Plumas County Mental Health's PEI Program Plan & Expenditure report May 2008.

PEI PROGRAM AND EXPENDITURE PLAN FACE SHEET Form No. 1

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

| County Name: Plumas | Date: 5/30/2008 |
|---|---|
| COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S): | |
| County Mental Health Director<br>Name: John Sebold, LCSW<br><br>Telephone Number: 530-283-6307<br><br>Fax Number: 530-283-6045<br><br>E-mail: jsebold@kingsview.org | Project Lead<br>Name: Pat Leslie<br><br>Telephone Number: 530-283-6307<br><br>Fax Number: 530-283-6045<br><br>E-mail: pleslie@kingsview.org |
| Mailing Address: 270 County Hospital Rd, Suite 109, Quincy CA 95971 | |

AUTHORIZING SIGNATURE
I HEREBY CERTIFY that I am the official responsible for the administration of Community Mental Health Services in and for said County; that I have not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and the administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2007-08, 2008-09 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief the administration budget and all related program budgets in all respects are true, correct, and in accordance with the law. Furthermore, I agree to conduct a local outcome evaluation for at least one PEI strategy, as identified in the County PEI Plan, in accordance with state parameters and will fully participate in the State Administered Evaluation.

Signature _____
County Mental Health Director Date

Executed at Quincy, California

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Acronyms and definitions within this application.

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

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

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

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

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

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

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

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

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

PEI = Prevention and Early Intervention. PEI is an approach in the way mental health system can provide services. Prevention programs provide public education initiatives and dialogue to enable access to mental health services at the earliest possible concern. Early Intervention indicates that mental health is a part of wellness.

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

TBD = To be determined.

WET = Workforce Education and Training is a component of the larger Mental Health Services Act.

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**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: Plumas** **Date: 5/27/2008**

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

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

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

    **c. Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process.** The MHSA Coordinator is responsible for facilitating the stakeholder process.

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**PEI, COMMUNITY PROGRAM PLANNING PROCESS Form No. 2**

2. **Stakeholder participation.** Explain **how** the county ensured that the stakeholder participation process **accomplished the following objectives:**

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

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 and race/ethnicity

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

response to #2.a.b. & c. is combined below.

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PCMH's PEI planning process consisted of eliciting input and guidance with regard to needs, priorities, on going or planned efforts and resources through meetings from October through December 2007. PCMH provided the MHSA principles, the Prevention and Early Intervention (PEI) funding allotment, goals and requirements.

PCMH considered testimony from stakeholders and partners within the following venues:

i. revisiting the original CSS stakeholder input process from 2005;

ii. researched the several community prevention plans and strategy plan (for other agencies/programs/coalitions, etc.) that utilized community input; and analyzed the results for strengths, assets, gaps, and un(der)served priorities and needs. Examples of plans, reviewed included: Plumas County System Improvement Plan; Plumas County Child Abuse Prevention Council; Family Violence Prevention Coalition and Juvenile Justice Commission.

iii. a multiagency discussion regarding meeting the service need(s) identified; and

iv. evaluation input, from families participating in the pilot run of the family therapy model proposed for PEI service program at PCMH.

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3. Explain **how** the county ensured that the Community Program Planning Process **included** the following required **stakeholders and training:**
    a. Participation of stakeholders as defined in Section 3200.270, CCR, including, but not limited to:
        • Individuals with serious mental illness and/or serious emotional disturbance and/or their families
        • Providers of mental health and/or related services such as physical health care and/or social services
        • Educators and/or representatives of education
        • Representatives of law enforcement
        • Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families.

Stakeholder outreach was conducted by Plumas County in the following venues:

- Informal feedback, during therapy services, from families in the juvenile justice system.
- Feedback from the small pilot project (solution focused family model) participants.
- As a regular agenda item on the Mental Health Advisory Board.
- Multi-agency communications during Interagency Case Management Team meetings; case conferencing at Social Services; individual non-profit staff member communications, and communications at the Health and Human Services Cabinet.
- The membership of the Plumas County Juvenile Justice Commission community strategic planning process including: youth representatives; Probation staff; District Attorney; Attorneys; Alcohol and Drug Department (A&D); and A&D Prevention Community Coalition; Public Health (education and services); Youth Violence Prevention Group; Foster Youth Liaison for Plumas Unified School District; Plumas Crisis Intervention & Resource Center; Family Focus Network; Family Empowerment Center; Plumas Rural Services Youth Center; Plumas Crisis Intervention and Resource Center; Child Abuse and Prevention Council.
- Management representatives from education, social services and private non-profits during interagency meetings.
- Representative from the local Family Empowerment Center.
- Round table discussion with District Attorney for a "family court" process and interaction with family therapy plan.
- Individual contacts with: judges, Probation Chief, Directors of Social Services, Health and Alcohol and Drug.

