Human Services Academy, when implemented, will utilize MCBHS staff to help teach the program, however the Primary Intervention Program will be staffed from students who are attending the Academy. Space and classroom materials will be provided for the MCBHS staff/instructor of the program by the schools.

PEI PROJECT SUMMARY

Form No. 3

6. Collaboration and System Enhancements

(Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.)

Currently MCBHS has strong collaborative relationships with the Madera County Department of Social Services, Madera Community Hospital, First Five, etc. Through the PEI process, MCBHS has been developing relationships with the Picayune Rancheria of the Chukchansi Indians Tribal Council and the North Fork Tribal TANF. As the project is implemented, we anticipate those relationships strengthening. MCBHS is just starting to forge relationships with the local churches. As time progresses, we anticipate those relationships intensifying. Those organizations and others representing various interests/citizens in the community will continue as we are able to provide education and linkage services to them.

(Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.)

There are no community-based mental health organizations located within Madera County other than MCBHS and its contract with Turning Point of Central California, Inc. for its Wellness/Recovery client-directed center, Hope House. Through PEI funds, MCBHS will be able to expand services to the mountain and Chowchilla areas for more client-directed programming. In addition, clients and family members will be able to be hired as Promotores/Community Workers to provide outreach, education, intervention and prevention services to the cities of Madera, Chowchilla and to the mountain region of Madera County.

MCBHS will continue to work with its health care providers to implement the co-location of services with primary health. MCBHS will also continue to work with the schools, First Five, Madera County Department of Social Services, the faith-based community to strengthen and build upon those systems and provide referrals and support for appropriate services.

(Describe how resources will be leveraged.)

Partnering agencies will provide space, materials and supplies for the services to be provided.

PEI PROJECT SUMMARY

Form No. 3

(Describe how the programs in this PEI project will be sustained.)

It is anticipated the Communities Partner Project will initially be sustained through PEI monies and the leveraging of community resources of our partners. Plans for future expansion of services and sustainability will be developed. Cultural competency training needs as well as other technical assistance will be identified and provided accordingly.

7. Intended Outcomes

(Describe intended individual outcomes.)

The Connected Communities Project

Expansion of Wellness/Recovery Center Services Program (Hope House)

- Reduced stigma
- Increased knowledge about symptoms of mental illness
- Increased knowledge on providing support to friends and family members suffering from a mental illness
- Reduction in suicide attempts/completions

Promotores Model/Community Worker Program

- Reduced stigma
- Increased knowledge about symptoms of mental illness
- Increased knowledge on providing support to friends and family members suffering from a mental illness
- Reduction in suicide attempts/completions

Parent Training, Teacher Training and Child Social Skills Training

- Reduced stigma
- Increased knowledge about parenting a child exhibiting behavioral issues or mental health needs
- Increased individual and family functioning
- Improved parent-child relationships

Responding in Peaceful and Positive Ways (RIPP)

- Reduced school drop-out, expulsion and suspensions
- Improved school performance
- Reduced involvement with law enforcement and courts
- Reduced incarceration in Juvenile Justice facilities
- Reduced violence
- Increased social support
- Increased appropriate help-seeking

Human Services Academy/Primary Intervention Program (PIP)

- Improvement in child's mental health
- Improvement in self esteem of youth at risk
- Increased understanding of child mental health and development
- Improved school performance
- Improve social and emotional development of young students

Co-location of staff with Physical Health Care Services

- Reduced stigma
- Increased knowledge about symptoms of mental illness
- Increased knowledge on providing support to friends and family members suffering from a mental illness

(Describe intended system and program outcomes.)

The Connected Communities Project

Expansion of Wellness/Recovery Center Services Program (Hope House)

- Increased client referrals to appropriate services
- Improved inter-agency referral process
- Increased community awareness about mental health issues
- Reduced stigma

PEI PROJECT SUMMARY

Form No. 3

Promotores Model/Community Worker Program

- Increased client referrals to appropriate services
- Improved inter-agency referral process
- Increased community awareness about mental health issues
- Reduced stigma
- Reduced disparities in access to mental health services
- Increased access to early intervention services in rural, isolated communities
- Improved cultural competence specific to the Latino and Native American communities in the provision of mental health services

