Mental Health Services Act
Prevention and Early Intervention
Component Plan

Ventura County Behavioral Health Department
Mental Health Services
August 4, 2009

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

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

County Name: Ventura	Date: August 4, 2009

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

County Mental Health Director	**Project Lead**
Name: Meloney Roy, LCSW Mental Health Director Telephone Number: (805) 981-2214 Fax Number: (805) 981-6438 E-mail: meloney.roy@ventura.org	Name: Susan Kelly, MFT PEI Coordinator Telephone Number: (805) 981-6440 Fax Number: (805) 981-6438 E-mail: susan.kelly@ventura.org
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AUTHORIZING SIGNATURE

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

Signature _____ _____

County Mental Health Director Date

Executed at _____, California

EXECUTIVE SUMMARY

Introduction

Prevention and Early Intervention (PEI) is one of five program components for funding under the Mental Health Services Act (MHSA). Through the MHSA initiative, Counties are now responsible to ensure the participation of the community in the assessment, planning and implementation of programs which will serve the mental health needs of their community.

Ventura County Behavioral Health in collaboration with the PEI Planning Committee has worked over the past year to ensure that the voice of our community has been heard. The commitment of the Planning Committee has been to elicit and share information and resources to discover our community shared vision for Prevention and Early Intervention programs.

MHSA - Background

The Mental Health Services Act was passed by California voters as Proposition 63, effective January 2005. The Act imposes a 1% tax on annual adjusted income over $1,000,000. MHSA was designed to create a comprehensive approach to the development of community-based mental health services and supports to reduce the adverse impact from untreated serious mental illness in adults and severe emotional disturbance in children and youth. Programs are to be designed in direct relationship with the cultural, ethnic and community needs as identified through an intensive and extensive community assessment process and should focus access toward those individuals and communities that have traditionally been un- or significantly underserved by the mental health system.

MHSA has also provided the opportunity to develop programs and supports which promote concepts of wellness and recovery for adults and older adults and resilience for children/youth and their families. This opportunity has shifted the manner and attitude toward mental illness to one of hope and recovery. In this light, the Prevention and Early Intervention component of MHSA provides the opportunity to create and expand supports to the community *prior* to a mental health diagnosis.

Prevention and Early Intervention

Prevention and Early Intervention is designed to bring mental health awareness into the lives of the community through educational initiatives and community dialogue. PEI builds the capacity for providing mental health early intervention services by facilitating access at the earliest possible signs of mental health problems. These opportunities are made possible by implementing services at sites throughout the community where people go for other activities, such as schools, health clinics and community organizations. By providing this level of access and education, “mental health becomes part of wellness for individuals and the community, reducing the potential for stigma and discrimination….” (*Calif. Dept. of Mental Health*)

The ***Prevention*** element of PEI includes programs and services which are designed to help prevent the development of serious emotional or behavioral disorders and mental illness. ***Universal Prevention*** is used to target an entire community of individuals who do not

necessarily have a higher risk of mental health need. ***Selective Prevention*** includes strategies and interventions targeted to individuals or selected groups who have a set of risk factors for the potential to develop a mental illness.

Early Intervention is directed toward individuals and families for whom a short-duration (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services; or to prevent a mental health problem from getting worse.

State Department of Mental Health (DMH) developed a framework for the planning and implementation of PEI programs. Included in this framework is the requirement that 51% of PEI funding be allocated to programs targeting children and transitional age youth. Additionally, five Key Community Mental Health Needs and six Priority Populations were identified for inclusion in projects:

Community Mental Health Needs	Priority Populations
Disparities in Access to Mental Health	Underserved Cultural Populations
Psycho-Social Impact of Trauma	Individuals Experiencing Onset of Serious Psychiatric Illness
At Risk Children, Youth and Young Adults	Children/Youth in Stressed Families
Stigma and Discrimination	Trauma Exposed
Suicide Risk	Children/Youth at Risk of School Failure
	Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

Utilizing this framework for our county PEI Planning, the strategies adopted by the Committee were based on an approach to assessment which included these Community Mental Health Needs and Priority Populations in the outreach activities and discussions held. The Planning Committee determined that utilizing this framework, identifying geographic areas within the county for assessment, and utilizing the data collected to drive the decision and recommendation process this Plan would ensure inclusiveness, balance and a commitment to expanding access to mental health preventative and early intervention supports, as well as provide a bridge to higher level services for those in need. Table 1 provides a summary of our proposed PEI Projects and corresponding interventions.

TABLE 1: RECOMMENDED PEI PROJECTS AND INTERVENTION MODELS

PEI Projects	Intervention Models	Target Population
Community coalitions – Funds allocated to time-limited projects that advance county strategic plans – Tailored to community needs – Increase engagement, education, awareness – Reduce stigma – Increase collaboration and coordination	**Examples of coalition activities:** – Promotores programs – Faith-based clergy council activities – Anti-stigma education campaigns specific to other PEI initiatives	All Ages: - Children (0 – 17 y.o.) - Transitional Age Youth (18-24 y.o.) - Adults (25 – 59 y.o.) - Older Adults (60+ y.o.)
Primary care services – Services available at primary care clinics – Intervention that address depression, trauma, and child behavior problems	– Depression Treatment Quality Improvement (DTQI) – Trauma Focused Cognitive Behavior Therapy – Prolonged Exposure Therapy for PTSD – Improving Mood Promoting Access to Collaborative Treatment (IMPACT)	All Ages: - Children (0 – 17 y.o.) - Transitional Age Youth (18-24 y.o.) - Adults (25 – 59 y.o.) - Older Adults (60+ y.o.)
School-based services – Services available on school sites – Interventions that address disruptive behavior, depression, trauma	– Strengthening Families Program – Depression Treatment Quality Improvement (DTQI) – Trauma Focused Cognitive Behavior Therapy	Children in elementary and high schools
Parenting – Brief and full parenting interventions – Available in home, schools, primary care and community based settings – Universal public education campaign	– Triple P Parenting	Children and their families
Early signs of psychosis intervention – Education and awareness campaign – Early identification and treatment	– Early Detection and Intervention for the Prevention of Psychosis (EDIPP)	Transitional Age Youth (ages 16 – 25 y.o.)

PEI Planning Committee

The Department thanks each and every member of this Planning Body for their insight, expertise and willingness to reach into our community and hear the voice of those we serve. The commitment, dedication and shared vision of the Planning Committee ensured an inclusive and expansive PEI Plan to support the mental health well-being of our community.

NAME	ORGANIZATION	NAME	ORGANIZATION
Alatorre, Tony	Clinicas del Camino Real	Hicks, Daniel	VCBH - ADP
Anderson, Cleo	St. Paul Baptist Church	Lopez, Arsenio	MICOP
Arner-Costello, Fran	VCOE-SELPA	Marquez-O'Neill, Barbara	Oxnard Community Action
Bartels, Bill	City of Fillmore	Mellick, Irene	Older Adults/Senior Concerns
Bates, Karyn	MHB – Consumer	Mendoza, Joe	Migrant Education
Bennett, Kris	AspiraNet	Mohorko, Edgar	Clergy Council
Bhavnani, Ratan	NAMI	Pentis, Gary	VC Sheriff
Brooking, Gane	MHB Older Adult Comm.	Pringle, Pete	VCBH – Youth & Family
Brudnicki, Cathy	VC Homeless Coalition	Ramirez, Jubal	TAY / Pacific Clinics
Campos-Juarez, Lucrecia	Clinicas del Camino Real	Reyes, Guadulupe	Oxnard School District
Casey, Diana	HCA Ambulatory Care	Roach, Pam	Mental Health Board
Chan, Patty	VC Public Health	Samples, Mary	VCOE
Collins, Mary Ellen	United Parents	Sternad, Erik	Interface Children and Family Services
Compton, George	Veteran's Services	Tatangelo, MA, Sue	Camarillo Health Care District
Contini, Patty	VCOE	Torres, Charlotte	First 5 Ventura County
Cortez, Patricia	El Centrito de la Colonia	Varela, Mark	VC Probation
Cotterell, Sherrianne	Rio School District	Vasquez, Armando	Keys Academy
Creadick, Debra	VC Human Services Agency		
Flores, Rogelio	Consul de Mexico - Oxnard		
Flores, Sonja	House Farmworkers		
Gertson, Linda	VCBH Adults - Manager		
Gomez, Jennifer	TAY Tunnel		
Gonzales, Laura	Coalition to End Family Violence		
Gray, Sonna	MHSA Liaison, Family Member		
Grothe, Pamela	Human Services Agency		
Gutierrez, Yvonne	El Concilio Board of Directors		
Handel, Deanna	First 5 Ventura County		

FORM 2

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

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

   a. **The overall Community Program Planning Process**

   Oversight for the community program planning process was provided by MHSA Coordinator Susan Kelly, who served as PEI Coordinator. She previously led the community program planning processes for Community Services and Supports, Workforce, Education and Training and Capital Facilities/Information Technology.