Continued on next page.

**PEI, COMMUNITY PROGRAM PLANNING PROCESS Form No. 2**

3. continued. How stakeholders were included.

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

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

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

PCMH views training for staff, consumers and the Mental Health Commission as an integral continuous process of development. The PCMH strives to implement and sustain a relationship in which all parties are fully informed in a transparent manner, are invited and expected to discuss and act as partners in decision making and are expected to evaluate outcomes of those decisions. The PCMH has 32.9 full time equivalent employees with less then 5% turnover in professional level staff in any 5 year period and very limited turnover in non professional level staff. As a result the staff tend to be well informed, well trained and prepared for involvement in a participatory management model of operation. In addition the Mental Health Commission has a core membership of long standing as a result of very limited turnover and strong commitment. Over the past three years consumer/family involvement has increased significantly. NAMI family representatives have over a 2 year history of consistent involvement with virtually no turnover. The size of the Commission is comparatively large significantly exceeding the mandate. The Commission has utilized CIMH training opportunities on three occasions in the past 5 years to expand their knowledge of specific issues including how to advocate specific positions. In addition the PCMH continuously informs the Commission of its activities and provides on going education regarding DMH initiatives, budgets personnel distributions, resource allocations and access/service challenges and modifications.

As a result of the above stated factors training specific to PEI was limited to informing participants in detail of the use and purpose of PEI funding including the budget implications of the anticipated funding. PCMH provided an overview of the components of the state framework for PEI community mental health needs and populations. PCMH revisited the information gathered in the CSS community input process of 2005. What was said then by county agencies

including social services, probation, local resource centers, Community Based Organizations, and hospitals identified the number of individuals they serve who need but have not received mental health services (unserved populations). At that time, these estimates totaled 262 individuals, including 81 youth, 134 adults, and 47 older adults. Since the CSS assessment, no statistically significant demographic shift has occurred in the community, much of what has been planned for the community remains valid. No new training was identified as needed or acquired for the processing of this PEI application.

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

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

Plumas County's CSS process previously identified the following **five things learned** about the community, with regard to the PEI appropriate target populations:

i. One need identified for children aged zero through five is for assurances of **community partnerships** with government and community based organizations **to deliver Parent Education**. The initial PEI planning in Plumas was a meeting centered around this topic. The outcome was that Plumas County Mental Health will partner with other agencies (community based organization, First Five Commission, and Social Services) to support enhancing the training of providers among agencies to be skilled in Parent Child Interactive Therapy (PCIT). Plumas County Mental Health intends to support this project with resources from within the MHSA component of Workforce Education and Training (WET), not PEI.

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

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

**PEI, COMMUNITY PROGRAM PLANNING PROCESS Form No. 2**

#4a. Continued. Lessons learned from CSS process.

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

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

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

The MHSA PEI Guidelines developed by DMH indicate that a goal of the planning process is to work through a logic model. Briefly the logic model is to: ID needs, target population, asset mapping, program/service selection, detail the services, and include quality measurements. PCMH has accomplished the planning processes while engaging the required community "sectors, systems, organizations and people that contribute to particular mental health outcomes in successful prevention and early intervention programs." (page 12 of guidelines). PCMH's list of involved stakeholders is detailed in the responses to numbers 2 & 3 above. Success is also noted by the inclusion and collaboration for referrals to PCMH's PEI Family Therapy model.

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**PEI, COMMUNITY PROGRAM PLANNING PROCESS Form No. 2**

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

a. The date of the public hearing: March 26, 2008.

b. A description of how the plan was circulated to representatives of stakeholder interests and any other interested parties who requested it.

- Electronic notification of the availability of the document was sent to all stakeholder individuals, agencies and departments who provide PCMH with email address.
- A News article ran once in the weekly Feather River Bulletin.
- The documents were posted on the county website www.countyofplumas.com.
- While attending meetings, PCMH administrators announced this public review process was underway.
- Twelve (12) individuals attended the public hearing process.

c. A summary and analysis of any substantive recommendations for revisions
There were no substantive recommendations for revisions.

