2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Program #1 - School-based Mental Health Promotion and Service Linkage

Date: September 28, 2010

Select one:
- ☐ **CSS**
- ☐ **WET**
- ☒ **PEI**
- ☐ **INN**

Prevention and Early Intervention				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, complete Exh. E4; If no, answer question #2
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☒	If yes, completed Exh. F4; If no, answer question #3
3.	Is the current funding requested greater than15% of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer question #4
4.	Is the current funding requested greater than 35% less of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer questions 5, 5a, and 5b
5.	Describe the proposed changes to the Previously Approved Program and the rationale for those changes.			
This project was originally expected to serve 25 individuals/families in its initial 6 months of implementation (Jan-June 2009). During this first six months of operation, the project received fewer referrals than expected, and consequently served fewer children. A proposed name change to "Early Intervention Program for Youth" is intended to reflect an expansion of the mechanisms for referral and access. While the formerly-approved program will remain intact, access to this program will be expanded beyond the interdisciplinary screening team of MHD and school districts. The Mental Health Prevention Goal, Approach, and Age Groups will remain the same. Referrals from additional sources will be entertained. This expansion offers opportunities to increase the access and impact of this prevention and early intervention program. The budget was annualized to reflect a full year of operation (the FY 09-10 budget for six months of operation was $142,083) plus an additional 12.5% to allow for program expansion. Total budgeted amount: $319,768				
5a.	If the total number of Individuals to be served annually is different than previously reported please provide revised estimates Total Individuals: _55_ Total Families: _55__			
5b.	If the total number of clients by type of prevention annually is different than previously reported please provide revised estimates: (No change in program goals)	**Prevention**	**Early Intervention**	
	Total Individuals:		55	
	Total Families:		55	

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☐	If no, answer question #3; If yes, complete Exh. F4
3.	Will the consolidated programs continue to serve the same estimated number of individuals?	☐	☐	If yes, answer question #4; If no, complete Exh. F4
4.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) How the Previously approved programs will be consolidated; and c) Provide the rationale for consolidation			

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Program #2 - Primary Intervention Project (PIP)

Date: September 28, 2010

Select one:
- ☐ CSS
- ☐ WET
- ☒ PEI
- ☐ INN

Prevention and Early Intervention				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☒	☐	If yes, complete Exh. E4; If no, answer question #2
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☒	If yes, completed Exh. F4; If no, answer question #3
3.	Is the current funding requested greater than15% of the previously approved amount?	☒	☐	If yes, complete Exh. F4; If no, answer question #4
4.	Is the current funding requested greater than 35% less of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer questions 5, 5a, and 5b
5.	Describe the proposed changes to the Previously Approved Program and the rationale for those changes.			
The scope of this program will reflect a full year of operation. As such, another community (El Dorado Hills) which is isolated in reference to mental health service delivery will be integrated into this pilot program. The Mental Health Prevention Goal, Model, target population and age group remain the same. Original budgeting for this plan was $86,851 for 6 months of operation; the equivalent annualized expenditures would be $173,702. With the inclusion of the El Dorado Hills service location, program costs will increase to $237,830, representing a 37% increase in expenditures.				
5a.	If the total number of Individuals to be served annually is different than previously reported please provide revised estimates Total Individuals: 306 Total Families: _____ We expect the number of children served to increase proportionally with the addition of another community site, to a total of 306 children.			
5b.	If the total number of clients by type of prevention annually is different than previously reported please provide revised estimates:	**Prevention**	**Early Intervention**	
	Total Individuals:	306		
	Total Families:			

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☐	If no, answer question #3; If yes, complete Exh. F4
3.	Will the consolidated programs continue to serve the same estimated number of individuals?	☐	☐	If yes, answer question #4; If no, complete Exh. F4
4.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) How the Previously approved programs will be consolidated; and c) Provide the rationale for consolidation			

*PEI Projects previously approved are now called Previously Approved Programs

PEI NEW PROGRAM DESCRIPTION

County: El Dorado

Program Number/Name: Program #2 – Primary Intervention Project (PIP)

Date: September 28, 2010

Instructions: Utilizing the following format please provide responses and refer to the instructions provided in the original PEI Guidelines, as noted in DMH Information Notices No.: 07-19 and 08-23. Complete this form for each new PEI Program and existing PEI Programs that made changes to Key Community Mental Health Needs, Priority Population, and/or funding as described in the Information Notice.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	**Transition-Age Youth**	**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	☒	☐		
4. Stigma and Discrimination	☒	☐	☐	☐
5. Suicide Risk	☒	☐	☐	☐

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

a. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s) and describe how the PEI program will reach/engage unserved and underserved multicultural communities.

A key feature of ensuring comprehensive and representative participation was providing a range of avenues for input and decision-making. Opportunities to participate in the Community Program Planning (CPP) process were ensured by mechanisms for information dissemination (announcements in meetings and groups attended by stakeholders, posted fliers, mass mailings, and the MHSA website providing meeting announcements, updates, and meeting minutes), education and training, outreach (comprehensive and targeted), open planning meetings, and a representative MHSA Advisory Committee. Options for anonymous input included a local phone line with a voice mailbox, an e-mail address, and use of written and online surveys. Outreach efforts included community meetings, readiness trainings, focus groups and key informant interviews which were intended to offer convenient one-time opportunities to gain information about the MHSA and to offer feedback. The detailed planning occurred in the planning and advisory committee meetings which were arenas for ongoing involvement. During Phase I, a mailing list of 390 individuals was created and over 500 survey questionnaires were completed. During Phase II, the mailing list expanded to 450 and over 185 survey questionnaires were completed.

El Dorado County's efforts to ensure a comprehensive and representative MHSA planning process included the following accomplishments during Phase I:

- 82 focus groups and readiness trainings reaching 925 respondents
- 23 key informant interviews
- 5 written surveys with a total of 545 responses
- An MHSA mailing list of 390 individuals used to send out announcements, surveys, meeting notifications, and updates.
- Local media (newspapers, cable television and radio) were used to announce community meetings and to inform the public of the MHSA planning activities and contact information.

In addition, the targeted outreach strategy that characterized Phase II ensured that we contacted the following groups via focus groups and/or use of key informant interviews:

County Mental Health Staff
Mental Health Commission Members
MHSA Program members (current consumers)
The Center for Violence-Free Relationships
NAMI members
CASA (Court Appointed Special Advocates) volunteers (TAY program)
Shingle Springs Rancheria (Native American services provider, tribe members and elders)
Youth Commission members
MORE (Mother Lode Rehabilitation Enterprises, Inc.) Disabled adults program – staff members
PFLAG (LGBT program) - volunteers
Caregivers Support Groups (various)
United Outreach (homeless services agency) - volunteers
Local Collaboratives
Headstart – Latino parents
Youth Groups (various)
Adult Drug Court Interdisciplinary Team
Teen Drug Court Representative
Juvenile Hall staff member
Alcohol and Drug Program (ADP) providers
School Nurses
School Psychologists
County Office of Education representative
Faith-based community organization members
Foster Parent Association - Representative
First 5 Commission Representative
County Office of Education – staff members
Public Guardian's Office – staff members
Early Childhood Council - Representative
Department of Human Services – staff members
School District Superintendents – staff members
County Public Health staff
Medical Library staff
County Veterans Services Office
Head Start - employees
Family Resource Centers – staff members
City Police
County Sheriff Department
County Superior Court
District Attorney's Office
Public Defender's Office
State Department of Rehabilitation
Medical Centers, Clinics, Hospitals
Council for Disabilities
Holistic Medicine Practitioners

Context:
Ensuring that the staff capacity, knowledge and skills are in place to address the County diversity issues is an ongoing challenge that is being addressed as part of the MHSA program development process. During the MHSA PEI CPP process, two MHSA Project Management Team members received training regarding use of the California Brief Multicultural Competency Scale - a diversity-training tool designed specifically for mental health practitioners with the goal of moving from cultural sensitivity to cultural competence. The goal has been to provide local Division-wide training for staff and community members over time. Implementation of this strategy, along with other strategies to address diversity of culture and language, has been significantly impacted by the Reduction in Force that took place in recent years. We have lost staff capacity related to this training, diversity, and interpretation and translation skills. Yet, the initial stage of this training process is reflected in this year's Quality Improvement Committee plan as part of the Cultural Competency sub-committee plan.

Race/Ethnicity:
The County demographics based on the 2000 Census were used during the MHSA CSS planning phase – a re-assessment pending the Census findings in 2010 will need to be conducted. To date, however, the EDC population profile is, as follows:

Race/Ethnicity:	
African American	0.7%
Asian American	2.7%
Latino	11.0%
Native American	1.4%
Caucasian	82.0%
Other	2.2%

Targeted outreach occurred where there were known groups or places where the Latino and Native American populations could be reached (English as a Second Language/ESL classes, Latino Family Resource Center, and the Rancheria). Together with the Caucasian population, this comprises 94.4% of the County population. The challenge is significant in relationship to outreach to the African American and Asian populations – together they comprise 3.4% of the County population – and we have not yet identified any particular group or setting to target for outreach purposes. It is unclear what comprises the category of "Other" but there is a growing population of Russian immigrants in the western County area closer to Sacramento. We have identified one potential contact person by which to begin to reach this population and a few of these stakeholders were represented in an outreach group.

Youth with disabilities, African American and Asian middle school students were among youth reached in the context of a special all day event which targeted youth who self-identified with a unique group or identity – typically along the lines of race/ethnicity. A MHSA team member participated in this event as a group facilitator. This event solicited their input in relationship to the exploratory question: "What is needed to help students like yourselves successfully move from middle to high school?" Issues of concerns with bullying were predominant, as was the feedback related to a need for the student voice in planning and decision-making.

Efforts to maintain feedback and dialogue with underserved populations have improved to a degree with experience and diversified MHSA service providers (Latino and Native American). The MHD is committed to continuing our efforts to improve further.

Language
Targeted outreach to the Latino population included use of bilingual/bicultural staff, focus groups at churches, ESL classes and a Latino Community Family Resource Center (FRC). In one interesting scenario, an ESL class hosted by the Latino Community FRC included a Vietnamese individual. During Phase I, extensive work was invested in getting materials translated into Spanish – including the Executive Summary of the original CSS plan. Furthermore, we had individuals at many of our key presentations available to provide interpretation for Spanish-speaking individuals. Our findings were that these resources were not utilized and that targeted outreach to small groups was a far more effective technique to engage this population in our community.

Geographic Regions
As indicated earlier, to address the separation of the Western Slope Region from South Lake Tahoe, we used teleconferencing equipment for almost all of the planning meetings. MHSA PEI training took place in person in SLT, as well, on two occasions. The Western Slope Region is expansive and beyond the County seat of Placerville, includes a community in the east (Pollock Pines), a community in the southern region (Somerset), a community to the north (Georgetown Divide), and one to the west (Cameron Park-El Dorado Hills). In addition to what is outlined below, outreach to existing community collaboratives did occur in Georgetown and El Dorado Hills. Greater efforts to identify effective ways to reach Pollock Pines and Somerset need to be made in the future.

Age Groups
Middle school, TAY, and high school students were reached via targeted outreach and/or participation in the planning meetings. There is an active EDC youth voice - they participate on their own commission (for example, giving feedback to the County regarding safety issues related to the Skate Board Park) and as full members on the El Dorado Hills Vision Coalition – and these groups were accessed as part of the MHSA PEI CPP process.

Gender and LGBT
Targeted outreach served to solicit feedback from representatives from PFLAG and agencies that serve to reduce domestic violence. The issues of personal safety and outreach to enhance access to services were important themes relevant to PEI

planning.

A strong theme that emerged from this process was the desire to intervene early on with youth from a strengths-based perspective – to build protective factors. The elementary school setting serves as both a site for both early identification and prevention intervention opportunities. It further serves to provide access to services in a non-stigmatized setting.

It is the intention of this program to better reach the un-served and under-served populations in a cost-effective manner. School-based strategies assist in accessing these communities. Each component program will be asked to have a specific plan regarding targeting and access for the underserved populations and to report on their results in the year-end progress report.

This project, **Primary Intervention Project (PIP)**, targets the PEI target population of *children and youth in stressed families* and, as such, is intended to address the community mental health needs surrounding *at-risk children*.

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

This program is a previously approved PEI program, but we are proposing to annualize the plan (the previously approved plan was for a period of 6 months) by including one additional site. The Oak Meadow Elementary School in El Dorado Hills had previously expressed an interest in partnering with the Vision Coalition and the MHD in hosting a PIP pilot site. This site is being proposed as part of the annualized plan. El Dorado Hills is a highly populated community within the County but, as this time, does not have a mental health services site.

The Vision Coalition was formed to help youth in El Dorado Hills by providing "positive youth development" opportunities, including financial support. Youth development opportunities are activities that increase knowledge and build strength, assets, skills, and talents to help young people reach their highest potential, in ways that are safe, healthy, and free from alcohol and drug use. Funds from federal and private sector grants as well as donations from individuals and businesses in the community support the Coalition's activities.

Mental Health Prevention Goal – To decrease school adjustment difficulties at an early age and build protective factors to foster youth resilience and mental health.

Model – targeted prevention.

Age group – Youth, ages 4-9.

Determinants to be addressed:

- Determinants of conduct disorders
- Determinants of substance abuse
- Both risk and protective factors related to family conflict and aggression

Intervention Strategy/Model:
The Primary Intervention Program (PIP) Project is an evidence-based practice that has been supported by the California Department of Mental Health since 1983 and is part of the California Early Mental Health Initiative (EMHI). Staff involved in this project will plan to attend the annual EMHI training conference, which provides training in various aspects of program implementation and skills development. The PIP's goal is to increase school adjustments as school-adjustment difficulties have been linked to later delinquency, substance abuse and drop-out rates.

The program provides screening to identify children with mild aggression, withdrawal and/or learning difficulties. It is a Mental Health Promotion model with behavioral control and adaptive assertiveness among the outcomes achieved.

Provider/Location:
The PIP project is a school-based collaboration between the affected County school district and the County Mental Health Division (MHD). Teachers and a screening team identify children (K-3) who are "at risk" of developing emotional problems as indicated by their school adjustment difficulties. Alternative recommendations will be provided for youth screened out and the screening team will partner with the referring teacher and family to this end. Trained school aides provide the PIP intervention in the form of 1:1 non-directive play for approximately 30-45 minutes per week for 12-15 weeks. This proposal includes a 12-15 week skills training group intervention strategy at some sites called "Second Step" – a violence prevention program which is also a part of the California Early Mental Health Initiative.