   Ventura County Behavioral Health (VCBH) established a PEI Planning Committee, comprised of 44 stakeholders who represented all required PEI sectors and areas of the County, including public and private providers across multiple disciplines, representatives from faith-based and underserved populations, and consumers and their family members. The PEI Planning Committee met every month for several hours from August 2008 through May 2009. PEI Planning Committee members also participated in geographically-based Area Team Work Groups, which worked closely with VCBH in:

   - providing overall guidance and feedback throughout the planning process;
   - ensuring that all required priority populations and sectors were represented in the needs assessment and strategy development components;
   - identifying and soliciting participants for the key informant interviews, focus groups and community forums;
   - providing strategy recommendations to the County; and
   - selecting programs responsive to community needs and priorities.

   The PEI Planning Committee, along with many other stakeholders (e.g., those participating in Key Individual Interviews, Focus Groups, and Community Forums) played a strong and critical role in the planning process: making recommendations for who should be included in the community assessment data collection initiatives; responding to focus group and interview questions designed to elicit community-level needs, barriers to access, and recommended PEI strategies; reviewing and evaluating findings from the qualitative and quantitative components of the data collection and community assessment process; recommending and voting on PEI programs and strategies; and ensuring that the process adhered to California Department of Mental Health requirements.

b. Coordination and management of the Community Program Planning Process

Working under the oversight of the PEI Coordinator, VCBH hired consultants with relevant expertise and experience who have collaborated in the development, coordination and management of the planning process.

Dr. Gabino Aguirre, who has extensive local experience with community capacity building and collaborative work in underserved communities, was responsible for ensuring that the planning process included the participation of the widest possible array of stakeholders. His particular emphasis was on managing stakeholder participation in the planning process by ensuring the involvement of grassroots organizations who traditionally have not been involved in mental health planning processes and whose constituents have been unserved or underserved by the mental health system.

VCBH also contracted with EvalCorp, an established applied research and consulting firm, to lead the community-based assessment initiative. Staff from EvalCorp Research & Consulting designed the community-based needs assessment strategy in collaboration with VCBH, and led the data collection and analysis activities, which were the underpinning of the community planning process. EvalCorp has experience with PEI data collection, analysis and report development in other counties, as well as extensive knowledge and understanding of the unique needs and existing resources/strengths of Ventura County, through their years of conducting community assessment and evaluation activities for VCBH's Alcohol and Drug Programs – Prevention Services, and First 5 Ventura County.

Finally, VCBH contracted with the California Institute for Mental Health (CIMH) who facilitated design of the proposed PEI projects. CIMH provided training to VCBH, the PEI Planning Committee and Area Teams around evidence-based practices and prevention and early intervention models, and facilitated planning meetings around selection of intervention models that were responsive to community needs, priorities and unique characteristics.

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

In addition to this planning team, three full-time Community Service Coordinators (CSCs), provided community outreach efforts to engage diverse and distinct stakeholders in the planning process. The CSCs were responsible for recruiting individuals to participate in geographic area workgroups, focus groups, key individual interviews, and attend the community forums. Often this was accomplished by soliciting input and suggestions from other community stakeholders. For example, members of the PEI Planning Committee were asked who might be appropriate to participate in the various workgroups and activities. Additionally, an analysis of the Committee was undertaken by EvalCorp to ensure that there was broad representation across Priority Populations and Sectors by its members.

Members of the Planning Committee were divided into five Area Teams, based on the five geographic areas of the county. The purpose of the teams was to help focus each member's expertise into a defined area, and to help coordinate and suggest participants for the focus groups, which were also conducted to engage additional community stakeholders in the planning process.

Key Individual Interviews were one method utilized for gathering qualitative data from stakeholders. Twenty-five Key Individual Interviews were conducted, with five interviews in each of the five geographic regions of the county. Interviewees in each region were representative of the PEI priority populations, mental health needs, age groups, and community sectors. The interviews gathered important information on:

1. Community mental health needs and impacts of unmet needs
2. Community strengths/protective factors
3. Prioritization of PEI mental health needs, age groups, and priority populations
4. Existing/needed prevention and early intervention services
5. Recommended strategies for effective PEI service delivery
6. Access/service barriers
7. Strategies to increase access to services in the community
8. Recommended strategies for outreach, education, and awareness

In addition, EvalCorp facilitated 24 focus groups, of which 11 were Area-based Focus Groups (two per region, with the exception of Oxnard, which had three). Great care was taken to include community members across various sectors (i.e., Education, Mental Health, Health, Law Enforcement, etc.) in the Area Focus Groups. Additionally, EvalCorp facilitated 13 Countywide Groups comprised of participants from unserved/underserved communities. Across the 24 focus groups, three were conducted in Spanish and 212 individuals participated overall. Information gleaned from the focus groups included:

1. Primary community mental health needs
2. Existing prevention and early intervention services/resources
3. Recommended PEI strategies/services to address community mental health needs
4. Community strengths/protective factors
5. Prioritization of PEI mental health needs, age groups, and priority populations,
6. Barriers to accessing services
7. Recommendations for informing communities about PEI

A comprehensive analysis and evaluation of the needs assessment data produced from the Key Individual Interviews and Focus Groups was undertaken and presented to the Planning Committee. EvalCorp also conducted an extensive data review and analysis of the county, based on multiple key indicators for each of the six Priority Populations and two of the Mental Health Needs identified by the state. A total of forty-six quantitative data indicators were analyzed by Area and city, whenever possible, and presented in the Data Indicator Report. This information proved to be a critical complement to qualitative information gathered through interviews and focus groups, demonstrating trends over time in unmet mental health needs and helping to establish community-level priorities.

The Planning Committee Area Teams mentioned earlier served an additional purpose, which included making PEI program recommendations based on that particular Area's strengths and needs. To this end, EvalCorp facilitated five Area Team Data Review Meetings based on findings from the Data Indicator Report, Key Individual Interviews, Area Focus Groups, and Countywide Focus Groups. CIMH also participated in each of the Area Team Data Review Meetings for the purposes of clarifying relationships between priorities, needs and prevention and early intervention programs.

Subsequently, CIMH and VCBH facilitated a pair of meetings with the Planning Committee to identify programs and specific prevention and early intervention models that would best address the needs of each geographic area, as well as countywide needs. The programs identified were grounded in the data analyses produced by EvalCorp and the results of the Area Team Data Review Meetings, and were responsive to priorities and needs of the community.

Finally, three community forums were held across the county after extensive outreach by staff and Area Teams. The outreach included the distribution of multi-lingual flyers, coordination with community- and faith-based organizations, and personal invitations. As an incentive to community residents, a light dinner was served before each of the forums. During the forums, participants were provided information about the recommended programs, and then given the opportunity to express their viewpoints, as well as complete a survey to inform the county of specific recommendations for delivery of PEI services. The goal of collaborating with the community, by providing an update regarding the PEI process and soliciting feedback from county residents, was achieved through the forums.

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

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

EvalCorp developed a series of intricate matrixes for the Key Individual Interviews, Area Focus Groups, and Countywide Focus Groups to validate broad representation across age groups, sectors, and geographical areas.