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

County: **Plumas** Workplan Name: **12-15 session Family Therapy** Date: 5/9/2008

| 1. PEI Key Community Mental Health Needs | Age Group | | | |
|---|---|---|---|---|
| Select as many as apply to this workplan: | Children and Youth (ages 0-17 years) | Transition -Age Youth (ages 16-25 years) | Adult | Older Adult |
| 1. Disparities in Access to Mental Health Services | | | | |
| 2. Psycho-Social Impact of Trauma | | | | |
| **3. At-Risk Children, Youth and Young Adult Populations** | **X** | N/A | N/A | N/A |
| 4. Stigma and Discrimination | | | | |
| 5. Suicide Risk | | | | |
| | | | | |

| 2. PEI Priority Population<br>Note: All workplans must address underserved cultural populations | Age Group | | | |
|---|---|---|---|---|
| A. Select as many as apply to this workplan: | Children and Youth (ages 0-17 years) | Transition -Age Youth (ages 16-25 years) | Adult | Older Adult |
| 1. Trauma Exposed Individuals | | | | |
| 2. Individuals Experiencing Onset of Serious Psychiatric Illness | | | | |
| **3. Children and Youth in Stressed Families** | **X** | N/A | N/A | N/A |
| 4. Children and Youth at Risk for School Failure | | | N/A | N/A |
| **5. Children and Youth at Risk of Juvenile Justice Involvement** | **X** | N/A | N/A | N/A |

PCMH selects the youth population, those served by Juvenile Justice. Juvenile Justice services youth aged 10 -12 years as "informal" cases only and 13 – 18 years of age as either (in)formal. PCMH's Family Therapy service model will serve 10-18 year old clients and families (either informal or formal Probation).

**PEI WORKPLAN SUMMARY Form No. 3**

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

**Input and Guidance:**

**Input**

- PCMH's PEI planning process consisted of eliciting input and guidance with regard to needs, priorities, on going or planned efforts and resources through several meetings from October through December 2007. Those organizations/groups that participated in the planning meetings included: The Plumas County Mental Health Commission (as the MHSA Advisory group) members include the following representatives: District Attorney; Family Empowerment Center; Head Start; NAMI; Peer Leader (adult); Plumas Crisis Intervention and Resource Center; Public Guardian; Public Health, nursing; Senior citizen resource and referral; Veteran's Affairs; Victims & Women's Safety; seven (7) adult clients; and two (2) family members (one youth client and one adult client). The Health and Human Services Cabinet: Alcohol and Drug services; Child Support Services; Mental Health; Public Health Agency; Probation; Social Services; Veteran's and Victim Witness.
- There are significant barriers to total inclusion of all "underserved" populations. It's important to keep in mind the small geographically fragmented nature of Plumas County. The largest individual community is approximately 7000 individuals with the next three largest communities averaging approximately 3500 residents. All communities are isolated with none closer then 35 miles from another. In addition rural communities are notably politically and socially conservative. The result of this "smallness," geographic distribution and conservative overlay is that people do not self identify themselves with labels or causes that might isolate them with regard to the larger community. Personal privacy and independence is generally highly valued and respected thus pushing or asking people to identify them selves by sexual orientation or lifestyle is seen as notably disrespectful in this rural environment. The result is there are no local organizations that identify with a sexual orientation or transgender thus input can only be attained through individual contacts. Historically the PCMH has been viewed as a safe place where individuals can both be themselves and express their more private thoughts thus the PCMH regularly works with gay, lesbian and bisexual individuals. Due to the above noted dynamics and small total population transgender individuals are rarely identified or self identify.
- The rural dynamic regarding sexual orientation and privacy creates barriers to input that are not completely resolvable by the PCMH. The PCMH uses the following two strategies to lessen the impact of this problem: 1) The

PCMH has utilized consumer surveys for approximately seven years. As such the PCMH's use of surveys predates the DMH mandate to survey consumer satisfaction. The PCMH collates the narrative responses from the biannual surveys and utilizes the collated data to inform the administrative team, providers and the Mental Health Commission regarding gaps in service and or regarding service delivery that consumers believe is particularly helpful. The PCMH periodically adds open end questions to the required DMH biannual consumer surveys to attain more detailed information about consumer perception. This allows consumers to directly voice concerns and to comment about desired changes in private less restrained manner. 2) The PCMH emphasizes the use of formal feedback process in each of its service contacts that promotes a partnership with consumers and providers. This process includes ending service contacts with an assessment of the consumer's perception regarding the contact. This process includes the following questions: 1) Was this helpful? 2) What was most helpful? 3) What might have been more helpful? Following group services this process is conducted with the total group.

- The PCMH recognizes that given the rural privacy/isolation dynamic it must have a strategy that assures respectful access, treatment and partnership for Lesbian, gay, bisexual and transgender individuals. The PCMH strategy for these individuals includes the following: 1) Continued focus on privacy and confidentiality, 2) Use of gender neutral language, 3) Staff challenges to discriminatory slurs and gender orientation, "put downs" and 4) Challenge the use of pathological paradigms in clinical assessment and treatment.