The PIP Program will:

- Serve students in kindergarten through third grade in public schools experiencing mild to moderate school adjustment difficulties. The services are school-based and low cost. Supervised and trained child aides provide weekly play sessions with the selected students.
- Ensure that students are selected for program participation through a systematic selection process that includes completion of standardized assessments and input from the school-based mental health professional and teachers.
- Encourage the involvement of parents/guardians and teaching staff to build alliances to promote student's mental health and social and emotional development. Parental consent is required for student participation.
- Have a core team consisting of school-based, credentialed mental health professionals, local mental health professionals (from a cooperating mental health entity) and child aides.
- Ensure that credentialed school-based mental health professionals provide ongoing supervision/training of child aides.
- Provide ongoing monitoring and evaluation of program services.

Three school districts (seven school sites) will provide the appropriate space for this project, an MHSA-funded, school-employed mental health professional who will participate in the screening and training sessions, and a coordinator to manage the collection and submission of program data. The intention is to ensure that this program is available in three regions of the County (the communities of South Lake Tahoe, the Georgetown Divide and El Dorado Hills) for a pilot of up to two years. This approach provides an opportunity to use MHSA funds to incubate efforts as the funds are not sufficient to provide for County-wide programs. The continued use of this model and the locations for use of these funds will be re-evaluated continuously as the community engages in ongoing MHSA PEI planning.

4. Activities

Activity Title	Proposed number of individuals or families through PEI expansion to be served through June 2011 by type of prevention:			Number of months in operation through June 2011
		Prevention	Early Intervention	
Primary Intervention Project (PIP)	Individuals: Families:	306		12
Total PEI Program Estimated Unduplicated Count of Individuals to be Served	Individuals: Families:	306		

5. Describe how the program links PEI participants to County Mental Health and providers of other needed services

PIP and Second Step Child Aides will be trained regarding referral and access to County Mental Health Services, including the Early Intervention for Youth Program and services for adults. Linkage to other needed services may be improved as a function of the agencies participation in the local Community Strengthening Groups in which collaboration with other providers is enhanced.

6. Describe collaboration with and system enhancements of other partners such as community based organizations, schools, and primary care.

This strategy involves community collaboratives, a mental health – school district collaboration, an interdisciplinary team screening process, and enhances mental health service access. As such, it represents a key system enhancement related to health promotion and the enhancement of protective factors that target areas of concern in EDC (family stress and the youth delinquency).

7. Describe intended outcomes.

The fundamental goals are to:

- Provide prevention and early intervention services at a young age.
- Provide services in a school-based setting to enhance access.
- Build protective factors by facilitating successful school adjustment.
- Target violence prevention as a function of a skills training.

8. Describe coordination with Other MHSA Components.

The MHSA CSS programs will be accessed through the Early Intervention for Youth Program clinicians proposed under Program #1 as the need arises – this may include the need for adult services. The WET Coordinator will be looking for opportunities to merge workforce development and the need for capacity building in the arena of prevention and health promotions in collaboration with the MHSA Project Coordinator.

The other MHSA components are still under development.

9. Provide a budget narrative for costs identified for this Program, as outlined in Exhibit F. Please include the number of FTE personnel positions/classifications and a brief description of each FTE's functions. Please include a brief description of operating costs, subcontracts/professional services, and non-recurring

expenditures associated with this PEI Program.

With the exception of the subcontracted costs associated with the addition of a new project location, there are few changes to the budget for this project.

Personnel costs totaling $48,422 provide for:

- 1.4 FTE Mental Health Aides who will provide weekly play sessions with selected students
- 0.1 FTE Mental Health Program Coordinator who will provide ongoing professional supervision, coordinate program activities, liaison with school personnel, and participate in the screening process.

Ongoing operating expenditures totaling $61,408 include the following:

- Program materials and toys, $2,100
- Transportation and mileage to school sites, $1,000
- Required staff training and the travel costs associated participation in the annual EMHI training conference, which is held in Southern California, $3,210
- Facility, overhead and indirect costs associated with program planning and implementation, $55,098

Subcontracted locations/services:

- El Dorado County Department of Education, $84, 000: contract to provide PIP services at two locations within the Georgetown Divide region of the County;
- Vision Coalition, $42,000: contract to provide PIP services at Oak Meadow Elementary School in El Dorado Hills.

Total program budget: 237,830

10. Additional Comments (Optional)

None.

County: El Dorado Date: 28-Sep-10

Program/Project Name and #: PEI #2 Primary Intervention Project (PIP)

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Other Expenditures*				$0
8. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Workforce Education and Training				
1. Personnel Expenditures				$0
2. Operating Expenditures				$0
3. Training Expenditures				$0
4. Training Consultant Contracts				$0
5. Residency Expenditures				$0
6. Internship Expenditures				$0
7. Mental Health Career Pathway Expenditures				$0
8. Stipend Funds				$0
9. Scholarship Funds				$0
10. Loan Repayment Funds				$0
11. Non-recurring Expenditures				$0
12. Other Expenditures*				$0
13. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Capital Facilities				
1. Pre-Development Costs				$0
2. Building/Land Acquisition				$0
3. Renovation				$0
4. Construction				$0
5. Repair/Replacement Reserve				$0
6. Other Expenditures*				$0
7. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Technological Needs				
1. Personnel				$0
2. Hardware				$0
3. Software				$0
4. Contract Services				$0
5. Other Expenditures*				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Prevention and Early Intervention (PEI)				
1. Personnel	$48,422	$84,000	$42,000	$174,422
2. Operating Expenditures	$61,408			$61,408
3. Non-recurring Expenditures				$0
4. Subcontracts/Professional Services			$2,000	$2,000
5. Other				$0
6. Total Proposed Expenditures	**$109,830**	**$84,000**	**$44,000**	**$237,830**

Innovation (INN)						
	1. Personnel					$0
	2. Operating Expenditures					$0
	3. Non-recurring Expenditures					$0
	4. Training Consultant Contracts					$0
	5. Work Plan Management					$0
	6. Other					$0
	7. Total Proposed Expenditures		**$0**	**$0**	**$0**	**$0**
B. REVENUES						
	1. New Revenues					
	a. Medi-Cal (FFP only)					$0
	b. State General Funds					$0
	c. Other Revenue					$0
	2. Total Revenues		**$0**	**$0**	**$0**	**$0**
C. TOTAL FUNDING REQUESTED			**$109,830**	**$84,000**	**$44,000**	**$237,830**

***Enter the justification for items that are requested under the "Other Expenditures" category.**
Justification:

Please include your budget narrative on a separate page.

Prepared by: Janet Stevens

Telephone Number: (530) 621-6226

PEI NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Action #2 – Primary Intervention Project

With the exception of the subcontracted costs associated with the addition of a new project location, there are few changes to the budget for this project.

Personnel costs totaling $48,422 provide for:

- 1.4 FTE Mental Health Aides who will provide weekly play sessions with selected students
- 0.1 FTE Mental Health Program Coordinator who will provide ongoing professional supervision, coordinate program activities, liaison with school personnel, and participate in the screening process.

Ongoing operating expenditures totaling $61,408 include the following:

- Program materials and toys, $2,100
- Transportation and mileage to school sites, $1,000
- Required staff training and the travel costs associated participation in the annual EMHI training conference, which is held in Southern California, $3,210
- Facility, overhead and indirect costs associated with program planning and implementation, $55,098

Subcontracted locations/services:

- El Dorado County Department of Education, $84, 000: contract to provide PIP services at two locations within the Georgetown Divide region of the County;
- Vision Coalition, $42,000: contract to provide PIP services at Oak Meadow Elementary School in El Dorado Hills.

Total program budget: $237,830

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Program #3 - Incredible Years

Date: September 28, 2010

Select one:
- ☐ CSS
- ☐ WET
- ☒ PEI
- ☐ INN

Prevention and Early Intervention				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, complete Exh. E4; If no, answer question #2
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☒	If yes, completed Exh. F4; If no, answer question #3
3.	Is the current funding requested greater than15% of the previously approved amount?	☒	☐	If yes, complete Exh. F4; If no, answer question #4
4.	Is the current funding requested greater than 35% less of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer questions 5, 5a, and 5b
5.	Describe the proposed changes to the Previously Approved Program and the rationale for those changes.			
The scope of this program will now reflect a full year of operation. As such, additional classes will be offered in various settings. Furthermore, the County plans to offer an Incredible Years (IY) training seminar to expand the capacity of Mental Health staff to conduct IY classes in the local community. The budget of the Incredible Years program has been increased to reflect the costs of additional class offerings at new locations, and to include operational costs for professional services for training, educational materials, travel, and staff time (salary and benefits). The Mental Health Prevention Goal, Model, target population and age group remain the same. The FY 09/10 budget for 6 months of operation was $21,360 (equivalent to $42,720 annually). The current request for $157,777 reflects an annualized program, with an expansion of program locations and the addition of training/education for additional staff trainers.				
5a.	If the total number of Individuals to be served annually is different than previously reported please provide revised estimates Total Individuals: ___282__ Total Families: 94			
5b.	If the total number of clients by type of prevention annually is different than previously reported please provide revised estimates:	**Prevention**		**Early Intervention**
	Total Individuals:	282		
	Total Families:	94		

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☐	If no, answer question #3; If yes, complete Exh. F4
3.	Will the consolidated programs continue to serve the same estimated number of individuals?	☐	☐	If yes, answer question #4; If no, complete Exh. F4
4.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) How the Previously approved programs will be consolidated; and c) Provide the rationale for consolidation			

*PEI Projects previously approved are now called Previously Approved Programs

PEI NEW PROGRAM DESCRIPTION

County: El Dorado

Program Number/Name: Program #3 – Incredible Years (IY)

Date: September 28, 2010

Instructions: Utilizing the following format please provide responses and refer to the instructions provided in the original PEI Guidelines, as noted in DMH Information Notices No.: 07-19 and 08-23. Complete this form for each new PEI Program and existing PEI Programs that made changes to Key Community Mental Health Needs, Priority Population, and/or funding as described in the Information Notice.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	**Transition-Age Youth**	**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	☒	☐		
4. Stigma and Discrimination	☒	☐	☒	☐
5. Suicide Risk	☒	☐	☒	☐

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

a. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s) and describe how the PEI program will reach/engage unserved and underserved multicultural communities.

A key feature of ensuring comprehensive and representative participation was providing a range of avenues for input and decision-making. Opportunities to participate in the Community Program Planning (CPP) process were ensured by mechanisms for information dissemination (announcements in meetings and groups attended by stakeholders, posted fliers, mass mailings, and the MHSA website providing meeting announcements, updates, and meeting minutes), education and training, outreach (comprehensive and targeted), open planning meetings, and a representative MHSA Advisory Committee. Options for anonymous input included a local phone line with a voice mailbox, an e-mail address, and use of written and online surveys. Outreach efforts included community meetings, readiness trainings, focus groups and key informant interviews which were intended to offer convenient one-time opportunities to gain information about the MHSA and to offer feedback. The detailed planning occurred in the planning and advisory committee meetings which were arenas for ongoing involvement. During Phase I, a mailing list of 390 individuals was created and over 500 survey questionnaires were completed. During Phase II, the mailing list expanded to 450 and over 185 survey questionnaires were completed.

El Dorado County's efforts to ensure a comprehensive and representative MHSA planning process included the following accomplishments during Phase I:

- 82 focus groups and readiness trainings reaching 925 respondents
- 23 key informant interviews
- 5 written surveys with a total of 545 responses
- An MHSA mailing list of 390 individuals used to send out announcements, surveys, meeting notifications, and updates.
- Local media (newspapers, cable television and radio) were used to announce community meetings and to inform the public of the MHSA planning activities and contact information.

In addition, the targeted outreach strategy that characterized Phase II ensured that we contacted the following groups via focus groups and/or use of key informant interviews:

County Mental Health Staff
Mental Health Commission Members
MHSA Program members (current consumers)
Center for Violence-Free Relationships
NAMI members
CASA (Court Appointed Special Advocates) volunteers (TAY program)
Shingle Springs Rancheria (Native American services provider, tribe members and elders)
Youth Commission members
MORE (Mother Lode Rehabilitation Enterprises, Inc.) Disabled adults program – staff members
PFLAG (LGBT program) - volunteers
Caregivers Support Groups (various)
United Outreach (homeless services agency) - volunteers
Local Collaboratives
Headstart – Latino parents
Youth Groups (various)
Adult Drug Court Interdisciplinary Team
Teen Drug Court Representative
Juvenile Hall staff member
Alcohol and Drug Program (ADP) providers
School Nurses
School Psychologists
County Office of Education representative
Faith-based community organization members
Foster Parent Association - Representative
First 5 Commission Representative
County Office of Education – staff members
Public Guardian's Office – staff members
Early Childhood Council - Representative
Department of Human Services – staff members
School District Superintendents – staff members
County Public Health staff
Medical Library staff
County Veterans Services Office
Head Start - employees
Family Resource Centers – staff members
City Police
County Sheriff Department
County Superior Court
District Attorney's Office
Public Defender's Office
State Department of Rehabilitation
Medical Centers, Clinics, Hospitals
Council for Disabilities
Holistic Medicine Practitioners

Context:
Ensuring that the staff capacity, knowledge and skills are in place to address the County diversity issues is an ongoing challenge that is being addressed as part of the MHSA program development process. During the MHSA PEI CPP process, two MHSA Project Management Team members received training regarding use of the California Brief Multicultural Competency Scale - a diversity-training tool designed specifically for mental health practitioners with the goal of moving from cultural sensitivity to cultural competence. The goal has been to provide local Division-wide training for staff and community members over time. Implementation of this strategy, along with other strategies to address diversity of culture and language, have been significantly impacted by the Reduction in Force that took in recent years. We have lost staff capacity related to this training, diversity, and interpretation and translation skills. Yet, the initial stage of this training process is reflected in this year's Quality Improvement Committee plan as part of the Cultural Competency sub-committee plan.

Race/Ethnicity:
The County demographics based on the 2000 Census were used during the MHSA CSS planning phase – a re-assessment pending the Census findings in 2010 will need to be conducted. To date, however, the EDC population profile is, as follows:

Race/Ethnicity:	
African American	0.7%
Asian American	2.7%
Latino	11.0%
Native American	1.4%
Caucasian	82.0%
Other	2.2%

Targeted outreach occurred where there were known groups or places where the Latino and Native American populations could be reached (English as a Second Language/ESL classes, Latino Family Resource Center, and the Rancheria). Together with the Caucasian population, this comprises 94.4% of the County population. The challenge is significant in relationship to outreach to the African American and Asian populations – together they comprise 3.4% of the County population – and we have not yet identified any particular group or setting to target for outreach purposes. It is unclear what comprises the category of "Other" but there is a growing population of Russian immigrants in the western County area closer to Sacramento. We have identified one potential contact person by which to begin to reach this population and a few of these stakeholders were represented in an outreach group.