Throughout the process VCBH was very successful at engaging consumers and family members, as well as representatives from underserved populations from across the county. Examples include:

a. Focus groups specific to the following underserved populations
   ii. African Americans
   iii. Ambulatory Care/Health
   iv. Consumers of Mental Health Services
   v. Deaf and Hard of Hearing – conducted utilizing ASL translators
   vi. Developmental Disabilities
   vii. Education (Pre-K, 0-5 through Elementary School)

viii. Education (Middle School through College)
ix. Faith-based Community
x. Immigrants/Farm workers – conducted in Spanish
xi. Juvenile Justice/Probation
xii. Older Adults
xiii. Transition-Age Youth (TAY)
xiv. Veterans

b. Consumer and family member participation on the Planning Committee and Area Teams, including representatives from the Client (Peer) Network, NAMI, and transition-age youth.
c. Planning committee representatives from the following underserved populations and/or services
xv. Homeless
xvi. Older adults
xvii. Faith-based community
xviii. Indigent farm workers
xix. Veteran's Services
xx. Ventura County Office of Education - Migrant Students division
xxi. African American community

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

Upon the recommendation of the Planning Committee, the planning process was organized geographically, in recognition of the unique needs and strengths of the various regions. EvalCorp conducted an extensive analysis of census data based on these geographic regions, which was then distributed and explained to Planning Committee members so that the analysis could serve as a basis for future decisions. As such, the quantitative and qualitative data collection was divided by the five geographic regions of the county. Representatives with expertise in each region were selected to participate in Key Individual Interviews and the 24 focus groups. Much thought was put into the overall process of data collection to ensure that there was representation across age, ethnic, gender, and language groups. For example, three of the focus groups were conducted in Spanish, the county's largest threshold language. Additionally, forms, brochures and outreach materials used in the community planning and assessment process also were available in Spanish.

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

As indicated above, there were consumer and family members represented throughout the planning process, with seats on the Planning Committee and participation in the focus groups and community forums. Outreach was done through our Mental Health Board, Client Network, peer-run wellness and recovery centers, and by having the Planning Committee members conduct additional outreach.

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

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

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

The Planning Committee and Area Teams, Key Individual Interviewees, and Focus Group participants were comprised of stakeholders from and across all of the required priority sectors. Detailed matrixes were developed to monitor and track participation of these stakeholders throughout each aspect of the planning process and for each data collection strategy (see matrices below). Particular attention and outreach occurred to ensure participation in every aspect of the planning process by individuals who represented diverse interests. Examples of participants from the categories listed above include:

- Consumer and family member participation as described in Question 2a
- County and private providers from mental health, probation, child welfare, ambulatory health care, public health, and other social services
- Professional (regional, district, and school administration, teachers, nurses) and other representatives from education, including preschool, elementary, middle and high school, and from the community colleges
- Sheriff's department and probation representatives

TABLE 2: Age Groups, Sectors, and Geographic Regions Represented by Interviewees

KEY INDIVIDUAL INTERVIEWS																					
INTERVIEWEES		Total Participants	AGE GROUPS					SECTOR REPRESENTATION										GEOGRAPHIC AREA				
			Prenatal - 5	Child	TAY	Adult	Older Adult	Underserved Cultural Pops.	Education	SMI & their Family	MHS Provider	Health	Social Services	Law Enforcement	Comm Fam Resource Cnrs	Employment	Media	1	2	3	4	5
1	KIIs - Area 1	5	X	X	X	X	X	X	X	X	X		X	X				X				
2	KIIs - Area 2	5	X	X	X	X	X	X	X	X	X	X	X		X	X			X			
3	KIIs - Area 3	5	X	X	X	X	X	X	X	X		X		X	X					X		
4	KIIs - Area 4	5	X	X	X	X	X	X		X	X	X	X								X	
5	KIIs - Area 5	5	X	X	X	X	X	X	X	X			X			X						X

TABLE 3: Age Groups, Sectors, and Geographic Regions Represented by Countywide Focus Group Participants

COUNTYWIDE FOCUS GROUPS																						
GROUP NAME		Total Participants	AGE GROUPS					SECTOR REPRESENTATION										GEOGRAPHIC AREA				
			Prenatal - 5	Child	TAY	Adult	Older Adult	Underserved Cult. Pop.	Education	SMI & their Families	MHS Provider	Health	Social Services	Law Enforcement	Comm Family Resource Ctrs	Employment	Media	1	2	3	4	5
1	African-American	7		X	X	X	X	X	X		X				X					X		
2	Ambulatory Care/Health	8	X	X	X	X	X	X	X		X	X	X		X	X		X	X	X	X	X
3	ARC/Developmental Disabilities	11	X	X	X	X	X	X	X	X	X		X		X	X		X	X	X	X	X
4	Consumers of MH Services	8	X	X	X	X	X	X	X	X	X	X	X	X	X			X	X	X	X	X
5	Deaf and Hard of Hearing	10			X	X	X	X		X	X		X						X	X	X	
6	Education (Pre-K and Elementary)	11	X	X		X	X	X	X		X	X	X		X			X	X	X	X	X
7	Education (9th - College)	9	X	X	X				X	X	X	X			X			X	X	X	X	X
8	Faith Communities	9	X	X	X	X	X	X	X				X	X	X			X		X	X	X
9	Immigrants/Farmworkers	8	X	X	X	X	X	X	X		X	X	X	X	X			X	X	X	X	X
10	Juvenile Probation	9		X	X			X						X				X	X	X	X	X
11	Older Adults	9			X	X	X	X			X	X	X					X	X	X	X	X
12	Veterans	7	X	X	X	X	X	X			X	X						X	X	X	X	X
13	Transition Age Youth	12	X	X	X	X	X	X	X	X	X		X		X			X	X	X	X	X

TABLE 4: Age Groups, Sectors, and Geographic Regions Represented by Area-based Focus Group Participants

AREA BASED FOCUS GROUPS																						
GROUP NAME		Total Participants	AGE GROUPS					SECTOR REPRESENTATION										GEOGRAPHIC AREA				
			Prenatal - 5	Child	TAY	Adult	Older Adult	Underserved Cult. Pop.	Education	SMI & their Families	MHS Provider	Health	Social Services	Law Enforcement	Comm Family Resource Ctrs	Employment	Media	1	2	3	4	5
1	Area 1, Focus Group 1	7	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X				
2	Area 1, Focus Group 2	6	X	X	X	X	X	X	X			X	X	X	X		X	X				
3	Area 2, Focus Group 1	8	X	X	X	X	X	X	X		X	X	X		X				X			
4	Area 2, Focus Group 2	8	X	X	X	X	X	X	X	X	X	X	X	X	X		X		X			
5	Area 3, Focus Group 1	10	X	X	X	X	X	X	X	X	X	X	X	X						X		
6	Area 3, Focus Group 2	10	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X			X		
7	Area 3, Focus Group 3	9	X	X	X	X	X	X	X	X	X		X	X						X		
8	Area 4, Focus Group 1	7	X	X	X	X	X	X	X	X	X	X	X		X						X	
9	Area 4, Focus Group 2	10	X	X	X	X	X	X	X			X	X	X		X					X	
10	Area 5, Focus Group 1	10	X	X	X	X	X	X		X	X	X	X	X	X		X					X
11	Area 5, Focus Group 2	9	X	X	X	X	X	X	X		X		X		X							X

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

Staff and stakeholders have received training throughout the PEI planning process. At the start of the planning process, 10 Early Planning Committee members attended the Statewide PEI Conference in Universal City. This included representation from law enforcement, education, probation, NAMI, United Parents and Client Network. This was an opportunity to gain an in-depth understanding of PEI goals and requirements as well as learn how other counties were conducting their planning processes. Also early in the planning process, a group of seven individuals, consisting of staff, consultants, and planning committee members, spent a full day with San Bernardino County MHSA staff and outside consultants. They had the opportunity to learn in-depth how San Bernardino approached its planning process.

The Planning Committee was provided with extensive orientation and training on PEI principles, goals, and requirements. This training was done by VCBH, EvalCorp, and CiMH, which also provided training to staff, the Planning Committee members, and the Area Teams on PEI models and Evidence-Based Practices.

Additionally, approximately 70 presentations/trainings for PEI information and dissemination were conducted and/or attended by VCBH. A list of these events is presented in **Table 5**.