**Guidance**

PCMH reviewed the numerous prevention plans within the community (to determine community assets and needs). From this data, PCMH identified selected theme(s) of community identified needed services for at-risk youth. The following identifies some of these selected community needs, which are: alcohol and drug education and intervention; residential treatment program; life skills, education of; enhanced/more of Wraparound services; positive behavior support specialties (in schools); care program (after school); parenting skills (development of); pediatric psychiatry; general early intervention services; increased and specialized mental health treatment; more case managers; peer counseling; strengthen families (parents need services so they can work with difficult children, increase parenting skills, earlier referrals for intensive services).

A recently issued matrix of "strategic prevention plans in Plumas County", collated by the Alcohol & Drug Prevention Community Coalition, records seven (7) prevention coalitions or mission oriented agencies and their efforts across twelve

(12) prevention domains. This matrix demonstrates the work being done with parenting skills, child abuse prevention (both curriculum and individual case support), child care enhancement of inclusion and adequacy of community supply, domestic violence prevention, etc.

**PEI WORKPLAN SUMMARY Form No. 3**
**B. continued. Summarize the stakeholder input**

**Selection of target population:**

Open discussions by stakeholders led to the following general agreements from the planning process participants regarding the components of the state framework for PEI community mental health needs and populations.

- Disparities in access, appears to be addressed in existing work plan #1 of Plumas County Community Services and Support Plan. Stakeholders felt that this CSS effort was adequately funded and the small funding from PEI should not be additionally utilized here. The original 2005 CSS planning process included input from individuals representing diverse points of view and interests including those of underserved populations. As an extension of the planning process the PCMH committed to working on the unfunded priorities, with the mental health commission assuring that the interests of underserved populations are and continue to be represented. The PCMH administration also believes it is accountable for representing the underserved populations and do not view the planning or implementation process as divisive or a battle of interests. Nor does the PCMH view the 2005 planning process or the CSS plan implementation as an end point in time. The PCMH is in a continuous planning process and on going relationship with served and underserved populations. For example the PCMH developed a plan outside the MHSA CSS plan, without MHSA funding to assess the need for services for pre-school children, a population described as underserved and not addressed by the CSS plan. The PCMH also without MHSA funding but as result of the CSS plan process implemented a small pilot project to assess the viability of court referred family treatment services. In addition the PCMH responded to demands directly presented by adult consumers regarding activity based therapy services, this again without the support of MHSA funding. All of these processes were the result of a continuous process of review and response to address unmet priorities of identified underserved populations noted in the CSS planning process. In addition all of these processes were reviewed by PCMHs commission that has a broadly representative membership including consumers and representatives of potentially underserved populations.

The Plumas County Mental Health Commission (as the MHSA Advisory group) members include the following representatives: District Attorney; Family Empowerment Center; Head Start; NAMI; Peer Leader (adult); Plumas Crisis Intervention and Resource Center; Public Guardian; Public Health, nursing; Senior citizen resource and referral; Veteran's Affairs; Victims & Women's Safety; seven (7) adult clients; and two (2) family members (one youth client and one adult client).

- The CSS planning process identified priorities in the 2005 planning process. The CSS planning process was very comprehensive and inclusive. As noted above, when the official CSS planning process ended, PCMH did not end or cease planning related to addressing underserved issues. The PCMH developed plans to address or further assess MHSA unaddressed/unfunded priorities, within other (non MHSA efforts) collaborations and other revenues.

- PCMH stakeholders are eager to join the statewide PEI efforts and believe that the state's anti-stigma projects will have more impact than a local effort. Stakeholders believe the significantly funded and with expertise in content for coordinated state efforts (ethnically & culturally specific programs and interventions and stigma & discrimination reduction) will better communicate with (the cultural population), outreach to and encouragement for access to services for psycho-social impact of trauma; underserved cultural populations; individuals experiencing onset of serious psychiatric illness; stigma and discrimination; and at suicide risk. The very limited funding available to Plumas would have to reach a very small known percentage of the population. The issues for Plumas are: the "bang for the buck", the "competing interests", and the expertise component. Thus, Plumas does not select to focus on these efforts/populations with the PEI local funds.

- Stakeholders in Plumas continue to request enhanced services to children. The prior MHSA CSS funding began to fill the gaps and enhanced services and supports to children, but did not fully address all issues of mental health services to children in families at risk. A quote from the minutes of the Mental Health Commission's meeting of July 2007 illustrates the continuing interest in services to youth. "(Member's name) *raised a concern that in the original process of setting priorities for Mental Health Services Act—Prop 63, serving the needs of children age 0 to 10 was a high priority. But when that age range was divided into 0-5 and 5-10 because of the different services that would be required, the priority points were of course reduced. Thus neither group was considered a top priority* (For CSS

funding) *even though kids age 0-10 had been important. Now with additional funding* (CSS funding amendments) *the needs of children 0-10 has still not been addressed. John Sebold, Plumas County MH Dept Director, acknowledged that the need remains and his preference is to put money into prevention rather than wait until problems get bigger and more expensive."* The MHSA Advisory unit recalled this issue when PEI planning began.