Youth with disabilities, African American and Asian middle school students were among youth reached in the context of a special all day event which targeted youth who self-identified with a unique group or identity – typically along the lines of race/ethnicity. A MHSA team member participated in this event as a group facilitator. This event solicited their input in relationship to the exploratory question: "What is needed to help students like yourselves successfully move from middle to high school?" Issues of concerns with bullying were predominant, as was the feedback related to a need for the student voice in planning and decision-making.

Efforts to maintain feedback and dialogue with underserved populations have improved to a degree with experience and diversified MHSA service providers (Latino and Native American). The MHD is committed to continuing our efforts to improve further.

Language
Targeted outreach to the Latino population included use of bilingual/bicultural staff, focus groups at churches, ESL classes and a Latino Community Family Resource Center (FRC). In one interesting scenario, an ESL class hosted by the Latino Community FRC included a Vietnamese individual. During Phase I, extensive work was invested in getting materials translated into Spanish – including the Executive Summary of the original CSS plan. Furthermore, we had individuals at many of our key presentations available to provide interpretation for Spanish-speaking individuals. Our findings were that these resources were not utilized and that targeted outreach to small groups was a far more effective technique to engage this population in our community.

Geographic Regions
As indicated earlier, to address the separation of the Western Slope Region from South Lake Tahoe, we used teleconferencing equipment for almost all of the planning meetings. MHSA PEI training took place in person in SLT, as well, on two occasions. The Western Slope Region is expansive and beyond the County seat of Placerville, includes a community in the east (Pollock Pines), a community in the southern region (Somerset), a community to the north (Georgetown Divide), and one to the west (Cameron Park-El Dorado Hills). In addition to what is outlined below, outreach to existing community collaboratives did occur in Georgetown and El Dorado Hills. Greater efforts to identify effective ways to reach Pollock Pines and Somerset need to be made in the future.

Age Groups
Middle school, TAY, and high school students were reached via targeted outreach and/or participation in the planning meetings. There is an active EDC youth voice - they participate on their own commission (for example, giving feedback to the County regarding safety issues related to the Skate Board Park) and as full members on the El Dorado Hills Vision Coalition – and these groups were accessed as part of the MHSA PEI CPP process.

Gender and LGBT
Targeted outreach served to solicit feedback from representatives of PFLAG and agencies that serve to address domestic violence. The issues of personal safety and outreach to enhance access to services were important themes relevant to PEI

planning.

Through this process, the desire to expand a highly successful existing program (indicated) in a universal and selective approach, was expressed. Another facet of the expansion strategy was to "bring it on the road" to provide parenting classes in community-based (vs clinic-based) settings. Parenting classes as a family-strengthening approach for both prevention and early intervention purposes is viewed as highly effective and valued. PEI funding is, therefore, proposed for use when the classes are targeting *universal and selective* populations – both in clinics and in the community.

It is the intention of this program to better reach the un-served and under-served populations in a cost-effective manner. The movement toward community-based sites for this program enhances visibility and access to these services for previously un-served populations. Use of bilingual and bicultural and partners will continue to be pursued to further assist in better serving under-served communities. Each component program will be asked to have a specific plan regarding targeting and access for the underserved populations and to report on their results in the year-end progress report.

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

This program was previously approved in January 2010 for a 6 month plan. Therefore, it is currently being annualized to provide 6 classes for the universal and selective populations. In addition, the ongoing need to expand the capacity of trainers will be addressed by pursuing training for new class facilitators.

Mental Health Prevention Goal – To promote emotional and social competence and prevent behavioral and emotional problems in young children by impacting multiple risk and protective factors that impact the development of conduct problems.

Approach – universal and selective prevention.

Age group – Youth, 2 - 12.

Determinants to be addressed:

- Determinants of conduct disorders
- Determinants of other common mental health concerns such as depression and anxiety
- Determinants of substance abuse
- Both risk and protective factors related to family conflict and aggression

The protective factors that will be addressed include bonding, opportunities, recognition and skills.

The risk factors that will be addressed include early and persistent antisocial behavior, family conflict, family management problems, favorable parental attitudes and involvement in problem behaviors, and lack of commitment to school.

Intervention Strategy/Model:
The **Incredible Years Program** is a set of comprehensive, multi-faceted, and developmentally-based curricula targeting 2-12 year old children, their parents, and school teachers. This strategy addresses the role of multiple interacting risk and protective factors in the development of conduct disorders. This intervention strategy thereby serves as a violence prevention strategy. Each program component is designed to work interactively with the others to promote emotional and social competence and prevent, reduce and treat behavioral and emotional problems in young children. This is a 12-14 week program with an estimated cost per un-insured family of $1000.

Provider/Location:
The County Mental Health staff will provide classroom facilitators and seek to work with community and/or school agencies to provide the space and PEI-funded childcare, meals and operational materials.

As a mental health promotion strategy, the goal is to bring this program to various community settings approximately six times this year in order to make this effective program available to stressed families County-wide. These classes are envisioned as providing opportunities to bring this program, one series at a time, to the outer-lying communities. The determination of the specific sites for these services is still under evaluation but the goal is to ensure some capacity for bilingual/bicultural services for the Latino community.

The host site will advertise the class series and will register clients. Along with the host site, the Mental Health clinician, other MHD personnel, and potentially school personnel will provide referrals and complete a pre-screening form with the family in the event that priority decisions need to be made for applicants. A representative from the host site will partner

with the assigned class facilitators to serve as a screening committee. Alternative recommendations will be provided for families screened out and the screening team will partner with the family to this end.

4. Activities

Activity Title	Proposed number of individuals or families through PEI expansion to be served through June 2011 by type of prevention:			Number of months in operation through June 2011
		Prevention	Early Intervention	
Incredible Years (IY)	Individuals: Families:	282 94		12
Total PEI Program Estimated Unduplicated Count of Individuals to be Served	Individuals: Families:	282 94		

5. Describe how the program links PEI participants to County Mental Health and providers of other needed services

The interdisciplinary screening team proposed under Program #1 comprised of Mental Health and County Office of Education personnel will serve as a key referral source to this program and the participating Mental Health clinicians (Program #1) will be charged with providing linkage to services for children and families in need. The Mental Health clinicians will receive training related to the available mental health services – including other MHSA services and services for adults – in order to ensure effective service brokerage. The clinicians' participation in the Community Strengthening Groups will also facilitate enhanced access to a range of services. Client participation in this program will serve to break down barriers, reduce stigma, and increase access to mental health and other services. The availability of this program will be marketed to community partners by the host sites.

6. Describe collaboration with and system enhancements of other partners such as community based organizations, schools, and primary care.

This program will be executed in collaboration with the County Office of Education and local community collaboratives and represents a systems enhancement in the form of increased school and community-based prevention services. Furthermore, this program builds on the current success of the MHSA CSS-funded Incredible Years classes which have been limited to families involved in the Specialty Mental Health level of treatment. Enhanced access for families (at the stage of PEI and including Medi-Cal and non-Medi-Cal families) is intended with this PEI program.

7. Describe intended outcomes.

The fundamental goals are to increase:

- Positive and nurturing parents
- Child positive behaviors, social competence, and school readiness skills
- Parent bonding and involvement with teachers/school
- Teacher classroom management skills

The goals also are to decrease:

- Harsh, coercive and negative parenting
- Children behavior problems

The Youth Outcome Questionnaire (YOQ) will be applied on a pre and post class basis.

8. Describe coordination with Other MHSA Components.

Coordination with the MHSA CSS program staff will be critical to ensure effective leveraging of the staff trained in this intervention strategy. Information regarding the availability of this program will be provided to MHSA CSS and WET program staff and participants as potential sources of referrals.

The WET Coordinator will be looking for opportunities to merge workforce development and the need for capacity building in the arena of prevention and health promotions in collaboration with the MHSA Project Coordinator.

The other MHSA components are still under development.

PEI NEW PROGRAM DESCRIPTION

9. Provide a budget narrative for costs identified for this Program, as outlined in Exhibit F. Please include the number of FTE personnel positions/classifications and a brief description of each FTE's functions. Please include a brief description of operating costs, subcontracts/professional services, and non-recurring expenditures associated with this PEI Program.

Budgeting for this program reflects the costs of additional class offerings at new locations, and includes operational costs for professional services for training, educational materials, travel, and staff time (salary and benefits). The FY 09/10 budget for 6 months of operation was $21,360 (equivalent to $42,720 annually). The current request for $155,777 reflects an annualized program and the addition of training/education for additional staff trainers.

- The personnel costs (salary, benefits and taxes) for presenting the Incredible Years workshops in six community-based settings total $48,168, based on the following:
  - Mental Health Clinician: Approximately 14 hours/week for 12 weeks, each session. With six sessions planned, this totals 1008 hours, or 0.5 FTE
- Additional personnel costs for IY training (six Mental Health Clinicians and two Mental Health Workers, each for 8 hours/day for three days): $7,703
- Operational Costs for the presentation of the six community IY sessions and training for eight MH staff include the following:
  - Facility, Indirect and Overhead costs facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing: $59,406
  - Role Play toys: $500
  - Child activity materials and food: $12,400
  - Parent books, materials, and door prizes: $6,600
  - Transportation (mileage) for clinicians to conduct community-based workshops: $2500
- One-Time, non-recurring expenditures:
  - Purchase of Incredible Years curriculum for older children/adolescents: $2,000
- Subcontracts/Professional Services:
  - Use of the South Lake Tahoe Tot Spot, including site supervision and the cost to provide an additional Child Care Worker, $1,500
  - Vision Coalition contract services for IY workshops in El Dorado Hills: $10,000
  - Incredible Years professional trainer time and expenses: $5,000

10. Additional Comments (Optional)

None.

County: El Dorado Date: 28-Sep-10

Program/Project Name and #: PEI #3 Incredible Years

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Other Expenditures*				$0
8. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Workforce Education and Training				
1. Personnel Expenditures				$0
2. Operating Expenditures				$0
3. Training Expenditures				$0
4. Training Consultant Contracts				$0
5. Residency Expenditures				$0
6. Internship Expenditures				$0
7. Mental Health Career Pathway Expenditures				$0
8. Stipend Funds				$0
9. Scholarship Funds				$0
10. Loan Repayment Funds				$0
11. Non-recurring Expenditures				$0
12. Other Expenditures*				$0
13. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Capital Facilities				
1. Pre-Development Costs				$0
2. Building/Land Acquisition				$0
3. Renovation				$0
4. Construction				$0
5. Repair/Replacement Reserve				$0
6. Other Expenditures*				$0
7. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Technological Needs				
1. Personnel				$0
2. Hardware				$0
3. Software				$0
4. Contract Services				$0
5. Other Expenditures*				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Prevention and Early Intervention (PEI)				
1. Personnel	$55,871		$10,300	$66,171
2. Operating Expenditures	$81,406		$1,200	$82,606
3. Non-recurring Expenditures	$2,000			$2,000
4. Subcontracts/Professional Services			$5,000	$5,000
5. Other				$0
6. Total Proposed Expenditures	**$139,277**	**$0**	**$16,500**	**$155,777**

Innovation (INN)						
	1. Personnel					$0
	2. Operating Expenditures					$0
	3. Non-recurring Expenditures					$0
	4. Training Consultant Contracts					$0
	5. Work Plan Management					$0
	6. Other					$0
	7. Total Proposed Expenditures		**$0**	**$0**	**$0**	**$0**
B. REVENUES						
	1. New Revenues					
	a. Medi-Cal (FFP only)					$0
	b. State General Funds					$0
	c. Other Revenue					$0
	2. Total Revenues		**$0**	**$0**	**$0**	**$0**
C. TOTAL FUNDING REQUESTED			**$139,277**	**$0**	**$16,500**	**$155,777**

***Enter the justification for items that are requested under the "Other Expenditures" category.**

Justification:

Please include your budget narrative on a separate page.

Prepared by: Janet Stevens

Telephone Number: (530) 621-6226

PEI NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Action #3 – Incredible Years

Budgeting for this program reflects the costs of additional class offerings at new locations, and includes operational costs for professional services for training, educational materials, travel, and staff time (salary and benefits). The FY 09/10 budget for 6 months of operation was $21,360 (equivalent to $42,720 annually). The current request for $155,777 reflects an annualized program and the addition of training/education for additional staff trainers.

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- Subcontracts/Professional Services:
  - Use of the South Lake Tahoe Tot Spot, including site supervision and the cost to provide an additional Child Care Worker, $1,500
  -Vision Coalition contract services for IY workshops in El Dorado Hills: $10,000
  - Incredible Years professional trainer time and expenses: $5,000

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Program #4 - Community Education Project

Date: September 28, 2010

Select one:
- ☐ CSS
- ☐ WET
- ☒ PEI
- ☐ INN

Prevention and Early Intervention				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, complete Exh. E4; If no, answer question #2
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☒	☐	If yes, completed Exh. F4; If no, answer question #3
3.	Is the current funding requested greater than15% of the previously approved amount?	☒	☐	If yes, complete Exh. F4; If no, answer question #4
4.	Is the current funding requested greater than 35% less of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer questions 5, 5a, and 5b
5.	Describe the proposed changes to the Previously Approved Program and the rationale for those changes.			
The proposed change to this program is designed to expand the scope and diversify the PEI strategies available to the community. Feedback received from the community indicated that an increased investment in educational prevention strategies was desirable as a cost-effective, pro-active measure. The Parenting Wisely scope will be expanded from the proposed 6 month scope to an annualized plan to allow resources to be purchased for use in various community settings. NAMI has requested training to diversity the types of classes that they can provide to the local community. PFLAG will broaden its target audience to network with various community-based service organizations and diversify its library of educational materials. Under this amended program, a Community Access Site (CAS) or web-based community education and information resource center for consumers of mental health services, family members and community stakeholders will be initiated, as well. This community referral site will provide free access to a comprehensive library of interactive online courses targeting the general public. Finally, this program will include a Consumer Leadership Academy providing educational opportunities designed to inform and empower consumers to facilitate meaningful participation in the broader community. To facilitate client and community involvement, funding and the establishment of a stipend program to address costs incurred for participants will be pursued. Total program budget: $69,109				
5a.	If the total number of Individuals to be served annually is different than previously reported please provide revised estimates Total Individuals: __230__ Total Families: __55__			
5b.	If the total number of clients by type of prevention annually is different than previously reported please provide revised estimates:	**Prevention**	**Early Intervention**	
	Total Individuals:	230		
	Total Families:	55		

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☐	If no, answer question #3; If yes, complete Exh. F4
3.	Will the consolidated programs continue to serve the same estimated number of individuals?	☐	☐	If yes, answer question #4; If no, complete Exh. F4
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*PEI Projects previously approved are now called Previously Approved Programs

	c) Provide the rationale for consolidation

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PEI NEW PROGRAM DESCRIPTION

County: El Dorado

Program Number/Name: Program #4 – Community Education Project

Date: September 28, 2010

Instructions: Utilizing the following format please provide responses and refer to the instructions provided in the original PEI Guidelines, as noted in DMH Information Notices No.: 07-19 and 08-23. Complete this form for each new PEI Program and existing PEI Programs that made changes to Key Community Mental Health Needs, Priority Population, and/or funding as described in the Information Notice.