Table 5
Ventura County: Participation/Presentations/Trainings for PEI

Date	Event	Purpose	Participants
May 16, 2008	May Is MH Month: "Beginning The Dialogue"	PEI Kick-Off Conference	450 Community Members
July 28/29, 2008	CiMH Regional Roundtable-PEI	Training	10 Community Partners
Aug 2008	Office of Education- Title IV Reps		
Aug 4, 2008	PEI Planning Review Workgroup	Planning	45
Aug 15, 2008	MHOAC Overview	Planning Workgroup	30
Oct 30, 2008	Regional MHSA meeting	PEI Coordination	20 S.B. and Ventura
Nov 5, 2008	Meeting with immigrant attorneys group	Outreach to immigrant population	4 participants
Nov 6, 2008	Met with SPESD representatives	Outreach through schools	6 participants
Nov 12, 2008	Big Brothers Big Sisters	Community Presentation	600 Spanish speaking parents
Nov 13, 2008	SP Weed and Seed Advisory Board	Outreach - juvenile justice youth diversion	9 participants
Nov 15, 2008	Parent-Schools Conference	information and outreach	85 parents, educators and community members
Nov 20, 2008	Farmworker housing group	information and outreach	8 participants
Nov 21, 2008	El Concilio Community Clinic	community outreach	3 participants
Nov 25, 2008	Interface Children Family Services	PEI and 2-1-1 program	3 participants
Dec 11, 2008	Presentation to SELPA	Informational Outreach	12 participants
Dec 12, 2008	Hispanic Mentorship Council	youth mentoring program	8 participants
Dec 15, 2008	Poder Popular Leadership Council	school and youth violence	18 participants
Dec 16, 2008	Clinicas del Camino Real	outreach strategies	4 participants
Dec 18, 2008	Cultural Competence Committee	building capacity in county agencies	9 participants
Dec 19, 2008	Family Resource Center (SP)	outreach and information	7 participants
Jan 2, 2009	Inlakech Cultural Center	outreach using the arts	5 participants
Jan 7, 2009	Clinicas community education/outreach workers	outreach and coordination of services	4 participants
Jan 8, 2009	County-wide Migrant Education Meeting	Presentation on MHSA-PEI	28 participants
January 2009	Oxnard Faith Based Coalition	Presentation	125 participants
Jan 13, 2009	High School counselors (OxUHSD)	opportunities in H. Schools	12 participants
Jan 15, 2009	House Farmworkers Area Group	Outreach farmworkers & agricultural community	7 participants
Jan 21, 2009	Schools Conference meeting	infusion of PEI into education	7 participants
Jan 24, 2009	Community schools meeting	PEI info and outreach	48 participants
Feb 4, 2009	Fillmore and Santa Paula outreach	info to general community	50 individual and agency contacts
Feb 7, 2009	Parent-Schools Conference	wellness and MHSA-PEI	100 participants
Feb 11, 2009	Teen Health Workshop	planning/youth outreach	16 participants
Feb 12, 2009	County Schools Nurses Group	PEI and Mental Health	12 participants
Feb 18, 2009	Meeting with ADP staff	community coalitions and RFP process	4 participants
Feb 24, 2009	Area 4 Team meeting	Information/coordination	7 participants
Feb 25, 2009	Area Team meetings (Areas 1 and 5)	Information/coordination	8 + 5 participants
Feb 25, 2009	Homeless Task Force meeting	issues of homelessness	15 participants
Feb 25, 2009	Latino Town Hall reception for	Intro of VCBH staff and	29 participants

	Director of VCBH	MHSA-PEI programs	
Feb 26, 2009	VC Alternative Educators Council	Truancy, juvenile justice diversion of high-risk students & PEI	9 participants
Feb 26, 2009	Area 2 Team meeting	Information/coordination	7 participants
Mar 2, 2009	Big Brothers Big Sisters	Planning/ mentoring efforts	5 participants
Mar 4, 2009	El Centrito de la Colonia	outreach to farmworker immigrant community	3 participants
Mar 6, 2009	NAMI Recognition Dinner	PEI/MHSA efforts/ advocacy	approximately 175 participants
Mar 10, 2009	CIMH meetings (Areas 2 and 4)	evidence-based practices	5 + 7
Mar 11, 2009	Carpe Diem Youth Conference	VCBH sponsored youth event	approximately 75 participants
Mar 12, 2009	Latino Behavioral Health Institute	Latino Access Issues	7 participants
Mar 17, 2009	CIMH meetings (Areas 1 and 5)	evidence-based practices	4 + 5 participants
Mar 18, 2009	Area Focus Groups (Area 4 and Area 1 (Span and Eng))	Data gathering effort in both English and Spanish	9 + 8 + 7 participants
Mar 19, 2009	Area 3 Focus Group	Data gathering effort	9 participants
Mar 25, 2009	Farmworker Housing Task Force	Information/presentation by CSCs	15 participants
Mar 26, 2009	Ministerial Association	Info on PEI and coming community forums	7 participants
Mar 26, 2009	Community leadership Committee	youth employment needs	18 participants
Mar 30, 2009	Keys Academy	planning info/community outreach	4 participants
Apr 1, 2009	SP Education Committee meeting	infusion of PEI services	7 participants
Apr 2, 2009	Oxnard Community Coalition	promotion of PEI planning	35 participants
Apr 3, 2009	Fillmore coalition group	planning and outreach	8 participants
Apr 6, 2009	Big Brothers Big Sisters meeting	Planning Collaboration	5 participants
Apr 22, 2009	Parent-Schools Conference meeting	Planning	11 participants
Apr 27, 2009	Clergy-Faith Community Group	PEI Info and planning	12 participants
Apr 28, 2009	Bracero Project Presentation	PEI info/outreach	75 participants
Apr 29, 2009	PEI Planning Committee Meeting	Decision Time. Linking findings to Project Recommendations/CiMH	57 participants
May 4, 2009	Area 1 Meeting	Data Review	8 participants
May 5, 2009	Area 2 & Area 4 meetings	Data Review	11 participants
May 5, 2009	Area 3 and Area 5 meetings	Data Review	18 participants
May 7, 2009	May/MH Month: Suicide Prevention, Intervention, Trauma	Outreach	346 participants
May 9, 2009	Parent Schools Conference	Info/outreach	74 participants
May 11, 2009	Area Teams Meeting	CIMH program models	40 participants
May 18, 2009	Mental Health Board	Data Presentation	35 participants
May 18, 2009	East County Community Forum	CIMH PEI planning & recommendations	28 participants
May 19, 2009	West County Community Forum	CIMH planning & recommendations	40 participants
May 20, 2009	Santa Clara Valley Community Forum	CIMH planning& recommendations	16 participants
May 27, 2009	PEI Planning Committee Meeting	Review Recommended EBP Models & Activities	37 participants

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

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

There are two key areas in which the PEI planning process has evolved from the CSS process, building further on lessons learned:

1. Strong Emphasis on a Data Driven Process and Reliance on EBPs
From the beginning, the planning process for the PEI plan has been founded on the idea that data should drive our needs assessment and decision making. VCBH has put an extensive amount of energy, resources, and emphasis on the collection of comprehensive needs assessment data to ensure an accurate, detailed, and complete picture of the prevention and early intervention needs and resources in our community. In this way, PEI programs have been developed based upon the needs and priorities as clarified by the needs assessment process.

Moreover, the needs assessment process has been enhanced by providing more training and support to stakeholders with the goal of increasing their informed participation. Training activities included, among other things, core information about prevention and early intervention programs and evidence based practices.

2. Broad and Diverse Stakeholder Participation
From the outset, the planning process has been stakeholder driven, with VCBH as facilitators of the process. There was significantly more diversity across stakeholders in the PEI planning process as compared to the CSS process. This was led by a heterogeneous planning committee, which was instrumental in soliciting participation by an even wider array of diverse community stakeholders. In addition to the required priority populations, VCBH was successful in securing participation representing various underserved populations, such as the immigrant farm worker and Mixteco communities, veterans, the homeless, and community advocates.