- For Plumas, children in families at risk became the focus of discussion, for potential use of PEI funds. Services to youth were discussed based on age of youth. During the PEI assessment and planning process, the only competing challenge (to serving teens) that arose was related to possibly targeting funding to day care service providers and children age 0-5. This challenge was supported by the rational that prevention dollars would attain the greatest impact if applied to the youngest population of individuals in need of service. The PCMH and MHSA Advisory unit (MH Commission) supported this concept, but believed that the 0-5 population was served sufficiently as a result of modifications in its System of Care approach. The PCMH shared data regarding requests for services for this population as well as its current access plan, as well as case narratives and responses to those narratives to address these concerns. The PCMH also shared plans related to WET expansion funding targeted to improve and increase partnership and community based capacity related to the 0-5 population. As a result of this process the MHSA Advisory unit (Mental Health Commission) and representatives of Head Start (a major representative of this population) agreed that the PCMHs efforts and plans were sufficient to address their specific concerns.

- As noted above the PCMH utilizes the commission meeting process to identify, prioritize and develop responses with stakeholders. The PCMH exceeds the mandated meeting requirements for commission meetings by nearly double the mandate to assure a collaborative continuous planning process. There was and is strong overwhelming consensus among the diverse commission membership that parenting/family based treatments were and remain the highest priority. This consensus developed as a result of a review of the comprehensive regional input process as well an on going review of priorities since implementation of the CSS plan. The PCMH Director reviewed the PEI plan development and plan with the commission prior to submission and there was total unequivocal agreement that the plan was consistent with the planning priorities established by the commission (see membership identified several times above). In addition the priorities were reviewed and confirmed by public partners in meetings with the Health and Human Services Cabinet which includes, Mental Health, Drug and

Alcohol, DSS, Health Department and Veterans Services. MHSA priorities and plans/addendums to plans are reviewed for comment at each meeting. There was total agreement with regard to the priorities established in the PEI plan in this context.

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

- Considered several populations and strategies for "caretakers". The following were discussed and not selected as a top priority either for reasons of concern regarding supplanting of funds or for reason(s) indicated: pregnant women with depression to be addressed with the four P's program. The home visiting team is doing a great job at meeting with women and potentially identifying cases needing referral for mental health services. Plumas County Mental Health would like to initially see the local First Five Commission support a prenatal depression support program and from that, the local need could be further developed. Also considered an "aide worker wellness program" because of the statistics tying depression to workers who provide care and meals. Although a strong fit to PEI and a need, it was not identified as a top priority in the community input avenue.
- Defined the neediest (of mental health services) subpopulation of "caretakers" as parents/guardians of at-risk or juvenile justice youth aged 10-18.
- Reconfirmed that even 2.5 years post the initial CSS community assessment process, effective services to this targeted population of caretakers is minimal. Thus, a service that intervenes with children/youth in stressed families was set as the desired service goal.

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

Youth involved in Plumas County Juvenile Justice System while in-county (not in placement) may be receiving individual counseling through memorandums of understanding between Plumas County Mental Health and Juvenile Justice. Yet, multi-agency communications received by PCMH (during Interagency Case Management Team meetings; case conferencing at Social Services; individual non-profit staff member communications, and communications at the Health and Human Services Cabinet meetings) repeatedly highlighted the underserved family situations. Community efforts were substantially underway for a non-profit group to provide family therapy to the families with children under the age of seven (7), who have experienced or are at risk of experiencing child abuse. PCMH is supportive of these efforts and plans for financial and clinical support and participation in implementing Parent Child Interactive Therapy (PCIT). PCMH is planning for the use of alternative MHSA resources (the workforce education and training component) to support PCIT. Additionally, a second non-profit has begun to implement a peer mentoring model. Thus, the plan is to contribute to the breadth of services and fulfill a remaining, unmet service need, by opting to utilize the limited Plumas County PEI financial resources for a family therapy model with at-risk teenagers. Thus, PCMH identified the service population as "children and youth that are stressed and involved with Juvenile Justice System". In addition, the PCMH attained confirmation of consumer support of this type of initiative when it implemented a family treatment group process in 2000. The vast majority of consumers involved in the project strongly advocated it's continuance but the PCMH was forced to cut the program due to budget constraints.