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	Children and Youth	**Transition-Age Youth**	**Adult**	**Older Adult**
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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 programs must address underserved racial/ethnic and cultural populations.**	**Age Group**			
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2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☒	☒
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☒	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒		
6. Underserved Cultural Populations	☒	☒	☒	☒

a. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s) and describe how the PEI program will reach/engage unserved and underserved multicultural communities.

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Caregivers Support Groups (various)
United Outreach (homeless services agency) - volunteers
Local Collaboratives
Headstart – Latino parents
Youth Groups (various)
Adult Drug Court Interdisciplinary Team
Teen Drug Court Representative
Juvenile Hall staff member
Alcohol and Drug Program (ADP) providers
School Nurses
School Psychologists
County Office of Education representative
Faith-based community organization members
Foster Parent Association - Representative
First 5 Commission Representative
County Office of Education – staff members
Public Guardian's Office – staff members
Early Childhood Council - Representative
Department of Human Services – staff members
School District Superintendents – staff members
County Public Health staff
Medical Library staff
County Veterans Services Office
Head Start - employees
Family Resource Centers – staff members
City Police
County Sheriff Department
County Superior Court
District Attorney's Office
Public Defender's Office
State Department of Rehabilitation
Medical Centers, Clinics, Hospitals
Council for Disabilities
Holistic Medicine Practitioners

Context:
Ensuring that the staff capacity, knowledge and skills are in place to address the County diversity issues is an ongoing challenge that is being addressed as part of the MHSA program development process. During the MHSA PEI CPP process, two MHSA Project Management Team members received training regarding use of the California Brief Multicultural Competency Scale - a diversity-training tool designed specifically for mental health practitioners with the goal of moving from cultural sensitivity to cultural competence. The goal has been to provide local Division-wide training for staff and community members over time. Implementation of this strategy, along with other strategies to address diversity of culture and language, has been significantly impacted by the Reduction in Force that took place in recent years. We have lost staff capacity related to this training, diversity, and interpretation and translation skills. Yet, the initial stage of this training process is reflected in this year's Quality Improvement Committee plan as part of the Cultural Competency sub-committee plan.

Race/Ethnicity:
The County demographics based on the 2000 Census were used during the MHSA CSS planning phase – a re-assessment pending the Census findings in 2010 will need to be conducted. To date, however, the EDC population profile is, as follows:

Race/Ethnicity:	
African American	0.7%
Asian American	2.7%
Latino	11.0%
Native American	1.4%
Caucasian	82.0%
Other	2.2%

Targeted outreach occurred where there were known groups or places where the Latino and Native American populations could be reached (English as a Second Language/ESL classes, Latino Family Resource Center, and the Rancheria). Together with the Caucasian population, this comprises 94.4% of the County population. The challenge is significant in relationship to outreach to the African American and Asian populations – together they comprise 3.4% of the County population – and we have not yet identified any particular group or setting to target for outreach purposes. It is unclear what comprises the category of "Other" but there is a growing population of Russian immigrants in the western County area closer to Sacramento. We have identified one potential contact person by which to begin to reach this population and a few of these stakeholders were represented in an outreach group.

Youth with disabilities, African American and Asian middle school students were among youth reached in the context of a special all day event which targeted youth who self-identified with a unique group or identity – typically along the lines of race/ethnicity. A MHSA team member participated in this event as a group facilitator. This event solicited their input in relationship to the exploratory question: "What is needed to help students like yourselves successfully move from middle to high school?" Issues of concerns with bullying were predominant, as was the feedback related to a need for the student voice in planning and decision-making.

Efforts to maintain feedback and dialogue with underserved populations have improved to a degree with experience and diversified MHSA service providers (Latino and Native American). The MHD is committed to continuing our efforts to improve further.

Language
Targeted outreach to the Latino population included use of bilingual/bicultural staff, focus groups at churches, ESL classes and a Latino Community Family Resource Center (FRC). In one interesting scenario, an ESL class hosted by the Latino Community FRC included a Vietnamese individual. During Phase I, extensive work was invested in getting materials translated into Spanish – including the Executive Summary of the original CSS plan. Furthermore, we had individuals at many of our key presentations available to provide interpretation for Spanish-speaking individuals. Our findings were that these resources were not utilized and that targeted outreach to small groups was a far more effective technique to engage this population in our community.

Geographic Regions
As indicated earlier, to address the separation of the Western Slope Region from South Lake Tahoe, we used teleconferencing equipment for almost all of the planning meetings. MHSA PEI training took place in person in SLT, as well, on two occasions. The Western Slope Region is expansive and beyond the County seat of Placerville, includes a community in the east (Pollock Pines), a community in the southern region (Somerset), a community to the north (Georgetown Divide), and one to the west (Cameron Park-El Dorado Hills). In addition to what is outlined below, outreach to existing community collaboratives did occur in Georgetown and El Dorado Hills. Greater efforts to identify effective ways to reach Pollock Pines and Somerset need to be made in the future.

Age Groups
Middle school, TAY, and high school students were reached via targeted outreach and/or participation in the planning meetings. There is an active EDC youth voice - they participate on their own commission (for example, giving feedback to the County regarding safety issues related to the Skate Board Park) and as full members on the El Dorado Hills Vision Coalition – and these groups were accessed as part of the MHSA PEI CPP process.

Gender and LGBT
Targeted outreach served to solicit feedback from representatives of PFLAG and other agencies that address domestic violence. The issues of personal safety and outreach to enhance access to services were important themes relevant to PEI planning.

Through this process, the identification of the priority populations specific to the Community Education Project is emerged from the analysis of the combination of high risk factors and limited resources for the TAY and LGBT population, the need for strategies to reach individuals and families for whom transportation served as a barrier, and the recognized value of learned experience in promoting health, supporting recovery, and building capacity.

It is the intention of this program to better reach the un-served and under-served populations in a cost-effective manner. Each of the methods proposed include use of peers or materials that designed to increase access. Each component program will be asked to have a specific plan regarding targeting and access for the underserved populations and to report on their results in the year-end progress report.

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

The Mental Health Promotions or Prevention Goal - Promotion of mental health through knowledge, education and skills training and the building of community capacity to promote mental health through community education. This strategy emphasizes the key role of diversity, consumers, and family in strengthening communities.

Intervention Strategies/Models - The Community Education Project diversity and expand its educational strategies:

Parenting Wisely Program (Selective and Indicated Prevention Approaches)
This parent training program targets parents with children ages 5-18. The Parenting Wisely Program uses a self-administered, interactive and multimedia CD-ROM as the training vehicle and thereby overcomes illiteracy and transportation barriers. This program is based on social learning theory, family systems theory, and cognitive theory and seeks to help families improve relationships and decrease conflict by improving parenting skills and enhancing family communication, mutual support, supervision and discipline. This program is recognized by SAMSHA as a model program. In the initial year, we proposed the purchase of ten (10) CD-ROMs for county-wide use. Much interest has been generated among our partner agencies and staff and we also determined that there is another set of materials targeting adolescents. Therefore, we intend to annualize this plan by purchasing ten (10) additional CD-ROMs in both English and Spanish.

NAMI training capacity building (Selective and Indicated Prevention Approaches)
The National Alliance on Mental Illness (NAMI) serves to provide awareness, education and advocacy as a means to offer hope, reform and health to the community. This group began in 1979 and represents families, friends and individuals affected by mental illness.

The local NAMI chapters have been successfully providing the Family to Family Program (a 12-week course provided to families, friends, and caregivers and community members) by NAMI volunteers free of cost. The family education approach is based on theories of stress, coping, and adaptation. The primary outcome of concern in family education is the well-being of the family and the program is not diagnosis-specific. This family education model provides information, coping skills training, and collaboration skills training. Enhancement of protective factors for family members serves as an early intervention strategy that positively impacts the recovery process of mental health consumers.

This 12-week program is taught by trained family member volunteers with the use of a highly structured, scripted manual. In weekly two- to three-hour sessions, family caregivers receive information about mental illnesses, treatments and medication, and rehabilitation. They learn self-care and communication skills as well as problem-solving and advocacy strategies.

While the research on the Family-to-Family Education Program is limited, a few studies have found that family members who participate in family education programs have greater knowledge and self-efficacy and are more satisfied with the patient's treatment than those who do not. In addition, the participants experienced significantly greater family, community, and service system empowerment and reduced displeasure and worry about the family member who had a mental illness.

This fiscal year, the Western Slope NAMI Chapter has been re-evaluating their needs and is proposing to expand the repertoire of classes available locally by sending three members to get trained as trainers in the following areas:

NAMI Basics Education:
The program is for parents and other caregivers of children and adolescents living with mental illnesses. The course is taught by trained/certified teachers who are the parents/caregivers of individuals who developed the symptoms of mental illness prior to the age of 13 years. The course consists of six classes offered weekly.

Provider Education:
The NAMI Provider Education Program is a 10-week course that presents a penetrating, subjective view of family and

consumer experiences with serious mental illness to line staff at public agencies who work directly with people with severe and persistent mental illnesses. This course helps providers realize the hardships that families and consumers face and appreciate the courage and persistence it takes to live with and recover from mental illness. A training plan and progress report for the fiscal year will be submitted to the MHD. MHSA funds are being request to cover travel costs not funded by NAMI.

PFLAG Community Education (Universal, Selective and Indicated Prevention Approaches)

As an approved PEI program under Community Education, the MHD is partnering with Parents, Families, Friends of Lesbians and Gays (PFLAG) to provide outreach, education and training to mental health providers and interested community members. PFLAG provides an opportunity for dialogue about sexual orientation and gender identity and acts to create a society that is healthy and respectful of human diversity. Their mission is to support diversity, community involvement to build understanding, education to reduce stigma, and advocacy to end discrimination.

To support this plan, funding will continue to be made available for informational packets and educational materials that PFLAG volunteers present to participants of their program. Volunteers will present the information kits together with a short training session to the target audience in partnership. Outreach costs such as mileage reimbursement, postage, packet materials and other multimedia information, and food costs may be paid for as well. An outreach plan and year-end progress report will be submitted to the MHD.

Community Information Access

Under this program, a Community Access Site (CAS) or web-based community education and information resource center for consumers of mental health services, family members and community stakeholders will be initiated, as well. This community referral site provides free access to a comprehensive library of interactive online courses targeting the general public.

Topics include:

- General mental health
- Addiction, treatment and recovery
- Issues facing families
- Needs of children and adolescents
- Living with mental illness and working toward recovery
- Workforce skills – including basic computer training
- Issues related to older adults
- Needs of returning veterans
- WRAP information Center.

In addition, areas for community news, a resource finder, and a newsfeed and research center are included in the design. Native Language Translation is provided via Google Translate which is embedded in CAS and allows visitors to convert web text to their native language.

Resources will be leveraged as the MHSA WET Action #2: Workforce Development. WET funds were previously approved to support the establishment of web-based professional education for the staff. This CAS site serves as an extremely cost-effective expansion component targeting community education.

Consumer Leadership Academy

This program will include a Leadership Academy providing educational opportunities designed to inform and empower consumers in relationship to meaningful participation in the broader community. This program has begun locally as a grassroots effort with very favorable response on both slopes. Consumers have identified a need for support related to transportation assistance, funding for food during activities, and training resources and fees. In addition, funding and the establishment of a stipend program to address costs incurred for participants will be pursued. One desired outcome is increased participation on the Mental Health Commission. Training will also be pursued through the California Institute on Mental Health (CIMH) for Mental Health Board Trainings and through the MHSA WET Regional Collaborative for the Recovery-Oriented Leadership series. Peer counselor training may also be included in future Leadership Academy training events.

For the Consumer Leadership Academy activities, transportation assistance for county-wide events will be made available on a quarterly basis. Healthy snacks will be funded for locally held monthly consumer meetings at both SLT and WS. Staff support for a range of these events will be provided, as well. The WET Coordinator, Patients Rights Advocate, and

Volunteer Coordinators, and Mental Health Aides on both slopes will collaborate with consumers on this project. A meaningful role in the community may serve to be one of the most effective preventive measures to relapse to illness.

Mental Health First Aid

The MHD proposes to engage the local community and participate in a training program sponsored by the Central Region Collaborative to establish community Mental Health First Aid Trainers. These individuals will attend a weeklong training fully funded by the Central Region MHSA WET funds and return to the County to provide the training described below.

The Mental Health First Aid program is an interactive session which runs 12 hours and provides certification which must be renewed every three years. This training introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and provides an overview of common treatment modalities. Mental Health First Aid is designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The evidence behind the program demonstrates that it does build mental health literacy and helps the public to identify, understand and respond to signs of mental illness.

Just as CPR training helps a layperson with no clinical training assist an individual following a heart attack, Mental Health First Aid training helps a layperson assist someone experiencing a mental health crisis, such as contemplating suicide. In both situations, the goal is to help support an individual **until appropriate professional** help arrives. Mental Health First Aiders learn a single 5-step strategy that includes assessing risk, respectfully listening to and supporting the individual in crisis, and identifying appropriate professional help and other supports. Participants are also introduced to risk factors and warning signs for mental health or substance use problems, engage in experiential activities that build understanding of the impact of illness on individuals and families; and learn about evidence-supported treatment and self-help strategies.

Specifically, participants learn:

- The potential risk factors and warning signs for a range of mental health problems, including: depression, anxiety/trauma, psychosis, eating disorders, substance use disorders, and self-injury
- An understanding of the prevalence of various mental health disorders in the U.S. and the need for reduced stigma in their communities
- A 5-step action plan encompassing the skills, resources and knowledge to assess the situation, to select and implement appropriate interventions, and to help the individual in crisis connect with appropriate professional care
- The evidence-based professional, peer, social, and self-help resources available to help someone with a mental health problem.

Audiences can include key professions, such as law enforcement and other first responders, nursing home staff, and school administration. Other participating entities include faith communities, employers and chambers of commerce, state policymakers, mental health advocacy organizations, families and the general public.

Mental Health First Aid has a strong evidence base. Four detailed studies have been completed - one trial 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. The study also found that Mental Health First Aid improved the mental health of the participants.