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

As indicated above, extensive analysis was done to track and ensure that participation and representation occurred across all priority populations. This included both representatives of and experts on the various priority populations, as well as individuals who are part of the priority populations. One of the countywide focus groups was specifically for and attended by transition-age youth. The matrixes developed for the Key Individual Interviews, Area Focus Groups, and Countywide Focus Groups certified there was broad representation across age groups, sectors, and geographical areas (see Section 3a). To ensure effective planning, continual feedback and evaluations were collected from all stakeholders throughout the process including the Planning Committee, Area Team members, Key Individual Interviewees,

focus group participants, and community forum attendees. Based on this feedback, at least 98% of participants were satisfied or very satisfied with the process. Additionally, participant data/information profiles were obtained and analyzed throughout the process to validate equitable and representative participation in the process.

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

a. The date of the public hearing:

The Public Hearing occurred July 20, 2009 just prior to the regularly scheduled Mental Health Board meeting. This Public Hearing took place after a 30-day posting of the Plan, from June 16, 2009 through July 16, 2009.

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

After review and recommendation by the Mental Health Board during their June regular meeting, the plan was posted on the VCBH page of the Ventura County website. Hard copies were made available upon request. Notification of the posting was announced to all MHSA stakeholders electronically. Additionally, notice of the hearing was widely circulated among all participants, interested community members, community-based organizations, and other community and government partners/agencies.

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

The Department received a total of 3 public comments during the 30-day review and 6 additional comments (some of which were also provided in writing) at the Public Hearing. Copies of the written comments are attached in Appendix V for review. Six of the Public Comments reflected community appreciation for the inclusive and thorough planning process which unfolded over the last year. Noting the breadth and depth of outreach efforts, each of these individuals, representing First 5, schools, primary care medical clinics, faith based councils and Community Action Coalitions, praised the inclusiveness of the community planning process. It was noted that a broad, diverse group of stakeholders, including representatives from groups that had been historically unserved or underserved by the mental health system, were actively included in the Plan development. Several comments expressed that the PEI Plan will provide the opportunity for collaboration and community partnerships in implementing universal prevention strategies. There was also support for some of the specific strategies included in the Plan, such as Triple P Parenting, that will be implemented in schools and at primary health care sites, to increase access and decrease stigma for those seeking assistance. The Special Education Local Plan Area representative noted disappointment that “Response to Intervention” (RTI) was not funded. In addition, one written comment indicated that the plan does not address the relationship between racism and mental health issues. Another writer indicated his disagreement with the Department’s use of the Institute of Medicine (IOM) model for prevention and stated that there was insufficient emphasis on universal prevention.

And one written submission made the request for consideration of an alternative program for employment mentoring.

A representative of the Department explained at the hearing that the State's directive was to use IOM framework in the development of the plan. Additionally, it was noted that Ventura County's distribution of universal and selective prevention as well as early intervention approaches is consistent with the results of the needs assessment and the community planning process, and it is similar to the distribution employed by other counties. In giving consideration to the public comments, the Mental Health Board thanked the community for its efforts in this exhaustive planning process. Although not all projects and recommendations can be included in project funding, the commitment to hear each voice and to assure inclusivity was reiterated.

After listening to and considering all comments presented, the Mental Health Board voted unanimously to recommend the Board of Supervisors review and approve the Plan to move forward to State DMH for review and approval.

d. The estimated number of participants:

Aside from 15 Behavioral Health Department staff, there were approximately 20 community members in attendance at the public hearing. Seven individuals made comments during the hearing. Several provided written comments as well, which are included as part of the Plan.

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

County: Ventura **PEI Project Name:** Community Coalitions **Date:** June 2009

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

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

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

The recommended PEI Project, Community Coalitions, is the result of a community-based needs assessment effort spearheaded by VCBH in collaboration with a 44 member PEI Planning Committee, representative of all PEI sectors and the County. The community-based needs assessment involved stakeholders at multiple levels who were identified to participate in the process based on their geographic representation, and representation within the following MHSA categories: age group, community sector, priority populations, and key PEI community mental health needs. The needs assessment was designed to collect both quantitative and qualitative data from various community sources as well from community stakeholders to inform the identification of PEI Projects. Quantitative data included existing data from multiple sources on key indicators representative of the MHSA defined priority populations. Qualitative data included direct input from community stakeholders in the form of 1) key individual interviews; 2) focus groups (area-based and countywide groups with specific populations); 3) Area Work Group data review meetings; and, 4) community forums. Please refer to Form #2 for specific details about the needs assessment program planning process.

The focus of this section will be twofold. First to describe the role stakeholders played at multiple levels in the selection of the Community Coalitions PEI Project; and, second to show how the quantitative and qualitative data collection strategies, analysis, and review process directly informed the selection of the Community Coalitions PEI Project as well as recommended interventions to be implemented as part of the Project.

<u>Stakeholder Input</u>
A countywide grass roots outreach effort was conducted to invite stakeholders to participate in the multilevel PEI Planning process. The 44 member PEI Planning Committee guided the overall planning process and formed area-based Work Groups responsible for reviewing the quantitative and qualitative data collected through the needs assessment and using the corresponding findings to recommend the Community Coalitions PEI Project and related evidence-based intervention models.

To reach the point at which Work Groups were able to review and use data to make PEI project recommendations, other stakeholder input was gathered through a systematic data collection process. Key individual interviews were conducted across the County with 25 stakeholders who were not only identified to participate in the process based on specific demographic and MHSA categories, but also were knowledgeable about a specific community, issue, or problem related to mental health prevention and early intervention. These individuals were asked to provide input on community and mental health needs, age group priorities and priority populations, existing and needed PEI services, and recommendations for providing effective PEI services.

Focus groups were conducted at two levels: 1) By geographic area of the County (at least two in each area); and, 2) Countywide representing 13 distinct populations: African Americans, Ambulatory Care professionals, Consumers, Deaf and hard of hearing, Developmental disabilities, Pre-K and elementary school students, High school and college students, Faith-based community members, Immigrants and farm workers,

Juvenile probation, Older adults, Transitional-age youth, and Veterans. The purpose of the focus groups was to conduct in-depth discussions with different community leaders, gatekeepers and other community members. Participants were selected because they were knowledgeable about their constituency and had insight into community mental health needs and strategies for PEI.

The PEI Planning Committee members also provided input on the types of key data indicators that would supplement, add to, and validate the qualitative findings from the key individual interviews and focus groups. Data were compiled on 46 primary indicators representing and categorized by the priority populations. Examples relevant to Community Coalitions will be provided in the *Data Analysis and Review* section. A complete presentation of the key indicator data compiled can be found in the Key Indicator Data Report in Appendix I.

Once the key indicators and the findings from the key individual interviews and focus groups were compiled, the five PEI Planning Committee Area Work Groups were convened and provided with copies of the Area-based reports along with a presentation of key findings across all three data collection strategies. (Interview and focus group reports are located in Appendix II.) Work groups were asked to react to and comment on the findings presented, as well as asked to use the findings to identify needed PEI services. The needed PEI services identified by each of the five Area Work Groups were compiled and an additional meeting was held with all five Area Work Groups present to review and comment upon the PEI Projects summarized in this report.

One additional level of stakeholder input was sought from community members throughout the County who had not had an opportunity to participate in the PEI Planning Committee, Area Work Groups, key individual interviews, or focus groups. Three Community Forums were held in one of each of three regions: East County, West County, and Santa Clara Valley. These forums were designed to share findings, present the recommended PEI Projects that emerged from the process and obtain additional comments and suggestions on the recommended PEI Projects and their corresponding interventions.

The Community Coalitions Project is one of five PEI Projects recommended as a result of input from stakeholders at multiple levels. The next section describes the community mental health needs, priority populations, and barriers reported by stakeholders that guided the Project selection and recommended interventions.

Data Analysis, Review, and Implications

Based upon findings across the three data collection strategies—key indicators, key individual interviews, and focus groups, Community Coalitions emerged as a vital project to provide several of the most highly recommended and needed PEI services. As shown in Table 2, education and outreach to increase awareness of mental health issues and services was the number one most recommended PEI strategy in interviews and countywide focus groups, and the third most recommended strategy in area focus groups. Other highly recommended strategies that the Community Coalitions PEI Project address include services that increase access and collaboration, coordination, and communication

amongst mental health providers, law enforcement, schools, social services, community organizations, and faith-based organizations.