**PEI WORKPLAN SUMMARY Form No. 3**

**B. Summarize the data analysis.**

**Data analysis:**
Plumas County Mental Health began reviewing the cost/benefits of prevention and early intervention programs for youth in 2005 by collecting information on various programs and initiating collaborative input and discussion with various community organizations. The discussions became more focused when the PCMH located a document produced by the, Washington State Institute of Public Policy entitled, "Benefits and Costs of Prevention and Early Intervention Programs for Youth" The PCMH widely distributed this document to help educate consumer, family and service partners regarding the potential and pitfalls of prevention and early intervention approaches. The PCMH conducted its own informal analysis and rating of the Washington State review of programs in an attempt to identify commonalities of successful programs and later targeted specific programs for follow up. As a result the MPH sent clinicians to trainings in Dialectical Behavior Therapy, (DBT) and Cognitive Behavioral Therapy, (CBT). Functional Family Therapy, (FFT) Multi-Systemic Therapy,

(MST) and Parent-Child Interaction Therapy, (PCIT) programs were also extensively reviewed. From 1996 through 2002 the PCMH conducted research in collaboration with The Ohio State University on a Solution Focused Treatment approach and over this period of time and to the present the PCMH has trained all clinical and case management staff in Solution Focused approaches. Solution Focused, (SF) approaches are highly congruent with the implementation of recovery principles and the PCMH was interested in adding a prevention and early intervention model that blended well with both recovery principles and Solution Focused principles. In reviewing possible models it appeared that Functional Family Therapy, (FFT) was generally most consistent with this goal. Even though the FFT model is highly proprietary the applicable principles that contribute to its success seem to be replicable for a small county that implements those principles in a focused and disciplined manner. Given the PCMH success in implementing an SF model that resulted in strong research support for its effectiveness the PCMH is confident that it can apply a similar level of rigor in implementing the salient elements of an FFT model.

Having identified the target population as youth at-risk and juvenile youth, and the strategy of family therapy, then PCMH utilized expertise with California Institute of Mental Health (CIMH) to assess potential best practices that serve the target population and that may meet the identified goals. PCMH also took input from Dr. Troy Armstrong, Director of the Center for Delinquency and Crime Policy studies at California State University in Sacramento. Those models that were considered included: Functional Family Therapy; Multi-dimensional Family Therapy; Multisystemic Therapy.

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

The following table is to provide specifics in understanding the adaptations to FFT that will best suit Plumas.

| Tasks | Functional Family Therapy | Plumas Solution-focused family therapy |
|---|---|---|
| **Target** | **Juvenile Justice youth involved families (aged 11-18)** | **Juvenile Justice youth involved families (aged 10-18)** |
| **Training of clinicians** | **Cost prohibitive, minimum of three therapists, training out of house, 3 years** | **Cost effective, one dedicated therapist, in-house training, existing staff trained in solution-focused therapy. Remote viewing and input from team of providers.** |
| **Case load per clinician** | **12-15 cases per week for 1 FTE, 35-40 families per year** | **57 individuals (19 families)** |
| **Delivery of method** | **Outpatient** | **Outpatient** |
| **Series of sessions** | **8-12, one hour sessions on average** | **12 sessions, one hour.** |
| **Evaluation tools** | **Sophisticated assessment (FAP), tracking (CSS) and monitoring system.** | **Psychoeducation fidelity scale. Vendor to be determined for clinical quality assessments.** |
| **Family intervention services for dysfunctional youth** | **Engage, motivate, change behavior, generalize** | **Engage, motivate, change behavior, generalize** |
| **Goal** | **Reduce recidivism 25-60%** | |

**3. PEI Work Plan Description:**

PCMH will simultaneously target children & youth at-risk and delinquent and the caregivers of these children. PCMH will provide a new, structured, short-term (12-15 session) therapeutic family program that is supported by MHSA PEI resources. The goals of the 12-15 session family therapy service model are: successfully engage and motivate the members of the family through strength-based relationship processes. Reduce and eliminate the problem behaviors and accompanying family relationship patterns; and progression to more generalized adaptation skills.

**Fiscal Year 2007/08** will be consumed predominantly by **planning and "gearing up" toward implementation**, for example:

a. Conduct the PEI outreach, data capture and analysis, public review and input and submission and resubmission and negotiations of the plan to the state department of Mental Health.
b. Staff the service and office support positions. To have clinical staff that has high availability, trained in interpersonal skill interventions (strength-based & solution focused, validation, positive interpretation, reattribution, reframing, and sequencing) and have administrative support (office, computer, furniture, program management, etc).
c. Set-up the clinical setting(s) for services.
d. Clinical support team, consists of a small group of clinicians, staff and peers (members of other families when appropriate), to view video and direct observations.
e. Target outreach to receive referrals for youth ages between 10 and 18 year-olds, all ethnic and cultural groups, from at-risk adolescents and their families. These referrals will be from underserved families with diverse family organization, presenting problems, cultures.
f. The Director of Plumas County Mental Health to provide development of the systematic training, supervision, process, and outcome assessment components.