Parent Training, Teacher Training and Child Social Skills Training

- Increased client referrals to appropriate services
- Improved inter-agency referral process
- Increased community awareness about mental health issues
- Reduced stigma
- Increased parenting education/training

Responding in Peaceful and Positive Ways (RIPP)

- Reduction in violence, physical and verbal
- Reduced rates of bringing weapons to school
- Reduced frequency of victimization and harassment
- Reduction in peer provocation
- Increase in life satisfaction

Human Services Academy/Primary Intervention Program (PIP)

- To provide students with career guidance, support, and training in one of the many human service career fields
- To equip and prepare students to be successful at a post-secondary institution and in their community
- Increase personal competencies related to life success
- Minimize the need for more extensive and costly services

PEI PROJECT SUMMARY

Form No. 3

Co-location of Staff with Physical Health Care Services

- Improved approaches for delivering integrated early mental health services in health care settings through positive relationships between service providers
- Expand community education, training opportunities and support for non-mental health professionals
- Expand interagency and interdisciplinary collaboration
- Increased access portals to mental health services

(Describe other proposed methods to measure success. What will be different as a result of the PEI project and how will you know?)

The Connected Communities Project

Through PEI funds, MCBHS will be hiring a Quality Improvement/Assurance Specialist. This position will help to develop and monitor outcomes and successes for the proposed programs.

Expansion of Wellness/Recovery Center Services Program (Hope House)

Performance Indicator: Program responsiveness to client needs
Measure: Degree of client involvement in the planning, design, delivery and evaluation of services
Domain: Process
Data Source: Questionnaires

Promotores Model/Community Worker Program

Performance Indicator: Degree to which clients experience an increase in psychological well-being through Promotores/Community Worker support services
Measure: Number of clients who experience an increased level of psychological well-being by receiving Promotes/Community Worker support services by

- A reduction in psychological distress,
- Increased sense of self-respect and dignity,

- Increased level of functioning and
- Degree to which clients feel good about themselves.

Domain: Outcomes
Data Source: Questionnaires

Parent Training, Teacher Training and Child Social Skills Training

Performance Indicator: Increased knowledge about parenting a child exhibiting behavioral issues or mental health needs
Measure: Number of parents who state they have increased their knowledge regarding parenting skills with a child exhibiting behavioral issues or mental health needs
Domain: Outcomes
Data Source: Questionnaires

Responding in Peaceful and Positive Ways (RIPP)

Performance Indicator: Reduced school drop-out, expulsion and suspensions
Measure: Number of clients who were expelled, dropped out or were suspended in prior school years compared to current school year
Domain: Outcomes
Data Source: School records as to the number of drop-outs, expulsions and suspensions

Human Services Academy/Primary Intervention Program (PIP)

Performance Indicator: Educational attainment for those who are in school
Measure: Number of clients who stay in school and complete the academy
Domain: Outcomes
Data Source: School records as to number of students completing the academy

Co-location of staff with Physical Health Care Services

PEI PROJECT SUMMARY

Form No. 3

Performance Indicator: Health status
Measure:

- Degree to which the health status of clients is maintained and improved
- Degree to which clients report positive changes in the problems for which they sought help

Domain: Outcome
Data Source: Questionnaires

PEI PROJECT SUMMARY

Form No. 3

8. Coordination with Other MHSA Components

Describe coordination with CSS, if applicable.

This plan proposes to transfer as program and staff that provide prevention and early intervention activities that are currently being funded through CSS funds. PEI programs will be coordinated to serve as the first point of entry to wellness and recovery for mental health services and activities. As necessary, PEI services will connect clients, youth and family members to CSS programs and other mental health services available from MCBHS.

The MHSA stakeholders/steering committee will continue to advise, monitor and provide input and feedback on all MHSA programs.

Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

WET funds will be used to purchase curriculums and training for the staff providing services through PEI programs.

Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

As Madera County implements the portion of MHSA utilizing Capital Facilities and Technology funds, staff and/or programs may be housed in buildings or utilize technology paid through that MHSA component.

PEI PROJECT SUMMARY

Form No. 3

9. Additional Comments (optional—limit to one page)

None.