Mental Health First Aid in the US can become as common as CPR and First Aid. It has the potential to reduce stigma, improve mental health literacy, and empower individuals. As such, it has great potential as a community capacity building educational strategy. Staff and community members will be invited to become trainers and develop a county training plan.

PEI NEW PROGRAM DESCRIPTION

4. Activities

Activity Title	Proposed number of individuals or families through PEI expansion to be served through June 2011 by type of prevention:			Number of months in operation through June 2011
		Prevention	Early Intervention	
Parenting Wisely	Individuals: Families:	 100		12
NAMI train the trainer	Individuals: Families:	 5		12
PFLAG	Individuals: Families:	100		12
Community Access Center	Individuals: Families:	100		6
Leadership Academy	Individuals: Families:	30		6
Mental Health First Aid	Individuals: Families:	60		6
Total PEI Program Estimated Unduplicated Count of Individuals to be Served	Individuals: Families:	290 105		

5. Describe how the program links PEI participants to County Mental Health and providers of other needed services

Community education, capacity and asset-building is the theme of this Community Education Program. Each of these programs will serve to decrease stigma, remove barriers, and to provide information regarding access to the MHD and other services in an extremely cost-effective manner. Training regarding the available mental health and MHSA services will be provided as well as a designated contact person for inquiries. The Community Navigator proposed under the Health Disparities Program #7 will be responsible for conducting an updated community assessment, asset mapping, and subsequent community training related to the local services available to the community.

6. Describe collaboration with and system enhancements of other partners such as community based organizations, schools, and primary care.

This strategy represents a commitment to collaboration with parents and advocacy groups, as well as an effort to support independent learning. Capacity building among families and advocacy groups serves to enhance the community safety net system.

7. Describe intended outcomes.

Overall – Increased knowledge, skills, and decreased stigma by use of cost-effective strategies that address barriers and under-served populations.

Parenting Wisely:

- Improvements in behaviors related to protective factors – general family functioning, family cohesion and parent-child bonding, family organization and unity, effectiveness of discipline, parental involvement with children and their schoolwork, supervision of school and peer activities, school grades, knowledge and use of good parenting skills, problem solving, and clear expectations.
- Reductions in behaviors related to risk factors - child problem/conduct behavior, maternal depression, parental use of physical punishment and yelling, spousal violence and violence toward children.
- Other outcomes include high parental ratings of interest, relevance, ease of use, and confidence in using parenting skills taught; increased participation in further parent education classes, teaches parents effective child supervision and disciplinary skills, resulting in increased bonding; improves family problem solving, which decreases conflict and improves family cohesion; increases parents' self-efficacy and validates their strengths; decreases coercive and authoritarian parenting practices, thereby reducing conflict; reduces blaming attributions, thereby increasing cooperative interactions; teaches a family systems perspective to reduce scapegoating.
- For children, clinically significant behavior improvement occurred during the time that their parents used the program.
- **Program completion rates for parents ranged from 83-91%.**

NAMI's Family to Family:

- Increased knowledge and coping skills thereby enhancing family resilience to deal with serious mental illness.

PFLAG's Community Education Program:

- Increased knowledge, sensitivity and awareness designed to decrease stigma and increase tolerance and acceptance, and ultimately access to services for the LGBT population.
- Reduction of risk factors for depression and suicide and improved mental and emotional health of an extremely high-risk population.
- Fewer incidents of harassment

8. Describe coordination with Other MHSA Components.

MHSA CSS and WET program staff will be provided with information regarding these programs and how to educate clients and families regarding access to these resources. These programs serve to enhance the work done in the Wellness Centers and leverage efforts outlined in the WET plan.

The WET Coordinator will be looking for opportunities to merge workforce development and the need for capacity building in the arena of prevention and health promotions in collaboration with the MHSA Program Manager.

The other MHSA components are still under development.

9. Provide a budget narrative for costs identified for this Program, as outlined in Exhibit F. Please include the number of FTE personnel positions/classifications and a brief description of each FTE's functions. Please include a brief description of operating costs, subcontracts/professional services, and non-recurring expenditures associated with this PEI Program.

Budgeting for this program consists of $11,707 in personnel costs (salaries, benefits and taxes) for staff:

- 0.04 FTE (82 hours) each for a Mental Health Clinician and a Mental Health Aide and 0.01 FTE (20 hours) Mental Health Program Coordinator to conduct and/or facilitate consumer and volunteer training activities;
- 0.02 FTE (40 hours) for a driver to provide transportation in order to bring participants from the West Slope and South Lake Tahoe together for collaborative events.
- 0.05 FTE (112 hours) total of Mental Health Clinician time to serve as Mental Health Aid Trainers for the community.

We have also budgeted one non-recurring purchase:

- $10,000 to purchase Parenting Wisely materials targeting adolescents: ten (10) CD-ROMs in both English and Spanish ($1,000 each)

And we have budgeted for additional training and professional services that we expect to be a one-time expense:

- $10,000 in consultant fees for the Consumer and Family Leadership Academy
- $1,200 to host professional training provided by staff from CiMH

Additional operating expenditures consist of:

- $2,000 to support NAMI training
- $2,000 to purchase materials and support PFLAG outreach, education and training activities
- $2,251 in facility, indirect and overhead costs required to support the program. Operating expenditures include costs allocated based on the former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225), including facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing.
- $2000 for travel, training, food and materials to introduce and recruit participants for the educational programs
- $5000 to establish a stipend program

In addition, we plan to purchase and incorporate various professional services:

- $12,400 to initiate, develop and host a Community Access Site (CAS) for web-based community education and information for consumers of mental health services, family members and community stakeholders

In sum, the program budget totals $69,109**.**

10. Additional Comments (Optional)

None.

County: El Dorado Date: 28-Sep-10

Program/Project Name and #: PEI #4 Community Education Project

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Other Expenditures*				$0
8. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Workforce Education and Training				
1. Personnel Expenditures				$0
2. Operating Expenditures				$0
3. Training Expenditures				$0
4. Training Consultant Contracts				$0
5. Residency Expenditures				$0
6. Internship Expenditures				$0
7. Mental Health Career Pathway Expenditures				$0
8. Stipend Funds				$0
9. Scholarship Funds				$0
10. Loan Repayment Funds				$0
11. Non-recurring Expenditures				$0
12. Other Expenditures*				$0
13. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Capital Facilities				
1. Pre-Development Costs				$0
2. Building/Land Acquisition				$0
3. Renovation				$0
4. Construction				$0
5. Repair/Replacement Reserve				$0
6. Other Expenditures*				$0
7. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Technological Needs				
1. Personnel				$0
2. Hardware				$0
3. Software				$0
4. Contract Services				$0
5. Other Expenditures*				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Prevention and Early Intervention (PEI)				
1. Personnel	$11,707			$11,707
2. Operating Expenditures	$18,802		$5,000	$23,802
3. Non-recurring Expenditures	$10,000		$11,200	$21,200
4. Subcontracts/Professional Services			$12,400	$12,400
5. Other				$0
6. Total Proposed Expenditures	**$40,509**	**$0**	**$28,600**	**$69,109**

Innovation (INN)						
	1. Personnel					$0
	2. Operating Expenditures					$0
	3. Non-recurring Expenditures					$0
	4. Training Consultant Contracts					$0
	5. Work Plan Management					$0
	6. Other					$0
	7. Total Proposed Expenditures		**$0**	**$0**	**$0**	**$0**
B. REVENUES						
	1. New Revenues					
	a. Medi-Cal (FFP only)					$0
	b. State General Funds					$0
	c. Other Revenue					$0
	2. Total Revenues		**$0**	**$0**	**$0**	**$0**
C. TOTAL FUNDING REQUESTED			**$40,509**	**$0**	**$28,600**	**$69,109**

***Enter the justification for items that are requested under the "Other Expenditures" category.**

Justification:

Please include your budget narrative on a separate page.

Prepared by: Janet Stevens

Telephone Number: (530) 621-6226

PEI NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Action #4 – Community Education

Budgeting for this program consists of $11,707 in personnel costs (salaries, benefits and taxes) for staff:

- 0.04 FTE (82 hours) for a Mental Health Clinician and 0.01 FTE (20 hours) Mental Health Program Coordinator to conduct and/or facilitate consumer and volunteer training activities.
- 0.04 FTE (82 hours) for a Mental Health Aide to support the Consumer Leadership Academy.
- 0.02 FTE (40 hours) for a driver to provide transportation in order to bring participants from the West Slope and South Lake Tahoe together for Consumer Leadership Academy collaborative events.
- 0.05 FTE (112 hours) total of Mental Health Clinician time to serve as Mental Health Aid Trainers for the community.

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Additional operating expenditures consist of:

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- $2,251 in facility, indirect and overhead costs required to support the program. Operating expenditures include costs allocated based on the former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225), including facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing.
- $2000 for travel, training, food and materials to introduce and recruit participants for the educational programs
- $5000 to establish a consumer Leadership Academy stipend program

In addition, we plan to purchase and incorporate various professional services:

- $12,400 to initiate, develop and host a Community Access Site (CAS) for web-based community education and information for consumers of mental health services, family members and community stakeholders

In sum, the program budget totals $69,109

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Program #5 - Wennem Wadati

Date: September 28, 2010

Select one:
- ☐ **CSS**
- ☐ **WET**
- ☒ **PEI**
- ☐ **INN**

Prevention and Early Intervention				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, complete Exh. E4; If no, answer question #2
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☒	If yes, completed Exh. F4; If no, answer question #3
3.	Is the current funding requested greater than15% of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer question #4
4.	Is the current funding requested greater than 35% less of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer questions 5, 5a, and 5b
5.	Describe the proposed changes to the Previously Approved Program and the rationale for those changes.			
This program will be implemented for the first time in FY 10-11. The budget therefore has been adjusted to reflect the period of operation that is expected within this fiscal year.				
5a.	If the total number of Individuals to be served annually is different than previously reported please provide revised estimates Total Individuals: __330_____ Total Families: ___60___			
5b.	If the total number of clients by type of prevention annually is different than previously reported please provide revised estimates:	**Prevention**		**Early Intervention**
	Total Individuals:	280		50
	Total Families:	60		

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☐	If no, answer question #3; If yes, complete Exh. F4
3.	Will the consolidated programs continue to serve the same estimated number of individuals?	☐	☐	If yes, answer question #4; If no, complete Exh. F4
4.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) How the Previously approved programs will be consolidated; and c) Provide the rationale for consolidation			

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Program #6 - Home-delivered Meals Wellness Outreach Program for Older Adults

Date: September 28, 2010

Select one:
- ☐ **CSS**
- ☐ **WET**
- ☒ **PEI**
- ☐ **INN**

Prevention and Early Intervention				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, complete Exh. E4; If no, answer question #2
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☒	☐	If yes, completed Exh. F4; If no, answer question #3
3.	Is the current funding requested greater than15% of the previously approved amount?	☒	☐	If yes, complete Exh. F4; If no, answer question #4
4.	Is the current funding requested greater than 35% less of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer questions 5, 5a, and 5b
5.	Describe the proposed changes to the Previously Approved Program and the rationale for those changes.			
The proposed name change is Wellness Outreach Program (WOP). The proposed change to the priority population is an expansion to the adult population. The Meals on Wheels Wellness and Outreach Program for Older Adults will remain intact and serve as the evaluation component program for PEI. The Mental Health Prevention Goal is proposed to be expanded to include early identification and intervention to mitigate the impact of mental distress and isolation within the adult population. The rationale for this proposed program expansion is based on community feedback regarding vulnerable adults who may not qualify for specialty mental health services and/or who may not be accessing mental health services but who are experiencing the risk factors associated with suicide, depression and isolation, limited social supports, and exposure to trauma – as addressed by this program. The intention is to expand the mechanisms for identification of vulnerable adults and referrals for screening and service linkage beyond the home-delivered meals program that exclusively targets older adults.				
5a.	If the total number of Individuals to be served annually is different than previously reported please provide revised estimates Total Individuals: __466__ Total Families: _110__			
5b.	If the total number of clients by type of prevention annually is different than previously reported please provide revised estimates:	**Prevention**		**Early Intervention**
	Total Individuals:	370		96
	Total Families:	88		22

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☐	If no, answer question #3; If yes, complete Exh. F4
3.	Will the consolidated programs continue to serve the same estimated number of individuals?	☐	☐	If yes, answer question #4; If no, complete Exh. F4
4.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) How the Previously approved programs will be consolidated; and c) Provide the rationale for consolidation			

*PEI Projects previously approved are now called Previously Approved Programs

PEI NEW PROGRAM DESCRIPTION

County: El Dorado

Program Number/Name: Program #6 – Wellness Outreach Program for Vulnerable Adults

Date: September 28, 2010

Instructions: Utilizing the following format please provide responses and refer to the instructions provided in the original PEI Guidelines, as noted in DMH Information Notices No.: 07-19 and 08-23. Complete this form for each new PEI Program and existing PEI Programs that made changes to Key Community Mental Health Needs, Priority Population, and/or funding as described in the Information Notice.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	**Transition-Age Youth**	**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	☐	☒		
4. Stigma and Discrimination	☐	☒	☒	☒
5. Suicide Risk	☐	☒	☒	☒

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

a. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s) and describe how the PEI program will reach/engage unserved and underserved multicultural communities.

A key feature of ensuring comprehensive and representative participation was providing a range of avenues for input and decision-making. Opportunities to participate in the Community Program Planning (CPP) process were ensured by mechanisms for information dissemination (announcements in meetings and groups attended by stakeholders, posted fliers, mass mailings, and the MHSA website providing meeting announcements, updates, and meeting minutes), education and training, outreach (comprehensive and targeted), open planning meetings, and a representative MHSA Advisory Committee. Options for anonymous input included a local phone line with a voice mailbox, an e-mail address, and use of written and online surveys. Outreach efforts included community meetings, readiness trainings, focus groups and key informant interviews which were intended to offer convenient one-time opportunities to gain information about the MHSA and to offer feedback. The detailed planning occurred in the planning and advisory committee meetings which were arenas for ongoing involvement. During Phase I, a mailing list of 390 individuals was created and over 500 survey questionnaires were completed. During Phase II, the mailing list expanded to 450 and over 185 survey questionnaires were completed.

El Dorado County's efforts to ensure a comprehensive and representative MHSA planning process included the following accomplishments during Phase I:

- 82 focus groups and readiness trainings reaching 925 respondents
- 23 key informant interviews
- 5 written surveys with a total of 545 responses
- An MHSA mailing list of 390 individuals used to send out announcements, surveys, meeting notifications, and updates.
- Local media (newspapers, cable television and radio) were used to announce community meetings and to inform the public of the MHSA planning activities and contact information.