Table 6
Most Frequently Recommended PEI Services

Key Individual Interviews	Countywide Focus Groups	Area Focus Groups
1. Education, Awareness, and Outreach	1. Education, Awareness, and Outreach	1. Services that Increase Access
2. Services that Increase Access	2. Service Provider Workforce Development and Training	2. School-based Services
3. School-based Services	3. Services that Increase Access	3. Education, Awareness, and Outreach
4. Parent/Family Education and Training	4. Collaborations, Coordination, and Communication	4. Collaborations, Coordination, and Communication
5. Culturally Competent Providers	5. School-based Services	5. Services for Parents and/or Families
6. Service Provider Workforce Development and Training	6. Parent Education and Training	6. Service Provider Workforce Development and Training

These prevention and early intervention services were recommended by stakeholders in order to meet the top prioritized mental health needs, priority populations, and age groups in the County. Key indicator data and interview and focus group discussions regarding the mental health needs in the five geographic regions of Ventura pointed to a significant concern for underserved cultural populations, disparities in access to mental health services, and stigma and discrimination across all age groups.

Underserved cultural populations were highly prioritized for both prevention and early intervention services by participants in interviews and focus groups (see Table 3). Stakeholders frequently commented that it was critical to address underserved cultural populations as they were predominant across the County and most unaware of, or unwilling to access mental health services for cultural reasons. Accordingly, stakeholders also viewed disparities in access to mental health services and stigma and discrimination as top mental health needs, particularly for marginalized populations in the County such as Latino/Hispanic families, immigrants, and farm workers.

Table 7
Top Priority Populations

Key Individual Interviews	Countywide Focus Groups	Area Focus Groups
1. Children and Youth in Stressed Families	1. Children and Youth in Stressed Families	1. Children and Youth in Stressed Families
2. Underserved Cultural Populations	2. Underserved Cultural Populations	2. Children At-risk for School Failure
3. Individuals Experiencing the Onset of Serious Psychiatric Illness	3. Children At-risk for School Failure	3. Underserved Cultural Populations
4. Children At-risk for School Failure	4. Trauma-exposed	4. Children and Youth At-risk of or Experiencing Juvenile Justice Involvement
5. Children and Youth At-risk of or Experiencing Juvenile Justice Involvement	5. Individuals Experiencing the Onset of Serious Psychiatric Illness	5. Trauma-exposed
6. Trauma-exposed	6. Children and Youth At-risk of or Experiencing Juvenile Justice Involvement	6. Individuals Experiencing the Onset of Serious Psychiatric Illness

Key indicator data show that Latinos/Hispanics are by far the largest racial/ethnic minority group in Ventura County, comprising 33% of the total population. However, in some areas of the County, Latinos/Hispanics make up as much as 70% of the population. Similarly, 26% of the countywide population primarily speaks Spanish in their homes, with the number of primarily Spanish-speakers rising to 55% in some areas of the County. In addition, there are a substantial number of residents who are migrant workers/farm workers and not included in the above-mentioned Census 2000 figures. Although it is difficult to estimate the size of the migrant population due to its nature, the number of youth in schools classified as migrant students can shed some light. In the 2007-2008 academic years, there were approximately 11,000 migrant students in the County. Furthermore, one quarter of the students in one area of the County was migrant students.

According to stakeholders in interviews and focus groups, these underserved cultural populations are highly in need of prevention and early intervention services. It was reported that negative mental health outcomes, such as depression and substance abuse, are more pervasive in marginalized populations due to the disparities in access to mental health services and the cultural stigma associated with mental health treatment.

During interviews and focus group, stakeholders overwhelmingly pointed out the limited access to mental health services across the County, citing the following barriers to accessing services: lack of services available (particularly bilingual and bicultural services), stigma and discrimination, lack of awareness of mental health issues and services, and lack of communication, coordination and collaboration amongst providers. Stakeholders discussed the challenges many Latino/Hispanic and Mixteco community members faced acknowledging and understanding mental health issues. In addition, when they do wish to seek mental health services, Latino/Hispanic and Mixteco populations are often unaware of services available, encounter language barriers, and have difficulties navigating the system.

As indicated above, the language spoken by mental heath providers may limit access and contribute to stigma as those who try to access services and are not able to find a provider in their language may feel stigmatized and discriminated against. Only 21% of the managed health care providers who contract with Ventura County Behavioral Health speak a language other than English. According to the Ventura County's Workforce Education and Training (WET) estimate, more Spanish-speaking mental health work force members are needed across the county. In 2008, it was estimated that 74 additional direct service personnel proficient in Spanish were needed to fill the 35% gap in need. Stakeholders suggested partnerships and collaborations with community organizations to help address language barriers, provide information about PEI services in native languages, coordinate referrals, and facilitate participation in prevention and early intervention services with underserved cultural populations, as well as the community at large.

In addition to language barriers, the cultural stigma associated with mental health and the lack of awareness about mental health issues and services are noteworthy considerations for underserved cultural populations. Stakeholders emphasized that many Latino/Hispanic community members would not seek services due to the shame associated with mental illness in their culture, lack of understanding of what mental health is, and fear and distrust of other individuals/organizations outside of their culture.

To overcome these barriers and meet the needs of underserved cultural populations, stakeholders recommended culturally and linguistically sensitive outreach and education to increase awareness of mental health overall, as well as awareness of mental health services and resources in the community. They emphasized the need for outreach to engage and meet community members in their "comfort zone" such as in schools, homes, churches, and community organizations. In addition, they suggested partnerships with community and faith-based organizations because outreach and education provided by trusted community leaders and entities would be most effective for underserved cultural populations.

Overall, the Community Collaborations PEI Project was considered best suited to address stigma and discrimination and disparities in access to services, particularly for underserved cultural populations, due to its ability to:

- Be tailored to specific community needs and resources in each area of the County;
- Engage community members in locations and ways that are comfortable and non-threatening to community members;
- Provide culturally and linguistically appropriate outreach to help overcome the stigma and discrimination associated with mental health;
- Educate community members about mental health through positive, non-stigmatizing materials and mediums; and
- Increase awareness of existing mental health services and resources;
- Facilitate participation in prevention activities; and,
- Increase access to early intervention services through coordinated referral procedures.

Using the findings from stakeholder input, the PEI Planning Committee Area Work Groups were able to identify the Community Coalitions PEI Project as an appropriate and needed approach to addressing the mental health needs of children, transition-age youth, adults and older adults. Similarly, the mental health needs that emerged from the findings directly implied the need for interventions that increase engagement and outreach, overcome stigma, coordinate referrals, and increase education and awareness about risk and protective factors, as well as services. It is of particular importance that Community Coalitions are tailored to community needs. Therefore, selected interventions may include Promotores, faith-based clergy council activities, and/or screening and referral activities dependent upon the needs and resources indicative of each area of the County.

3. PEI Project Description:

Community Coalitions

The Community Coalitions program is primarily responsive to the overwhelming priority, as identified by the community planning process, to increase awareness and education about the need for, and availability of, respectful and effective mental health prevention and early intervention services. Moreover, that education and outreach be provided in a manner that is sensitive to the needs of Ventura County's ethnically/culturally diverse communities and reduces stigma and access barriers.

This project is intended to consist of 4-6 "grassroots" coalitions each of which will be funded to provide education and outreach specific to the needs for their local community. These coalitions will consist of local collaborative groups (for example, local faith and civic organizations, schools, social service and mental health agencies, law enforcement) that are committed and prepared to develop educational materials and execute a range of outreach activities to (1) inform their local community about mental health issues, (2) reduce stigma, (3) facilitate participation in universal and selective prevention activities, (4) increase access to early intervention services, and (5) coordinate referral activities.

Community coalitions will function as a foundation for the other 4 proposed PEI projects, and each coalition will be expected to promote the five goals listed above. All coalition activities are universal and selective prevention in nature. Moreover, the coalitions, among other things, will all be expected to incorporate and make use of universal prevention educational materials that are apart of three specific intervention models associated with several of the other projects (Triple P Parenting Level 1, Early Detection and Intervention for the Prevention of Psychosis, Improving Mood Promoting Access to Collaborative Treatment) discussed in greater length under the relevant PEI projects.