The Budget page is located at the end of this plan

Form No. 4

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

County Name:
Madera Madera County Date: 12/03/08

PEI Project Name: Connected Community

Provider Name (if known): Madera County Behavioral Health Services

Intended Provider Category: Mental Health Treatment /Service Provider

Proposed Total Number of Individuals to be served:	FY 08-09	0	FY 09-10	300
Total Number of Individuals currently being served:	FY 08-09	0	FY 09-10	150
Total Number of Individuals to be served through PEI Expansion:	FY 08-09	0	FY 09-10	450
Months of Operation:	FY 08-09	0	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				
0.50	Supervising Mental Health Clinician		$39,222	$39,222
1.00	Mental Health Clinician		71,510	71,510
0.33	MHSA Coordinator		25,886	25,886
0.50	Health Education Coordinator		26,040	26,040
1.25	Mental Health Case Worker		58,371	58,371
.0.50	Administrative Analyst		30,939	30,939
1.75	Program Assistant		61,807	61,807
1.00	Accounting Technician		39,389	39,389
b. Benefits and Taxes @ 25.88 %			123,332	123,332
c. Total Personnel Expenditures		$0	$476,496	$476,496
2. Operating Expenditures				
a. Facility Cost		$0	$62,681	$62,681
b. Other Operating Expenses		$0	17,000	17,000
c. Total Operating Expenses		$0	$79,681	$79,681
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
	Hope House Expansion	$0	$645,968	$645,968
		$0	$0	$0
		$0	$0	$0
a. Total Subcontracts		$0	$645,968	$645,968
4. Total Proposed PEI Project Budget		$0	$1,202,145	$,1202,145

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	$0	$1,202,145	$1,202,145
6. Total In-Kind Contributions	$0	$0	$0

CONNECTION COMMUNITES PROJECT (1)

FORM 4 - BUDGET NARRATIVE

A. Expenditures

2. **Personnel Expenditures**: The actual estimated expenditures are $476,496.
   a. **Proposed Staffing:** A 0.50 FTE Clinical Supervisor, 1.00 FTE Mental Health Clinicians, 0.33 FTE MHSA Coordinator, 0.50 Health Education Coordinator, 1.25 FTE Case Workers, 0.50 Administrative Analyst, 1.75 FTE Program Assistant, and 1.00 FTE Accounting Technician. Salaries are based on current Madera County salaries approved by the Board of Supervisors. **Total FTE: 6.83**.

   b. **Proposed Staffing Justification:** The Clinical Supervisor and Mental Health Clinician will supervise the ongoing community education and cultural competence components of this program. The MHSA Coordinator and Health Education Coordinator will provide prevention/early intervention and outreach services. The Case Workers will provide linkage with the mental health system and community residents. The Program Assistant will provide direct support to the program staff. The Administrative Analyst and the Accounting Technician will provide statistical data collection for the program and develop and maintain the necessary data for reporting the outcome and other data requirements.

   c. **Employee Benefits**: Benefits for the 6.83 FTE are based on the current Madera County benefits package that includes the following: FICA 0.0608, Medicare 0.0142, PERS 0.1622, and health insurance coverage of $585.29 per month based on full time equivalency.

   d. **Facility Cost:** The actual estimated expenditures are $62,681. This includes translation and interpreter services. Travel and transportation staff will use a County van or will be reimbursed at 55 cents per mile if they use their own vehicle. This rate will be modified to the current rate as authorized by the Madera County Board of Supervisors. The Madera County Board of Supervisors adopts the current Internal Revenue Service business travel rate General Office includes the estimated costs for office supplies, phone system, cell phones, educational materials, program flyers and bulletins. Operating expenditures also include the building lease and utilities. The cost of obtaining the training material for Mental Health Aid, CASRA, and Love N Logic.

   e. **Operating Expenditures:** The estimated expenditures for the purchase of one car in the amount of $17,000.

3. **Subcontracts/Professional Services**: The estimated expenditure for this contract is $645,968. Hope House is a drop–in center for client

empowerment/socialization that has expanded to a Wellness/Recovery Center; The Wellness Recovery Action Plan Training has been utilized along with participants hired as staff, and peer support groups, and a town hall meeting for participants input for planned activities.

B. Revenue

1. New Revenues

There is no additional revenue anticipated for this program.