**3. Work Plan Description:** continued.

**Fiscal Year 2008/09 will be the service program start-up year** of the 12-15 session family therapy program and involve the following:

Engaging families:

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

Therapeutic Family Sessions (12)

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

**3. Work Plan Description:** continued.

**Fiscal Year 2008/09 will be the start-up year** of the 12-15 session family therapy program and involve the following:

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

During the 12-15 therapeutic sessions the therapy team may feel it appropriate to help an individual or family obtain and/or link to additional mental health assessment and treatment or to other services and supports, i.e. substance abuse prevention and treatment; basic needs (food, housing, employment, etc.).

Evaluation:
System outcomes:

- Fidelity to a family psychoeducation fidelity scale utilized by New York State.
- More community organizations providing identification and early intervention for short-term mental health services. The measurable result = increase in number of appropriate individuals and families identified as needing, and who receive, prevention program and early intervention services.
- Increase family access to early mental health services.

Clinical outcomes: (short, non-intrusive measures of client's perspective and clinician's broad and general assessments); trend analysis to compare the pattern of change for pre and posttests (time TBD).

- Enhance behaviors related to protective factors (…self-esteem, decision making and its applicability, personal control, interpersonal communication, prosocial group behavior, prosocial activities)
- Reduction in behaviors related to risk factors (….impulsiveness, poor decision making and coping skills, learned helplessness, poor social/interpersonal skills, susceptibility to negative peer influences, nonparticipation in school/social activities)
- Reduce removal of children from home and in placement.

**PEI WORKPLAN SUMMARY Form No. 3**
**4. Strategies**

| Strategy Title | Proposed number of individuals or families through PEI expansion to be served through June 2009 by type | | Number of months in operation through June 2009 |
|---|---|---|---|
| | Prevention | Early Intervention | |
| 12-session family therapy | Individuals: 57[a]<br>Families: 19[b] | Individuals:<br>Families: | July 2008 –June 2009 = 12 |
| n/a | Individuals:<br>Families: | Individuals:<br>Families: | |
| n/a | Individuals:<br>Families: | Individuals:<br>Families: | |
| n/a | Individuals:<br>Families: | Individuals:<br>Families: | |
| n/a | Individuals:<br>Families: | Individuals:<br>Families: | |
| n/a | Individuals:<br>Families: | Individuals:<br>Families: | |
| Total Work Plan estimated, unduplicated, count of individuals to be served. | Individuals: 57<br>Families: 19 | Individuals:<br>Families: | |

Notes:
a. estimating that "families" will consist of 3 individuals (either 2 adults and 1 child or 1 adult and 2 children) on average.
b. estimated 19 families per 12-15 week sessions, with four –series of sessions per year. The determination of number of families is calculated within the constraints of fiscal and personnel resources, for specifics see the fiscal budget and related narratives.

**PEI WORKPLAN SUMMARY Form No. 3**

**5. Alternate Strategies**

- ✓ Please check box if any of the strategies listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate strategies (refer to Instructions for Form No. 3).

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

PCMH has successfully implemented solution-focused therapy for several years with other target populations. Thus, PCMH proposes to utilize universal components of service, from both the Functional Family Therapy (FFT) and Parent Child Interactive Therapy (PCIT) models, both have consumer centered outcomes. PCMH designed an adapted program to implement a family therapy model (akin to FFT) that is suited for this rural, small county. Services shall be performed at PCMH, where access to remote viewing is already structurally available, and professional case review is most readily accessible. Additionally, the Juvenile Justice cases will be adjudicated in Quincy, and is in proximity to the main referring partner (Probation Department). This program will be complementary, not competitive, to any existing services the child and family are participants in. PCMH shall annually evaluate this 12-15 session family treatment model for level of adherence to the framework of the family psycho-education fidelity scale.

**PEI WORKPLAN SUMMARY Form No. 3**

**6. Linkages to County Mental Health and Providers of Other Needed Services**
During the 12-15 therapeutic sessions the therapy team may feel it appropriate to help an individual or family obtain and/or link to additional mental health assessment and treatment or to other services and supports, i.e. substance abuse prevention and treatment; basic needs (food, housing, employment, etc.). There exist linkages and referral methods in Plumas County with PCMH, due to the small rural nature, most health professionals are familiar with one another and a phone call and/or a referral sheet is all that is usually needed. If any PEI participant needs mental health assessment or extended treatment, then the client will be informed and appropriate referrals made whether they be for the primary health care provider, or mental health assessment and treatment, or psychiatric medication evaluation.