PEI resources will be used primarily as "seed" funding to support and enhance the work of the community coalitions, with the expectations that the coalitions will expand and sustain their education and outreach work through coordination with other local initiatives and volunteerism.

Additionally, in order to advance coordinated referrals, the Children's Outreach and Engagement Project (Work plan 3) will be transferred from Community Services and

Supports to PEI - Project Plan 1, Community Coalitions. This CSS project currently provides the outreach and education activities within specific un- and underserved communities that is in keeping with the goals of both PEI and this recommended Community Coalition project. As this CSS project evolved, it became apparent that the activities and individuals served fell into the categories of selective prevention and early identification of children at risk for key mental health indicators. In this way, increased integration of services and supports is achieved.

Per direction provided by the PEI Planning Committee, community coalitions will be selected from within targeted communities, based on a combination of need (as indicated by a significant gap between mental health needs in the community and access to/use of mental health services) and the readiness of the collaborative (as indicated by the strength of collaborative development and linkage to the target community) to successfully carryout and sustain the education and outreach activities.

The geographical boundaries for communities, under this initiative, will correspond to the Neighborhoods for Learning. Neighborhoods for Learning is a countywide initiative, spearheaded by First 5 Ventura County, involving parents, schools, early childhood educators, and service providers working together to offer a web of support for young children and families designed by and for each community (see www.first5ventura.org/parents-caregivers/neighborhoods-for-learning). The county is divided into eleven Neighborhoods for Learning that is inclusive of all regions of the county. Each Neighborhood for Learning's geographical boundaries conforms to the boundaries of a school district or group of districts. The Neighborhoods for Learning were developed after extensive community planning and involve of web of health, dental, mental health and early childhood education services, coordinated through regional resource centers.

VCBH will fund Community Coalitions based on a competitive bidding process. This is consistent with direction given by the PEI Planning Committee, based on their appreciation that the PEI resources are limited, and that the intent be that those coalitions that are selected have sufficient funding to be effective.

Successful respondents will need to meet the following conditions: (1) Partner with Neighborhoods for Learning, and other local civic and faith organizations, school districts, city municipalities, service providers and county agencies to ensure responsiveness, ownership, and sustainability. (2) Develop plans specific to the needs of un- and underserved ethnic and cultural populations specific to their communities. (3) Include participation and direction from local community leaders who are members of the targeted underserved communities. (4) Demonstrate clear strategies for carrying out education and outreach activities. (5) Demonstrate viable strategies for sustainability.

Other than incorporating educational materials associated with the three intervention models noted above, coalitions will be encouraged to develop strategies that are uniquely suited to their respective communities, for example, a Promotores program or similar model for reaching out to underserved populations. These strategies will be documented and their impacts, in terms of increased access to use of selective prevention and early intervention services, will be monitored.

Although each coalition will develop educational materials and carry out a range of outreach activities, the nature of those activities is not being prescribed in advance; rather creativity is being encouraged so that coalitions can be highly responsive to their respective communities, with direction being provided by local leaders representing underserved ethnic groups. Priority groups include migrant farm workers, first general immigrants from Mexico, and Mixteco populations. However, key milestones for all coalitions are as follows:

- A process for requesting and selecting coalitions will be established
- 4-6 community coalitions will be selected and funded based on criteria described above
- Community coalitions will develop educational information including, but not limited to, material associated with the 3 specified universal prevention models (Triple P, EDIPP, IMPACT)
- Outreach activities will be implemented, specific to each community coalition, and may include community events/fairs, training (for teachers, primary care centers, resources centers), media campaign (newsletters, newspaper articles, television and radio spots), and so forth
- Outreach activities will be documented by VCBH along with impact on access to and use of selective prevention and early intervention services, as established under PEI Projects 2-5.

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Community Coalitions	**Individuals:** 5,000 **Families:** 2,500	Individuals: Families:	12
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 5,000 **Families**: 2,500	**Individuals: Families**:	12

Community Coalition activities are entirely universal and selective prevention in nature. The number of individuals and families who will be exposed to educational materials and outreach activities is expected by be quite high. The proposed numbers are based on the conservative assumption that 10 individuals will be affected by the coalitions work for every individual who receives an early intervention under one of the four projects.

5. Linkages to County Mental Health and Providers of Other Needed Services
The Community Coalitions will serve as the foundation for the other 4 PEI projects, and dovetail with the Neighborhoods for Learning, and the larger mental health and social services system, encompassing both formal and informal services and supports. Coalitions will be expected to increase help seeking on the part of individuals and families, and reduce access barriers, such that access to and use of both formal and informal services and supports will be enhanced.

The nature of the linkages between each of the coalitions and the larger service system will vary in accordance with constituents of each coalition and the needs and resources of their community. However, in every case, formal referral structures will be in place to ensure that individuals in need of treatment level services will have access to the full range of opportunities under the VCBH Mental Health Plan and Full Service Partnership programs. This will largely be accomplished through the work of the Children's Outreach and Engagement Project and VCBH's newly established STAR program that is responsible for coordinating, streamlining and facilitating countywide triage, assessment, referral and linkage to ensure that all VCBH resources are optimally managed.

6. Collaboration and System Enhancements
Community Coalitions will, in every case, build upon and enhance existing, local community collaborative structures, including but not limited to the Neighborhoods for Learning. All coalitions will be expected to develop strategies to sustain and expand education and outreach activities through coordination with related initiatives (current and future) and through the resources of their collaborative partners and volunteerism.

7. Intended Outcomes
Community coalitions are expected to engage local communities, through collaborative efforts, to embrace mental health promotion, as a local community responsibility, and in turn to engage in strategic education and outreach activities that reduce stigma, and increase protective factors, help seeking and access to formal and informal services and supports. Specific intended outcomes include:

- Inform their local community about mental health issues
- Reduce stigma and other barriers to seeking and receiving services and supports
- Facilitate participation in universal and selective prevention activities
- Increase access to early intervention services
- Coordinate referral activities

8. Coordination with Other MHSA Components
Formal referral structures will be in place to ensure that individuals in need of treatment level services will have access to Full Service Partnership programs when appropriate.

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: **Ventura** Date: June 9, 2009

PEI Project Name: **1. Community Coalitions**

Provider Name (if known): **Various (See Below)**

Intended Provider Category: **Ethnic or Cultural Organization**

Proposed Total Number of Individuals to be served:	FY 09-10	5000
Total Number of Individuals currently being served:	FY 09-10	
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	5000
Months of Operation:	FY 09-10	12

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 09-10		Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages TBD	$44,079	$0	$44,079
	$0	$0	$0
b. Benefits and Taxes @ **44%** **44%**	$19,615	$0	$19,615
c. Total Personnel Expenditures	$63,694	$0	$63,694
2. Operating Expenditures			
a. Facility Cost **8%**	$5,096	$0	$5,096
b. Other Operating Expenses **49%**	$31,210	$0	$31,210
c. Total Operating Expenses	$36,306	$0	$36,306
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
a-1 Children's Outreach & Engagement	$150,000	$0	$150,000
a-2 Education, Awareness & Collaboration	$350,000	$0	$350,000
a-2 Training	$22,000	$0	$22,000
a. Total Subcontracts	$522,000	$0	$522,000
4. Total Proposed PEI Project Budget	$622,000	$0	$622,000
B. Revenues (list/itemize by fund source)			
		$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$622,000	$0	$622,000
6. Total In-Kind Contributions	$0	$0	$0

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

FORM NO. 4 (cont)

CONTRACTOR (a-1)	
1) Boys & Girls Club	$50,000
2) Guadalupe Church	$50,000
3) St. Paul Baptist Church	$50,000
	$150,000
CONTRACTOR (a-2)	
1) TBD	$350,000
CONTRACTOR (a-3)	
1) TBD	$22,000

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

County: Ventura **PEI Project Name:** Primary Care Services **Date:** June 2009

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

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
B. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	X	X	X	X
2. Individuals Experiencing Onset of Serious Psychiatric Illness	X	X	X	X
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	X	X	X	X

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

The recommended PEI Project, Primary Care Services, is the result of a community-based needs assessment effort spearheaded by the VCBH in collaboration with a 44 member PEI Planning Committee, representative of all PEI sectors and the County. The community-based needs assessment involved stakeholders at multiple levels who were identified to participate in the process based on their geographic representation, and representation within the following MHSA categories: age group, community sector, priority populations, and key PEI community mental health needs. The needs assessment was designed to collect both quantitative and qualitative data from various community sources as well from community stakeholders to inform the identification of PEI Projects. Quantitative data included existing data from multiple sources on key data indicators representative of the MHSA defined priority populations. Qualitative data included direct input from community stakeholders in the form of 1) key individual interviews; 2) focus groups (area-based and countywide groups with specific populations); 3) Area Work Group data review meetings; and, 4) community forums. Please refer to Form #2 for specific details about the needs assessment program planning process.