In addition, the targeted outreach strategy that characterized Phase II ensured that we contacted the following groups via focus groups and/or use of key informant interviews:

County Mental Health Staff
Mental Health Commission Members
MHSA Program members (current consumers)
Center for Violence-Free Relationships
NAMI members
CASA (Court Appointed Special Advocates) volunteers (TAY program)
Shingle Springs Rancheria (Native American services provider, tribe members and elders)
Youth Commission members
MORE (Mother Lode Rehabilitation Enterprises, Inc.) Disabled adults program – staff members
PFLAG (LGBT program) - volunteers
Caregivers Support Groups (various)
United Outreach (homeless services agency) - volunteers
Local Collaboratives
Headstart – Latino parents
Youth Groups (various)
Adult Drug Court Interdisciplinary Team
Teen Drug Court Representative
Juvenile Hall staff member
Alcohol and Drug Program (ADP) providers
School Nurses
School Psychologists
County Office of Education representative
Faith-based community organization members
Foster Parent Association - Representative
First 5 Commission Representative
County Office of Education – staff members
Public Guardian's Office – staff members
Early Childhood Council - Representative
Department of Human Services – staff members
School District Superintendents – staff members
County Public Health staff
Medical Library staff
County Veterans Services Office
Head Start - employees
Family Resource Centers – staff members
City Police
County Sheriff Department
County Superior Court
District Attorney's Office
Public Defender's Office
State Department of Rehabilitation
Medical Centers, Clinics, Hospitals
Council for Disabilities
Holistic Medicine Practitioners

Context:
Ensuring that the staff capacity, knowledge and skills are in place to address the County diversity issues is an ongoing challenge that is being addressed as part of the MHSA program development process. During the MHSA PEI CPP process, two MHSA Project Management Team members received training regarding use of the California Brief Multicultural Competency Scale - a diversity-training tool designed specifically for mental health practitioners with the goal of moving from cultural sensitivity to cultural competence. The goal has been to provide local Division-wide training for staff and community members over time. Implementation of this strategy, along with other strategies to address diversity of culture and language, have been significantly impacted by the Reduction in Force that took place in recent years. We have lost staff capacity related to this training, diversity, and interpretation and translation skills. Yet, the initial stage of this training process is reflected in this year's Quality Improvement Committee plan as part of the Cultural Competency sub-committee plan.

Race/Ethnicity:
The County demographics based on the 2000 Census were used during the MHSA CSS planning phase – a re-assessment pending the Census findings in 2010 will need to be conducted. To date, however, the EDC population profile is, as follows:

Race/Ethnicity:	
African American	0.7%
Asian American	2.7%
Latino	11.0%
Native American	1.4%
Caucasian	82.0%
Other	2.2%

Targeted outreach occurred where there were known groups or places where the Latino and Native American populations could be reached (English as a Second Language/ESL classes, Latino Family Resource Center, and the Rancheria). Together with the Caucasian population, this comprises 94.4% of the County population. The challenge is significant in relationship to outreach to the African American and Asian populations – together they comprise 3.4% of the County population – and we have not yet identified any particular group or setting to target for outreach purposes. It is unclear what comprises the category of "Other" but there is a growing population of Russian immigrants in the western County area closer to Sacramento. We have identified one potential contact person by which to begin to reach this population and a few of these stakeholders were represented in an outreach group.

Youth with disabilities, African American and Asian middle school students were among youth reached in the context of a special all day event which targeted youth who self-identified with a unique group or identity – typically along the lines of race/ethnicity. A MHSA team member participated in this event as a group facilitator. This event solicited their input in relationship to the exploratory question: "What is needed to help students like yourselves successfully move from middle to high school?" Issues of concerns with bullying were predominant, as was the feedback related to a need for the student voice in planning and decision-making.

Efforts to maintain feedback and dialogue with underserved populations have improved to a degree with experience and diversified MHSA service providers (Latino and Native American). The MHD is committed to continuing our efforts to improve further.

Language
Targeted outreach to the Latino population included use of bilingual/bicultural staff, focus groups at churches, ESL classes and a Latino Community Family Resource Center (FRC). In one interesting scenario, an ESL class hosted by the Latino Community FRC included a Vietnamese individual. During Phase I, extensive work was invested in getting materials translated into Spanish – including the Executive Summary of the original CSS plan. Furthermore, we had individuals at many of our key presentations available to provide interpretation for Spanish-speaking individuals. Our findings were that these resources were not utilized and that targeted outreach to small groups was a far more effective technique to engage this population in our community.

Geographic Regions
As indicated earlier, to address the separation of the Western Slope Region from South Lake Tahoe, we used teleconferencing equipment for almost all of the planning meetings. MHSA PEI training took place in person in SLT, as well, on two occasions. The Western Slope Region is expansive and beyond the County seat of Placerville, includes a community in the east (Pollock Pines), a community in the southern region (Somerset), a community to the north (Georgetown Divide), and one to the west (Cameron Park-El Dorado Hills). In addition to what is outlined below, outreach to existing community collaboratives did occur in Georgetown and El Dorado Hills. Greater efforts to identify effective ways to reach Pollock Pines and Somerset need to be made in the future.

Age Groups
Middle school, TAY, and high school students were reached via targeted outreach and/or participation in the planning meetings. There is an active EDC youth voice - they participate on their own commission (for example, giving feedback to the County regarding safety issues related to the Skate Board Park) and as full members on the El Dorado Hills Vision Coalition – and these groups were accessed as part of the MHSA PEI CPP process.

Gender and LGBT
Targeted outreach served to solicit feedback from representatives of PFLAG and other agencies that address domestic violence. The issues of personal safety and outreach to enhance access to services were important themes relevant to PEI planning.

The identification of the priority populations then resulted from community concerns related to clients who were no longer engaged in treatment and concerns about limited access to services. Vulnerability of adults who are isolated and/or who were not eligible for various social service systems were identified as a priority issue and the need to outreach to these individuals and ensure a safety net was proposed as an approach to pilot given the limited capacity of the MHD at this time.

This expansion proposal specifies that the un-served and under-served populations will be reached via partnership with volunteer programs that have "eyes on" in the community, utilization of outreach workers, and the availability to provide some early screening, service linkage and drop in group services for vulnerable adults.

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

Mental Health Prevention Goal – Collaboration with community partners, outreach, community education, early identification and intervention to mitigate the impact of mental distress.

Approach – Selected and Indicated Prevention.

Age group – Adults (18+)

Determinants to be addressed: Risk factors associated with suicide – depression and isolation, limited social supports, and exposure to trauma.

Intervention Strategy/Model:
The Outreach Program for Vulnerable Adults will address vulnerability due to mental distress and isolation. Various strategies will be employed including outreach and engagement services, early identification, screening, service linkage, and safety net brief mental health services.

A. Partnership with the existing Home-Delivered Meals program provided by the County Human Services Department – which currently serves approximately 800 seniors - by funding Health Services services to 1) provide education and training related to mental health issues to staff, volunteers, clients and community members, 2) screen for older adults and caregivers for depression, and 3) provide brief treatment and/or referral, as appropriate. This model serves to decrease risk factors, increase protective factors, and provides community-based support. Programs and tools with demonstrated success (i.e., Gatekeepers model, use of the PHQ-9) will be applied in this program. The required PEI program evaluation project will continue to focus on this component program.

B. Partnership with NAMI and the STARs program - Sheriff's Team of Active Retirees – which utilizes senior volunteers who complete a three-week course in law enforcement, communications, and first aid to be the "eyes and ears" of the Sheriff's Department. This program expansion proposes to provide additional training for interested volunteers regarding the signs of mental distress. These individuals can then do welfare checks on adults who have been identified by NAMI and the MHD as vulnerable and isolated individuals. Mechanisms for early intervention services will be provided, as well. As such, incorporation of the MHD's partnership with NAMI and the STARs program serves to build the capacity to serve the community in a pro-active manner.

C. Partnership with the MHD's Wellness Center by establishing extensions of this program in two ways. 1) Wellness Outreach Ambassadors will serve as another layer of early intervention by applying use of outreach and early identification of vulnerable adults, screening and service linkage for mental health services, substance abuse screening, and primary healthcare services; and 2) the Clubhouse Membership Program will allow some program capacity to provide screening, service linkage and time-limited rehabilitative services to adults who may not require specialty mental health services but who are deemed "at-risk" of needing such services and who can potentially benefit from services offered in the Wellness Center.

PEI NEW PROGRAM DESCRIPTION

4. Activities

Activity Title	Proposed number of individuals or families through PEI expansion to be served through June 2011 by type of prevention:			Number of months in operation through June 2011
		Prevention	Early Intervention	
Home-delivered Meals Wellness Outreach Component	Individuals: Families:	350 88	76 22	
STARs	Individuals: Families:	20	20	
Wellness Outreach Ambassadors and linkage to Clubhouse Memberships	Individuals: Families:	10	10	
Total PEI Program Estimated Unduplicated Count of Individuals to be Served	Individuals: Families:	458	118	

5. Describe how the program links PEI participants to County Mental Health and providers of other needed services

Many resources will be leveraged to provide services to address identified mental health needs:

- The MHSA WET-funded Friendly Visitor Program will continue to recruit and train volunteers to provide in-home support for interested and appropriate candidates.
- The MHSA CSS-funded Wellness and Recovery Services Program will provide assessment, brief treatment, and case management, as appropriate.
- The County Mental Health Division will be accessed for specialty mental health services.
- The Area Agency for Aging (AAA) service delivery system will be accessed for health and social services.
- The existing Senior Peer Counselor Program will be accessed to provide peer support, as appropriate.

Furthermore, linkages to resources in support of sustaining healthy community-based living will be accessed, as well, through the Health Services staff and Wellness Outreach Ambassadors. This may include linkage to supports for physical health, financial, transportation, and social and culturally-specific needs.

6. Describe collaboration with and system enhancements of other partners such as community based organizations, schools, and primary care.

This strengths-based strategy represents an enhancement to existing assets within our community – the Home-Delivered Meals Program and the MHSA CSS Wellness and Recovery Services Program. The existing adult and older adult systems of care will be utilized for referrals and service delivery collaboration through referral and attendance at regular collaborative meetings. Participants include the Human Services, Health Services (including both the Public Health and Mental Health Divisions), Sheriff, and Probation Departments.

7. Describe intended outcomes.

The fundamental goals are:

- To provide early detection and increased access to screening, assessment, and early intervention for depression and suicide.
- To prevent the onset of major depression, to reduce the negative outcomes of untreated depression, and to prevent the tragic consequences of suicide.
- To reduce the risk of institutionalization and homelessness among adults.
- To provide linkage to the appropriate level (least restrictive) of mental health and other needed services.
- To provide training, knowledge and skills related to mental health for clients, family members, and the broader community, thereby promoting mental health and independent living.
- To provide these services in a proactive (outreach) and community (home-based) model thereby reducing disparities in service access for older, vulnerable, and isolated adults.

8. Describe coordination with Other MHSA Components.

Integration with the MHSA CSS programs will occur as a function of incorporating the Older Adult Community Education and Training Program under the PEI component. In addition, referrals to the MHSA CSS-funded Wellness and Recovery Services Program will offer opportunities for further assessment, specialty mental health treatment, and case management for appropriate individuals. Finally, under MHSA Workforce Education and Training, the Friendly Visitor Program will offer options for volunteer and peer support for appropriate older adults. The other MHSA components are still under development.

9. Provide a budget narrative for costs identified for this Program, as outlined in Exhibit F. Please include the number of FTE personnel positions/classifications and a brief description of each FTE's functions. Please include a brief description of operating costs, subcontracts/professional services, and non-recurring

expenditures associated with this PEI Program.

Budgeting for this program consists of the following personnel costs, estimated to total $91,301 for salaries, benefits and taxes:

- 2.0 FTE Mental Health Aides to function as Wellness Outreach Ambassadors. These staff members will provide direct, early outreach services in partnership with existing community support programs (e.g., primary health care providers, NAMI) and within the MHD Wellness Center to provide screening, service linkage and time-limited rehabilitative services to adults who do not require specialty mental health services but are deemed "at-risk". These positions will be staffed both on the West Slope of the County and in South Lake Tahoe.
- 0.2 FTE supervisor positions will provide program oversight in both locations and will provide additional mental health training to interested community partners from the Home-Delivered Meals program, NAMI, STARS, etc.

In addition, we estimate a total of $108,858 in operating expenditures, to include:

- $10,000 in support of outreach activities for both clients and volunteers, to include food, training, travel (mileage), and materials.
- Additional operating expenditures of $98,858 include facility costs such as rent, utilities, and janitorial services on the West Slope and in South Lake Tahoe, as well as indirect and overhead expenses, including clinical management, computing equipment and software licensing required to support the program.

Total program budget: 200,159

10. Additional Comments (Optional)

None.

County: El Dorado Date: 28-Sep-10

Program/Project Name and #: PEI #6 Wellness Outreach Program (WOP)

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Other Expenditures*				$0
8. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Workforce Education and Training				
1. Personnel Expenditures				$0
2. Operating Expenditures				$0
3. Training Expenditures				$0
4. Training Consultant Contracts				$0
5. Residency Expenditures				$0
6. Internship Expenditures				$0
7. Mental Health Career Pathway Expenditures				$0
8. Stipend Funds				$0
9. Scholarship Funds				$0
10. Loan Repayment Funds				$0
11. Non-recurring Expenditures				$0
12. Other Expenditures*				$0
13. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Capital Facilities				
1. Pre-Development Costs				$0
2. Building/Land Acquisition				$0
3. Renovation				$0
4. Construction				$0
5. Repair/Replacement Reserve				$0
6. Other Expenditures*				$0
7. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Technological Needs				
1. Personnel				$0
2. Hardware				$0
3. Software				$0
4. Contract Services				$0
5. Other Expenditures*				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Prevention and Early Intervention (PEI)				
1. Personnel	$91,301			$91,301
2. Operating Expenditures	$108,858			$108,858
3. Non-recurring Expenditures				$0
4. Subcontracts/Professional Services				$0
5. Other				$0
6. Total Proposed Expenditures	**$200,159**	**$0**	**$0**	**$200,159**

Innovation (INN)						
	1. Personnel					$0
	2. Operating Expenditures					$0
	3. Non-recurring Expenditures					$0
	4. Training Consultant Contracts					$0
	5. Work Plan Management					$0
	6. Other					$0
	7. Total Proposed Expenditures		**$0**	**$0**	**$0**	**$0**
B. REVENUES						
	1. New Revenues					
	a. Medi-Cal (FFP only)					$0
	b. State General Funds					$0
	c. Other Revenue					$0
	2. Total Revenues		**$0**	**$0**	**$0**	**$0**
C. TOTAL FUNDING REQUESTED			**$200,159**	**$0**	**$0**	**$200,159**

***Enter the justification for items that are requested under the "Other Expenditures" category.**

Justification:

Please include your budget narrative on a separate page.