PEI Administration Budget Worksheet

Form No.5

County: Madera Date: 12/03/08

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2008-09	Budgeted Expenditure FY 2009-10	Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator					0
b. PEI Support Staff					0
c. Other Personnel (list all classifications)					0
Administration		0.62		$8,267	$8,267
Fiscal		1.16		6,736	6,736
Quality Control		1.22		9,551	9,551
					0
d. Employee Benefits				8,528	8,528
e. Total Personnel Expenditures			$0	$33,082	$33,082
2. Operating Expenditures					
a. Facility Costs			$0	$427	$427
b. Other Operating Expenditures			$0	4,617	4,617
c. Total Operating Expenditures			$0	$5,044	$5,044
3.County Allocated Administration					
a. Total County Administration Cost			$0	$7,629	$7,629
4. Total PEI Funding Request for County Administration Budget			$0	$45,755	$45,755
B. Revenue					
1. Total Revenue					$0
C. Total Funding Requirements			$0	$45,755	$45,755
D. Total In-Kind Contributions			$0	$0	$0

Mental Health Service Act Prevention and Early Intervention Component Administrative Budget Worksheet

FORM 5 BUDGET NARRATIVE

A. Expenditures:

Personnel Expenditures

a. Other Personnel: Salaries are based on the current Madera County Salary Schedule approved by the Board of Supervisors. There are no significant changes in staffing categories.

Administration

The Behavioral Health Services (BHS) administrative staff (Director and Assistant Director) time related to Mental Health Services Act functions.

Fiscal

BHS fiscal staff (1.0 FTE Account Clerk, 2.3 FTE Account Technicians, 0.3 Accountant Auditor, and 1.0 FTE Staff Services Manager, plus 1.0 FTE Office Assistant) is responsible for human resources reporting, client account receivables, payment of outside vendors, contract development, and contract monitoring. The budget reflects the estimated staff time related to Mental Health Services Act functions. The actual estimated expenditures are $6,736

Quality Control and Management

BHS quality control and management staff (1.0 FTE Staff Services Manager, 2.0 FTE Administrative Analysts, 1.0 FTE Clinical Supervisor, and 3.00 FTE Program Assists) are responsible for input of client services and reposting of the necessary data to the appropriate state department. The budget reflects the estimated time related to Mental Health Services Act functions. The actual estimated expenditures are $9,551.

b. Employee Benefits

The personnel benefits are supported by the FTE's as disclosed in Exhibit 5 of the Mental Health Services Act Prevention and Early Intervention Component and Supports Administration Budget Worksheet. These expenditures are based on the current County Human Resources position allocation. Benefits rates of FICA at 0.0608, Medicare at 0.0142, PERS at 0.1622 and Health, Dental and Vision at an estimate of $585.49 per month for each staff. The actual estimated expenditures are $8,528.

1. **Facility Cost:**
   The actual estimated expenditures are $427. This includes the building lease and utilities.

2. Operating Expenditures:

The actual estimated expenditures are $4,617. This includes Professional Services of the MIS contract based on the MHSA staff need of the client system and translation and interpreter services. Travel and outreach staff will use a County van or will be reimbursed at 55 cents per mile if they use their own vehicle. General Office includes the estimated costs for office supplies, phone and cell phones, educational materials, program flyers and bulletins.

4. County Allocated Administration

a. Countywide Administration (A-87): The countywide cost allocation for County Administration expenditures is estimated to be $7,629. There is a signification increase due to the growth in Madera County Behavioral Health Services (BHS) Department. The growth has resulted in an increase in the BHS share of the A-87 plan costs.

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:	Madera
Date:	12/03/2008

		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	The Connection Community Plan	$0	$1,202,145	$1,202,145	$360,644	$180,322	$516,922	$144,257
				$0				
				$0				
				$0				
				$0				
				$0				
				$0				
				$0				
				$0				
	Administration		45,755	$45,755				
	Total PEI Funds Requested:	$0	$1,247,900	$1,247,900	$360,644	$180,322	$516,922	$144,257

*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).