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

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

**PEI WORKPLAN SUMMARY Form No. 3**

**8. Intended Outcomes** The 12-15 session family therapy program has the following intended outcomes:

| **Outcome of (who/what)** | **Description of outcome** | **Method of measure** | **Periods of evaluation** |
|---|---|---|---|
| System outcome | Demographics of participants:<br>• Who:<br>• What problem/needs are addressed<br>• Besides family therapy, what service(s) is the family referred to, and how many individuals referred.<br>• Fidelity to family psycho-education fidelity scale | Client/family information :<br>• age, gender, race/ethnicity and culture<br>• type of problems/needs<br><br>FPE fidelity Scale, akin to New York State | Intake & ongoing.<br><br>Semi-annually |
| System outcome | Assess for barriers and successes | • referrals are occurring<br>• therapy timeframe is adequate<br>• family successes<br>• implementation challenges<br>• assessment of the level of extent, quality and nature of collaboration with partner organizations (referring sources) | Semi-annually |
| Family outcome | Participating families show fewer negative consequences from emotional and behavioral disturbances | Self-report | Pre and post |
| Family outcome | Reduce negative communication & develop family focus | Family perspective to clinician | Pre and post |
| Individual (child) outcome | Reduce the behavior of impulsiveness, related to risk factors.[1] | Short, non-intrusive measures of client perspective and clinical assessments. | Pre and post |
| Individual(child) outcome | Enhance school attendance behaviors related to protective factors.[2] | Short, non-intrusive measures of client perspective and clinical assessments. | Pre and post |

1. Reduction in behaviors related to risk factors (….impulsiveness, poor decision making and coping skills, learned helplessness, poor social/interpersonal skills, susceptibility to negative peer influences, nonparticipation in school/social activities).
2. Enhance behaviors related to protective factors (…self-esteem, decision making and its applicability, personal control, interpersonal communication, prosocial group behavior, prosocial activities)

Potential use of a commercial software evaluation product. PCMH's research on two potential vendors is still being conducted.

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

Additionally, it is anticipated that PEI will be incorporated into the Plumas County MHSA technology plan when developed, and be an integral part of services.

Plumas County Mental Health's PEI Program Plan & Expenditure report May 2008.

Forms 4 and 5 (budgets) are Excel tables and attached to this document.

PREVENTION AND EARLY INTERVENTION BUDGET SUMMARY

| Form No. 6 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Instruction: Please provide a listing of all Workplans submitted for which PEI funding is being requested. This form provides a Workplan number and name that will be used consistently on all related workplan documents. It identifies the funding being requested for each workplan from the form No. 4 for each workplan by the age group to be served, and the total PEI funding request. Also insert the Administration funding being requested from Form No.5. | | | | | | | | |
| County: Plumas County | | | | | | | | |
| Date: May 9, 2008 | | | | | | | | |
| Fiscal Year | | | | Funds Requested by Age Group | | | | |
| # | List each Work plan | FY 07/08 | FY 08/09 | Total | Children, Youth, and their Families (ages 0-17years) | Transition Age Youth (ages 16-25 yrs) | Adult | Older Adult |
| 12-15 session Family Therapy | | $100,000 | $100,000 | $200,000 | $200,000 | $0 | $0 | $0 |
| $0 | | | | | | | | |
| $0 | | | | | | | | |
| $0 | | | | | | | | |
| $0 | | | | | | | | |
| $0 | | | | | | | | |
| $0 | | | | | | | | |
| $0 | | | | | | | | |
| $0 | | | | | | | | |
| Administration is within the program budget, see form No. 4. | | | | | | | | |
| Total PEI Funds Requested: | | $100,000 | $100,000 | $200,000 | $200,000 | $0 | $0 | $0 |

**Form No. 7 LOCAL EVALUATION OF A WORKPLAN**
County: Plumas Date: 12/28/2007

- ✓ Plumas County's population officially recorded in 2004 was less than 21,000; thus, we are a "very small county with population less than 100,000" and **opt to exempt** ourselves from the requirement of this local outcome evaluation (per DMH PEI Guidelines, page 26).

Workplan Name: 12-15 session Family Therapy
**1. a. Identify the strategies (from Form No. 3 PEI Workplan Summary), the county will evaluate and report on to the State**.

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

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

**3. Table of demographics.**

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

**5. How will data be collected and analyzed?**

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

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

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