Prepared by: Janet Stevens

Telephone Number: (530) 621-6226

PEI NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Action #6 – Wellness and Outreach Program for Vulnerable Adults

Budgeting for this program consists of the following personnel costs, estimated to total $91,301 for salaries, benefits and taxes:

- 2.0 FTE Mental Health Aides to function as Wellness Outreach Ambassadors. These staff members will provide direct, early outreach services in partnership with existing community support programs (e.g., primary health care providers, NAMI) and within the MHD Wellness Center to provide screening, service linkage and time-limited rehabilitative services to adults who do not require specialty mental health services but are deemed “at-risk”. These positions will be staffed both on the West Slope of the County and in South Lake Tahoe.
- 0.2 FTE supervisor positions will provide program oversight in both locations and will provide additional mental health training to interested community partners from the Home-Delivered Meals program, NAMI, STARS, etc.

In addition, we estimate a total of $108,858 in operating expenditures, to include:

- $10,000 in support of outreach activities for both clients and volunteers, to include food, training, travel (mileage), and materials.
- Additional operating expenditures of $98,858 include facility costs such as rent, utilities, and janitorial services on the West Slope and in South Lake Tahoe, as well as indirect and overhead expenses, including clinical management, computing equipment and software licensing required to support the program.

Total program budget: $200,159

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Program #7 - Health Disparities Initiative

Date: September 28, 2010

Select one:
- ☐ **CSS**
- ☐ **WET**
- ☒ **PEI**
- ☐ **INN**

Prevention and Early Intervention				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, complete Exh. E4; If no, answer question #2
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☒	☐	If yes, completed Exh. F4; If no, answer question #3
3.	Is the current funding requested greater than15% of the previously approved amount?	☒	☐	If yes, complete Exh. F4; If no, answer question #4
4.	Is the current funding requested greater than 35% less of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer questions 5, 5a, and 5b
5.	Describe the proposed changes to the Previously Approved Program and the rationale for those changes.			

This program will continue to target the priority population of the Latino population through use of the Promotora model, peer and family support, and group intervention strategies. The Native American population will be served under Program #5 – Wennem Wadati.

Health disparities (including the significant finding that individuals with serious mental illness have a life expectancy that is 25 years less compared to those without these diseases) affects populations with a range of characteristics – many of which are found among individuals suffering from mental distress. Access and utilization of services can serve as a first step toward the elimination of these disparities. Therefore, the proposed changes serve to include the following priority populations in this program by the provision of service pathways between behavioral health and primary health care providers and the use of Community Navigators to target these groups that experience disparities in access to healthcare services:

- At risk of homelessness;
- Adults with co-occurring disorders; and,
- Adults suffering from mental distress/mental illness with disparities of access to primary healthcare services.

A key element of this systems development approach includes the application of a community capacity building framework in which movement to natural supports enriches recovery, strengthens community, and enhances access to services.

5a.	If the total number of Individuals to be served annually is different than previously reported please provide revised estimates Total Individuals: __250__ Total Families: __250_		
5b.	If the total number of clients by type of prevention annually is different than previously reported please provide revised estimates:	**Prevention**	**Early Intervention**
	Total Individuals:	125	125
	Total Families:	125	125

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above

*PEI Projects previously approved are now called Previously Approved Programs

PREVIOUSLY APPROVED PROGRAM

2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☐	If no, answer question #3; If yes, complete Exh. F4
3.	Will the consolidated programs continue to serve the same estimated number of individuals?	☐	☐	If yes, answer question #4; If no, complete Exh. F4
4.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) How the Previously approved programs will be consolidated; and c) Provide the rationale for consolidation			

*PEI Projects previously approved are now called Previously Approved Programs

PEI NEW PROGRAM DESCRIPTION

County: El Dorado

Program Number/Name: Program #7 – Health Disparities Initiative

Date: September 28, 2010

Instructions: Utilizing the following format please provide responses and refer to the instructions provided in the original PEI Guidelines, as noted in DMH Information Notices No.: 07-19 and 08-23. Complete this form for each new PEI Program and existing PEI Programs that made changes to Key Community Mental Health Needs, Priority Population, and/or funding as described in the Information Notice.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	**Transition-Age Youth**	**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	☒	☒		
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☒	☒	☒	☒

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

a. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s) and describe how the PEI program will reach/engage unserved and underserved multicultural communities.

The stakeholder input and data analysis for this program initiated during the CSS planning stage as this program was initially funded under CSS and then approved for funding under PEI in January 2010.

Community Program Planning Process
An extensive community outreach and planning process took place between February and October 2005 to identify the priority unmet mental health needs in the community.
In total, over 900 community members were consulted.

El Dorado County Mental Health conducted:

- 82 focus groups and MHSA trainings
- 23 interviews
- 5 written surveys resulting in 545 responses

In addition, 104 community representatives were involved in the workgroup planning process, including mental health consumers and their family members. In this comprehensive process, members representing a broad range of service providers were included in the workgroups and on the Advisory Committee, and updates were provided regularly to the Mental Health Commission.

Themes revealed through community outreach efforts

- A desire for community collaboration with County Mental Health.
- Safe and stable housing for transition age youth and adults who are mentally ill.
- Integrated services with substance abuse treatment facilities, schools, health facilities, and community agencies serving our target populations.

- Mental health treatment for the uninsured and underinsured, particularly children and older adults.
- Prevention of out-of-home placements for children and older adults.
- A need for case management.
- Access to concrete supports, such as housing, transportation, financial supports, employment and financial assistance that serve as barriers to service access.
- Improved outreach – particularly to the Latino community – to reduce stigma and discrimination that serve as barriers to accessing services.

Organizational Structure and Process
Community feedback, collaboration and planning were achieved in a variety of ways. Individual interviews, focus groups, MHSA trainings, and written surveys were used to inform community members and solicit feedback regarding the MHSA. Workgroups and writing teams reviewed the information and data and established recommendations for priority populations, model programs, and effective strategies. An Advisory Committee reviewed these proposals and, based on the community process, made recommendations to the Director of County Mental Health.

Community Planning Update and Lessons Learned
The goal of the El Dorado County Health Disparities Program is to collaborate with existing organizations and communities in the areas of outreach, engagement and provision of support services while adding the availability of culturally-relevant services for the underserved populations. Each of these strategies is intended to build on the strengths and self-determination of the community, families and individuals. Furthermore, there has been a growing understanding and perspective in relationship to the range of characteristics of the many groups impacted by stigma, discrimination, and disparities in service access. In addition, the lack of service integration as an added barrier has been increasingly voiced by community partners – particularly as resources in all areas of service delivery have declined. Finally, the absence of a sufficient safety net – particularly for those with co-occurring disorders (mental illness and substance abuse and/or mental illness and other chronic diseases) and homeless/at risk of homelessness– is a recurring theme in our community.

To begin to better address these issues, collaborative efforts to establish defined linkage mechanisms between behavioral healthcare providers, including substance abuse providers, and primary healthcare providers along with the support of Community Navigators to obtain these and other natural community supports is proposed under the PEI Health Disparities Initiative.

The identification of the priority populations and issues proposed to be served under this expanded Health Disparities Initiative resulted from the earlier CPP process (Latino Engagement Initiative) and the more recent CPP process (health disparities in access to behavioral health and physical healthcare services) as follows:

Latino Engagement Initiative (continuing program with no changes)

Community Mental Health Issue: Isolation and peer and family problems.

Priority Population(s): Over 600 Latinos in the target population are unserved.

Prevention Goal: Mental Health promotion and early intervention.

Desired Outcomes: Decreased mental distress and the related health indicators among the target population.

Identified strategy: Culturally-specific outreach, engagement, early identification of needs, service linkage, and peer and family prevention and early intervention strategies.

Establishment of Service Pathways between Behavioral Healthcare and Primary Care Providers

Community Mental Health Need: Disparity in life span experienced by adults with serious mental illness and insufficient safety net services for those with co-occurring disorders and at risk of homelessness.

Priority Population(s): Adults suffering from mental distress or mental illness, who lack a medical home and are affected by co-occurring disorders, and/or are at risk of homelessness.

Prevention Goal: Early identification of need for access to primary care for high risk adults who may be addressing multiple challenges (mental distress, co-occurring substance abuse problems, other chronic diseases, and/or unstable residence).

Desired Outcomes: Improved health status by means of access to behavioral health and/or physical healthcare services.

Identified strategy: Establishment of pathways for service access and use of Community Navigators to establish linkage

between behavioral healthcare and primary care providers, as well as natural community supports.

Each of these components will outreach, engage and link underserved populations by use of targeted strategies.

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

This project, the **Health Disparities Initiative**, serves as a comprehensive outreach, engagement, service linkage, and early intervention strategy.

The previously approved component targets all ages of the Latino community, and therefore targets the following PEI target populations: *trauma exposed individuals, individuals experiencing onset of serious psychiatric illness, children and youth in stressed families, children and youth at risk for school failure and at risk of or experiencing juvenile justice involvement.* As a result, this program is intended to address the community mental health needs of *disparities in access to mental health services, psycho-social impact of trauma, at-risk children, youth and young adult populations, stigma and discrimination, and suicide risk.*

The former CSS-funded Health Disparities Initiative included contracted outreach and case management services for the Native American population. Under the approved PEI plan, Program #5 - Wennem Wadati – will serve this population.

Intervention Strategy/Model - Latino Engagement Initiative:
The goal of the El Dorado County Latino Engagement Initiative is to collaborate with existing agencies in the areas of outreach, engagement and provision of support services in order to build upon the strengths and self-determination of the Latino community, families and individuals, and to promote well-being by increasing access to healthcare services.

Desired Outcomes:
- Increased mental health service utilization by the Latino community.
- Decreased isolation which results from unmet mental health needs.
- Decreased peer and family problems which result from unmet mental health needs.

The MHSA vision for the Latino population in El Dorado County is one in which there is community awareness and understanding regarding mental illness and mental health thereby removing the stigma that creates barriers to service access. Further, the vision reflects an integrated system of service delivery that provides the necessary services and supports to successfully address all of the mental health needs of the Latino community. Finally, the hope is that outcomes, such as hopefulness, wellness, and self-efficacy, the meaningful use of time and capabilities, safe and adequate housing, and a network of supportive relationships, result from MHSA service use.

Two community-based agencies provide the services for this workplan – one in the Western Slope and another in South Lake Tahoe. In the Western Slope, the Promotoras (peer outreach workers) provide the majority of the services. Consistent with the Prevention Model, the agency findings were that proactive support served to alleviate symptoms of emotional distress and the need for more extensive services. In South Lake Tahoe, while the emphasis started with the provision of bicultural and bilingual mental health services, the effectiveness of psycho-education, support groups, and peer counseling initially for women, but later for men and for children emerged. In addition, Promotora outreach and engagement services are used to address barriers to healthcare access.

Behavioral Health and Primary Health Systems Linkage:
This new component is intended to build upon a local successful model of service integration, the Access El Dorado (ACCEL) Initiative's Care Pathways model. Care Pathways are a jointly developed series of shared, coordinated, and standardized steps/processes which are used by community health partners to bring about solutions to identified health challenges. Care Pathways currently in use within our County focus on helping individuals to: secure health insurance coverage; secure a medical home; use a medical home appropriately; access pediatric mental health services; and gain access to specialty care services. These cross-agency Pathways include step-by-step actions for obtaining the identified objective, resolving problems/barriers, and tracking outcomes.

Through this PEI plan, we are proposing to include pathways which facilitate linkage between behavioral health, primary care, and natural community supports, for adults faced with mental distress and co-occurring substance abuse or chronic disease issues, and/or are at-risk of homelessness. A key element of this systems development approach also includes an application of the community capacity building framework in which movement to natural supports enriches recovery, strengthens community, and enhances access to services. Specifically, we intend to develop a Pathway to ensure an effective two-way referral process relative to mental health services (for primary care clients that may need referral to County Mental Health's high level of specialty mental health services, or for stabilized County Mental Health clients that

become appropriate for referral to primary care for their psychiatric medication management, along with a lower level of behavioral health services available at a primary care setting such as a community health center/clinic). We also intend to develop a Pathway to ensure that clients who are appropriately receiving specialty mental health services from County Mental Health, are also referred to and properly using a primary care medical home to address other health issues. Ultimately, we'd like to develop additional Care Pathways/processes for improved integration of Mental Health, primary care, and alcohol/drug services. Once the proposed Pathways are developed and implemented, they will be available for use with multiple community health partners throughout our County.

Program start-up to establish new Pathways

BACKGROUND
The ACCEL Initiative is a community-wide collaborative whose purpose is to make El Dorado County a healthier community, especially within our vulnerable populations, by uniting, maximizing, connecting and focusing health resources. PEI funding is proposed to be used to leverage existing resources and expertise. To support the development of new Pathways described above, we intend to procure support from individuals with prior experience in developing, implementing, and using Care Pathways in El Dorado County. We also propose obtaining evaluation support services from the Sphere Institute, or a similar firm specializing in outcome evaluation.

The goals and objectives of ACCEL since its inception in 2002 were:

- To improve access to health care for individuals, particularly children, by developing an outreach, enrollment and retention program to assist individuals by enrolling them in low and no cost public health insurance. A second focus was to reduce the barriers to care for the publicly insured by increasing clinic capacity, expanding rural clinics, establishing a new FQHC, and developing a public network utilizing private physicians.

- To develop and implement cross-agency outcomes-based Care Pathways to resolve problems/barriers and track outcomes to improve health care. Through the use of Care Pathways, Referral Specialists, Community Health Workers (CHWs) and Mental Health Workers (MHWs) help individuals and families navigate health systems and agencies to ensure appropriate health care has been obtained and utilized (currently including one pathway to facilitate Pediatric Mental Health Consults).

- To improve the use of health information technology by implementing a software application (iREACH) used by Referral Specialists, CHWs, MHWs and other health care partners to track client progress through Care Pathways.

This project seeks to support a system development phase to expand the ACCEL care pathways to increase access and linkage for adults with behavioral healthcare and primary healthcare needs. Support from the ACCEL Care Pathways team (in areas of systems development, quality assurance, technical support, and professional involvement of the physician champions) will be leveraged. Inclusion of an evaluation component will be critical to measure the success of this pilot which is intended to ultimately be utilized with primary care providers throughout the community. Some areas of support are intended to be time limited for start-up purposes.