County: Madera Date: November 7, 2008

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

PEI Project Name:

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

The Connected Communities Project

Expansion of Wellness/Recovery Center Services program (Hope House)

- Expansion to mountain area and if fiscally possible, expansion to Chowchilla
- Promotores Model/Community Worker incorporating
    a. CASRA training, (curriculum paid through WET plan), Mental Health First Aid Training, (curriculum paid through WET plan)

Parent Training, Teacher Training and Child Social Skills Training;

- Incredible Years (curriculum paid through WET plan)
- Love and Logic (curriculum paid through WET plan)
- Effective Black Parenting (curriculum paid through WET plan, Los Niños Bien Educados (curriculum paid through WET plan)

Responding in Peaceful and Positive Ways (RIPP)

Human Services Academy/Primary Intervention Program (PIP)

Co-location of staff with Physical Health Care Services

1. b. N/A
2. N/A

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	3	6	9	3	3	3	3
Asian Pacific Islander							
Latino	16	29	45	13	16	16	16
Native American	3	6	9	3	3	3	3
Caucasian	9	18	27	8	9	9	9
Other (Indicate if possible)							
AGE GROUPS							
Children & Youth (0-17)	10	20	30	12	7	10	10
Transition Age Youth (16-25)	7	13	20	15	24	7	7
Adult (18-59)	7	13	20	0	0	7	7
Older Adult (>60)	7	13	20	0	0	7	7
TOTAL	31	59	90	27	31	31	31

Total PEI project estimated ***unduplicated*** count of individuals to be served 300

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

The program will be required to gather data and report participant demographic data (age, ethnicity, geographic location, language, etc.)

Program will be required to report contacts on a monthly and quarterly basis.

Program will be required to supply a logic model and evaluation plan narrative that will address:

- Collection of client demographic data
- Maintaining records of client participation, training provided to staff, etc.
- Assist evaluator in developing and administering any program assessment tools
- MCBHS data as appropriate.

5. How will data be collected and analyzed?

Questionnaires will be distributed collected once every six months. The questionnaires will be anonymous. Clients will be encouraged to complete the questionnaires but not forced.

MCBHS record data will be collected as appropriate.

Data will be analyzed by MCBHS MHSA staff. Data will be reported to MCBHS staff/administration and to the contract provider, Turning Point of Central California, Inc. Data will also be reported to the Steering Committee, Mental Health Board and other entities as appropriate, e.g., State DMH, MC Board of Supervisors, External Quality Review Organization (EQRO), etc.

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

The contractor will be required to show evidence of cultural competency. All evaluation instruments will be administered in the language in which the program is provided. Clients will be asked for their suggestions to improve cultural competency.

Currently contractor staff is invited to any training sponsored by MCBHS. This will continue including any cultural competency training.

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

MCBHS will work with the contractor, Turning Point of Central California Inc., to ensure fidelity to the model. This will require a description of procedures, staff development, monitoring and other steps to be implemented to ensure program fidelity.

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

MCBHS will report findings to the MHSA Steering Committee, Mental Health Board, Quality Improvement Committee, Turning Point and any interested clients/community partners.

MADERA BOARD OF SUPERVISORS

MEMBERS OF THE BOARD

BOARD OF SUPERVISORS
COUNTY OF MADERA

MADERA COUNTY GOVERNMENT CENTER
200 WEST FOURTH STREET/MADERA, CALIFORNIA 93637
(559) 675-7700 / FAX (559) 673-3302 / TDD (559) 675-8970

TANNA G. BOYD, Chief Clerk of the Board

File No: 08114

Date: December 16, 2008

In the Matter of CONSIDERATION OF APPROVAL TO SUBMIT THE BEHAVIORAL HEALTH SERVICES' PREVENTION AND EARLY INTERVENTION PLAN TO THE CALIFORNIA STATE OVERSIGHT AND ACCOUNTABILITY COMMISSION AND THE DEPARTMENT OF MENTAL HEALTH, BEHAVIORAL HEALTH SERVICES DEPARTMENT.

Upon motion of Supervisor Moss, seconded by Supervisor Wheeler, it

is ordered that the attached be and it is hereby adopted as shown.

I hereby certify that the above order was adopted by the following vote, to wit:

AYES: Supervisors Bigelow, Moss, Dominici, Rodriguez and Wheeler.
NOES: None.
ABSTAIN: None.
ABSENT: None.

Distribution:

ATTEST: TANNA G. BOYD, CLERK
BOARD OF SUPERVISORS

By Briana Para
Deputy Clerk

✓Auditor
✓Behavioral Health Services
✓CAO
✓California State Oversight and Accountability (via Behavioral Health Services)
✓Department of Mental Health (via Behavioral Health Services)
✓Granicus