Use of Community Navigators
MHD staff will work collaboratively with the El Dorado County Community Health Center (a local FQHC), and other experienced resources, to develop and implement new Care Pathways specifically designed to improve health access and outcomes for adult clients with mental health needs. To support new Care Pathway design and implementation, we also propose funding staff within County Mental, as well as six months of dedicated staff (we anticipate a Clinical Social Worker, at approx. $48,000) within the El Dorado County Community Health Center. We are referring to these cross-agency staff as Community Navigators since, during Pathway implementation/use, they will help individuals navigate the Care Pathways medical systems/processes and will ensure that any problems/barriers to accessing appropriate services are resolved. They will also actively work with clients to promote related self-care behaviors and assist in identifying and obtaining other natural supports that may be available within our communities to promote client wellness and recovery. During the initial 6 months, it is anticipated that program start-up will require a higher level of systems development and implementation work and therefore time-limited funding is requested to support the active participation of these health partners. After initial development, the ongoing navigation will be related to supporting clients needing services.

Community Capacity Building and Access to Natural Supports
The Community Navigators will serve to both promote access to healthcare services as well as community natural supports. In this area, program start up will include partnering with Community Resource Center, various

community agencies and groups, and communities at large to identify community assets and resources and to mobilize movement toward linkage, integration and/or collaboration. The ability to access the community's natural supports is anticipated to both further client recovery while strengthening the community.

4. Activities

Activity Title	Proposed number of individuals or families through PEI expansion to be served through June 2011 by type of prevention:			Number of months in operation through June 2011
		Prevention	Early Intervention	
Latino Engagement	Individuals: Families:	50 50	50 50	12
Behavioral and Primary Healthcare Pathways	Individuals: Families:	25 25	25 25	6
	Individuals: Families:			
Total PEI Program Estimated Unduplicated Count of Individuals to be Served	Individuals: Families:			

5. Describe how the program links PEI participants to County Mental Health and providers of other needed services

To date, linkages for mental health treatment between the MHD and community-based providers has been occurring with varying levels of success. The goal of achieving a seamless and diverse system of care remains. The establishment of new pathways and the support of Community Navigators is intended to ensure that successful service linkage becomes a reality for adults that have unmet behavioral health and physical healthcare needs.

Linkage to culturally-specific services for the Latino, Native American, African American, and Asian populations, among others (including LGBT-specific services) is critical to effective PEI service delivery and these MHSA programs provide some valuable options (including the Community Education Program). However, additional research and networking will need to occur in order to address a broader range of racial and ethnic groups and other groups who experience disparities in access and outcomes. Outreach and engagement and the use of focus groups will be explored as part of an ongoing effort to do Community Program Planning for MHSA programs. Use of Community Navigators should also contribute constructively to a growing understanding of the diversity of community unmet needs.

6. Describe collaboration with and system enhancements of other partners such as community based organizations, schools, and primary care.

This program continues to provide mental health system enhancements by incorporating four community-based agencies: two that serve the Latino population under their MHSA contract, the local FQHC, and a new non-profit targeting individuals and families who are homeless. Furthermore, it facilitates increased integration between the Alcohol and Drug Programs under the Public Health Division and the Mental Health Division. This project will benefit from the working relationships that these agencies have with a range of service providers thereby further diversifying the reach of the mental health system.

Collaboration with community providers will occur at many levels: Information-sharing, referrals, collaborative service planning, and cross-training. On a client-by-client basis, collaboration may occur with a community-based organization (CBO) that provides culturally-specific services (including those integrated with the critical access points in the school and primary healthcare systems). Use of a prevention and early intervention model typically benefits from collaboration and linkage to natural resources within the client's community for ongoing support. The Health Disparities program providers serve as experts, consultants and trainers to this end and will assist in providing training for the MHSA PEI staff and others in cultural competence, use of interpreter services and cultural brokers, and resource brokerage, as well.

7. Describe intended outcomes.

The fundamental goals are to:

- Continue to provide a recognized and trusted access point for the Latino population relative to prevention and mental health services;
- Engage previously un-served or under-served individuals in need of mental health services;
- Provide identification, screening, referral and linkage to support services that will influence the determinants of health indicators, such as suicide.
- Provide support, education, and early intervention strategies that are culturally relevant and focused on building protective factors and decreasing risk factors;
- Reduce the barriers of stigma and discrimination among the Latino populations and others who are in need of behavioral healthcare needs integrated with other primary healthcare services;
- Decrease the disparity in mental health access among the Latino population; and,

- Increase behavioral health/primary care healthcare access for those experiencing signs of mental distress, co-occurring disorders, and/or those who are at-risk of homelessness.

High-risk populations to be targeted in this program include the Latino population of all ages and adults with behavioral healthcare and primary healthcare unmet needs. Targeted cultural goals and desirable outcomes include linkage with culturally-specific services, identification of culturally familiar support, and resources by which to recognize, return to, and celebrate cultural identity and traditions, and reduction of stigma and discrimination as barriers to integrated healthcare.

8. Describe coordination with Other MHSA Components.

Familiarity with the Health Disparities programs among CSS program staff exists. Improvement related to referral and communication mechanisms will be the focus on the upcoming year. The WET Coordinator will also look for opportunities to merge workforce development and the need for capacity building in the arena of prevention and health promotions in collaboration with the MHSA Project Coordinator. The other MHSA components are still under development.

9. Provide a budget narrative for costs identified for this Program, as outlined in Exhibit F. Please include the number of FTE personnel positions/classifications and a brief description of each FTE's functions. Please include a brief description of operating costs, subcontracts/professional services, and non-recurring expenditures associated with this PEI Program.

Funding for this project includes continuation of services originally included as part of the Latino Engagement Initiative:

- Personnel costs (salary, benefits and taxes) for a 0.1 FTE for a County Liaison / Utilization Review Coordinator: $12,772
- Subcontracted, professional services to provide preventative mental health services to the Latino population on the West Slope (WS) of El Dorado County and in South Lake Tahoe:
  - Family Connections (WS), $114,000
  - Family Resource Center (Tahoe), $149,409
- Educational materials and supplies, $2,227
- Facility costs, indirect and overhead expenditures of $6,856. Operating expenditures include costs allocated based on the former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225), including facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing.

The new components of this program (estimated to start in January 2011 and expected to be operational for 6 months of the fiscal year) include the following:

- Personnel expenditures to facilitate and implement the Behavioral Health and Primary Health Systems Linkage component, totaling $89,319
  - Psych Tech, 20 hours/week for 25 weeks (approximately 500 hours or 0.25 FTE)
  - Care Pathways/QA Manager, 16 hours/week for 25 weeks (approximately 400 hours or 0.2 FTE)
  - Community-based Mental Health Clinician, 40 hours a week for 25 weeks (approximately 1,000 hours or 0.5 FTE)
  - Additional 4 hours/week for 25 weeks (approximately 100 hours or 0.05 FTE) County Liaison / Utilization Review Coordinator
  - Medical Office Assistant 8 hours/week for 25 weeks (approximately 200 hours or 0.1 FTE)
  - Mental Health Program Coordinator at 4 hours/week for 25 weeks (approximately 100 hours or 0.05 FTE)
- Additional operating expenditures (as detailed above) in the amount of $62,675
- Subcontracted, professional services to develop and implement cross-agency outcomes-based Care Pathways and to mobilize movement toward linkage, collaboration and integration of physical and mental health services:
  - Care Pathways Physician Champion (MD in the role of Liaison/Advocate), $6,000
  - Program Evaluation Services for Care Pathways program, $5,000
  - Community Health Clinic, $48,000

Total program budget: $496,258

10. Additional Comments (Optional)

None.

County: El Dorado Date: 28-Sep-10

Program/Project Name and #: PEI #7 Health Disparities Initiative

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Other Expenditures*				$0
8. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Workforce Education and Training				
1. Personnel Expenditures				$0
2. Operating Expenditures				$0
3. Training Expenditures				$0
4. Training Consultant Contracts				$0
5. Residency Expenditures				$0
6. Internship Expenditures				$0
7. Mental Health Career Pathway Expenditures				$0
8. Stipend Funds				$0
9. Scholarship Funds				$0
10. Loan Repayment Funds				$0
11. Non-recurring Expenditures				$0
12. Other Expenditures*				$0
13. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Capital Facilities				
1. Pre-Development Costs				$0
2. Building/Land Acquisition				$0
3. Renovation				$0
4. Construction				$0
5. Repair/Replacement Reserve				$0
6. Other Expenditures*				$0
7. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Technological Needs				
1. Personnel				$0
2. Hardware				$0
3. Software				$0
4. Contract Services				$0
5. Other Expenditures*				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Prevention and Early Intervention (PEI)				
1. Personnel	$102,091		$311,409	$413,500
2. Operating Expenditures	$71,758			$71,758
3. Non-recurring Expenditures				$0
4. Subcontracts/Professional Services			$11,000	$11,000
5. Other				$0
6. Total Proposed Expenditures	**$173,849**	**$0**	**$322,409**	**$496,258**

Innovation (INN)						
	1. Personnel					$0
	2. Operating Expenditures					$0
	3. Non-recurring Expenditures					$0
	4. Training Consultant Contracts					$0
	5. Work Plan Management					$0
	6. Other					$0
	7. Total Proposed Expenditures		**$0**	**$0**	**$0**	**$0**
B. REVENUES						
	1. New Revenues					
	a. Medi-Cal (FFP only)					$0
	b. State General Funds					$0
	c. Other Revenue					$0
	2. Total Revenues		**$0**	**$0**	**$0**	**$0**
C. TOTAL FUNDING REQUESTED			**$173,849**	**$0**	**$322,409**	**$496,258**

***Enter the justification for items that are requested under the "Other Expenditures" category.**

Justification:

Please include your budget narrative on a separate page.

Prepared by: Janet Stevens

Telephone Number: (530) 621-6226

PEI NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Action #7 – Health Disparities

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  - Community Health Clinic, $48,000

Total program budget: $496,258

FY 2010/11 **EXHIBIT E4**

PEI BUDGET SUMMARY

County: El Dorado **Date:** 9/28/2010

	PEI Programs		FY 10/11 Requested MHSA Funding	Estimated MHSA Funds by Type of Intervention		Estimated MHSA Funds by Age Group				
	No.	Name		Prevention	Early Intervention	Children and Youth	Transition Age Youth	Adult	Older Adult	
Previously Approved Programs										
1.	1	Early Intervention Program for Youth	$319,768	$0	$319,768	$127,908	$127,907	$47,965	$15,988	
2.	5	Wennem Wadati - A Native Path to Healing	$116,865	$99,335	$17,530	$23,373	$46,746	$23,373	$23,373	
3.			$0							
4.			$0							
5.			$0							
6.			$0							
7.			$0							
8.			$0							
9.			$0							
10.			$0							
11.			$0							
12.			$0							
13.			$0							
14.			$0							
15.			$0							
16.	Subtotal: Programs*		$436,633	$99,335	$337,298	$151,281	$174,653	$71,338	$39,361	Percentage
17.	Plus up to 15% County Administration		$65,495							15.0%
18.	Plus up to 10% Operating Reserve		$50,213							10.0%
19.	Subtotal: Previously Approved Programs/County Admin./Operating Reserve		$552,341							
New Programs										
1.	2	Primary Intervention Project (PIP)	$237,830	$237,830	$0	$237,830	$0	$0	$0	
2.	3	Incredible Years	$155,777	$155,777	$0	$116,833	$0	$31,155	$7,789	
3.	4	Community Education Project	$69,109	$69,109	$0	$17,277	$17,277	$17,278	$17,277	
4.	6	Wellness Outreach Program (WOP)	$200,159	$160,127	$40,032	$0	$20,016	$80,064	$100,079	
5.	7	Health Disparities Initiative	$496,258	$248,129	$248,129	$124,065	$124,064	$124,065	$124,064	
6.	Subtotal: Programs*		$1,159,133	$870,972	$288,161	$496,005	$161,357	$252,562	$249,209	Percentage
7.	Plus up to 15% County Administration		$173,870							15.0%
8.	Plus up to 10% Operating Reserve		$133,300							10.0%
9.	Subtotal: New Programs/County Admin./Operating Reserve		$1,466,303							
10.	**Total MHSA Funds Requested for PEI**		$2,018,644							

*Majority of funds must be directed towards individuals under age 25. Percent of funds directed towards those under 25 years = 62%

Note: Previously Approved Programs that propose changes to Key Community Health Needs, Priority Populations, and/or funding as described in the Information Notice are considered New.

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

x Previously approved with no changes

☐ New

Date: September 28, 2010	County Name: El Dorado
Amount Requested for FY 2010/11: $ 21,700	

A. Briefly describe your plan for using the Training, Technical Assistance and Capacity Building funding and indicate (if known) potential partner(s) or contractor(s).

El Dorado County Health Services Department (HSD) staff and community members have recently participated in a MHSA-funded and CIMH-sponsored Learning Collaborative on Capacity Building Strategies with consultants John Ott and Rose Pinard. The community is, therefore, in the early stages of identifying a strategic plan to operationalize this framework.

Capacity to do even this critically important step is a challenge at this time. Yet, there is a core group of tremendously committed HSD and community members who are continuing to meet to carry the momentum forward.

Critical elements that require support in order to engage in continued learning related to this model include networking with other counties engaged in this process and the continued use of the consultants. Further, it is anticipated that a structure by which to incorporate a broader range of County partners in the process is an important goal and these funds will be used, therefore, in part to this end.

The HSD will also leverage the State funding for the Capacity Building Learning Collaborative to ensure that the local County funds are used in the most efficient and effective manner.

B. The County and its contractor(s) for these services agree to comply with the following criteria:

1) This funding established pursuant to the Mental Health Services Act (MHSA) shall be utilized for activities consistent with the intent of the Act and proposed guidelines for the Prevention and Early Intervention component of the County's Three-Year Program and Expenditure Plan.
2) Funds shall not be used to supplant existing state or county funds utilized to provide mental health services.
3) These funds shall only be used to pay for the programs authorized in WIC Section 5892.
4) These funds may not be used to pay for any other program.
5) These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by WIC Section 5892.
6) These funds shall be used to support a project(s) that demonstrates the capacity to develop and provide statewide training, technical assistance and capacity building services and programs in partnership with local and community partners via subcontracts or other arrangements to assure the appropriate provision of community-based prevention and early intervention activities.
7) These funds shall be used to support a project(s) that utilizes training methods that have demonstrated the capacity to increase skills and promote positive outcomes consistent with the MHSA and PEI proposed guidelines.

Certification

I HEREBY CERTIFY to the best of my knowledge and belief this request in all respects is true, correct, and in accordance with the law.

_____

Director, County Mental Health Program (original signature)