The focus of this section will be twofold. First to describe the role stakeholders played at multiple levels in the selection of the Primary Care Services PEI Project; and, second to show how the quantitative and qualitative data collection strategies, analysis, and review process directly informed the selection of the Primary Care Services PEI Project as well as the recommended interventions to be implemented as part of the Project.

<u>Stakeholder Input</u>
A countywide grass roots outreach effort was conducted to invite stakeholder participation in the PEI Planning process at multiple levels. The 44 member PEI Planning Committee guided the overall planning process and formed area-based Work Groups responsible for reviewing the quantitative and qualitative data collected through the needs assessment and use those findings to recommend the Primary Care Services PEI Project and select the evidence-based intervention models corresponding to community needs and populations.

To reach the point at which Work Groups were able to review and use data to make PEI project recommendations, other stakeholder input was gathered through a systematic data collection process. Key individual interviews were conducted across the County with 25 stakeholders who were not only identified to participate in the process based on specific demographic and MHSA categories, but also were knowledgeable about a specific community, issue, or problem related to mental health prevention and early intervention. These individuals were asked to provide input on community and mental health needs, age group priorities and priority populations, existing and needed PEI services, and recommendations for providing effective PEI services.

Focus groups were conducted at two levels: 1) By geographic area of the County (at least two in each area); and, 2) Countywide representing 13 distinct populations: African Americans, ambulatory care professionals, consumers, deaf and hard of hearing, developmental disabilities, pre-K and elementary school students, high school and college

students, faith-based community members, immigrants and farm workers, juvenile probation, older adults, transitional-age youth, and veterans. The purpose of the focus groups was to conduct in-depth discussions with different community leaders, gatekeepers and other community members. Participants were selected because they were knowledgeable about their constituency and had insight into community mental health needs and strategies for PEI.

The PEI Planning Committee members also provided input on the types of key data indicators that would supplement, add to, and validate the qualitative findings from the key individual interviews and focus groups. Quantitative data were compiled on 46 primary indicators representing and categorized by the priority populations. Examples relevant to Primary Care Services will be provided in the *Data Analysis and Review* section. A complete presentation of the key indicator data compiled can be found in the Key Indicator Data Report in Appendix I.

Once the key indicators and the findings from the key individual interviews and focus groups were compiled, the five PEI Planning Committee Area Work Groups were convened and provided with copies of the Area-based reports along with a presentation of key findings across all three data collection strategies. (Interview and focus group reports are located in Appendix II.) Work groups were asked to react to and comment on the findings presented, as well as asked to use the findings to identify needed PEI services. The needed PEI services identified by each of the five Area Work Groups were compiled and an additional meeting was held with all five Area Work Groups present to review and comment upon the PEI Projects summarized in this report.

One additional level of stakeholder input was sought from community members throughout the County. Three Community Forums were held in one of each of three regions: East County, West County, and Santa Clara Valley. These forums were designed to share the needs assessment findings, present the recommended PEI Projects that emerged from the process, and obtain additional comments and suggestions on the recommended PEI Projects and their corresponding interventions.

The Primary Care Services PEI Project is one of five PEI Projects recommended as a result of input from stakeholders at multiple levels. The next section describes the community mental health needs, priority populations, and barriers reported by stakeholders that guided the Project selection and recommended interventions.

Data Analysis and Review

Based upon findings across the three data collection strategies—key indicators, key individual interviews, and focus groups—Primary Care Services emerged as a highly recommended project for Ventura County. Primary Care Services are a vital means of addressing the mental health needs and priority populations emphasized by community stakeholders. Key indicator data and interview and focus group discussions in the five geographic regions of Ventura County highlighted the need to reduce disparities in access to mental health services, stigma and discrimination, the psycho-social impact of trauma, and suicide risk, by making prevention and early intervention services available and accessible in non stigmatizing settings for all age groups, with an emphasis on

underserved cultural populations, trauma-exposed individuals, and those experiencing the onset of serious psychiatric illness.

Table 8
Prioritized Mental Health Needs

Key Individual Interviews	Countywide Focus Groups	Area Focus Groups
1. At-risk Children, Youth, and Young Adult Populations	1. Disparities in Access to Mental Health Services	1. At-risk Children, Youth, and Young Adult Populations
2. Disparities in Access to Mental Health Services	2. At-risk Children, Youth, and Young Adult Populations	2. Disparities in Access to Mental Health Services
3. Stigma and Discrimination	3. Stigma and Discrimination	3. Psycho-social Impact of Trauma
4. Psycho-social Impact of Trauma	4. Psycho-social Impact of Trauma	4. Suicide Risk
5. Suicide Risk	5. Suicide Risk	5. Stigma and Discrimination

As shown in Table 4, the need to reduce disparities in access to mental health services, as well as stigma and discrimination consistently emerged as a top priority among interviewees and focus group participants. Specifically, stakeholders emphasized the dearth of services in Ventura County that address the mental health needs of all age groups. Furthermore, stakeholders noted that those services that do exist do not have the capacity to meet the high demand across the County, which leaves those in need of mental health services vulnerable to escalating and exacerbated mental health issues. According to interviewees and focus group participants, those particularly at-risk of exacerbated mental health issues are the underserved cultural populations.

As noted in Table 3 in the Community Coalitions section, underserved cultural populations were highly prioritized for both prevention and early intervention services across stakeholders in interviews and focus groups. Stakeholders also noted a high need to increase knowledge about mental health as a means of reducing stigma and increasing access. Among the underserved in general, there is a lack of understanding of what mental heath is and what it means to be emotionally healthy, as well as an uneasiness and unwillingness to access services for cultural reasons. It was reported that this issue is acute among the Hispanic community, especially the Mixteco community and migrant farm workers. (Key indicator data presented in the Community Coalitions section show the estimated number of families represented by this particular group.) Other underserved cultural populations mentioned during interviews and focus group discussions included the deaf and hard of hearing community, African Americans, the developmentally disabled, and veterans.

As part of addressing the needs of the underserved cultural populations, key indicator data and interview and focus group discussions emphasized a high need for prevention and early intervention services that address trauma-exposure and suicide risk across age groups. Key indicator data show that almost one-third of Ventura County households are living at or below the 200 percent poverty level. According to interview and focus groups discussions, financial hardship and living in sub-standard conditions puts families at-risk of domestic and community violence, divorce (sometimes due to deportation), depression, and suicide, resulting in the need for services to address these mental health issues.

Key indicator data also provide further evidence of trauma-exposure among children and older adults. In 2008, 8,139 child abuse referrals were made, with two areas of Ventura County representing 21 percent and 45 percent of those referrals. Furthermore, the percentage of children removed from their homes or in foster care ranged from 3 to 40 percent across the five geographic areas of Ventura County. As a consequence of these conditions, interviewees and focus group participants reported a rising number of children and youth who are acting out and displaying disruptive behaviors. It also was reported that children and youth are exhibiting the signs of depressed mood, showing evidence of self-harm such as cutting, and attempting suicide. These mental health concerns among children and youth also suggest the need to provide parents with the tools they need to address and manage associated issues that emerge among their children such as poor academic performance, troublesome behaviors, and inappropriate emotional responses.

With respect to older adults, among the reported cases of abuse perpetrated on older adults and adults in Ventura County in 2008, 41 and 24 percent of those cases represented two of the five County geographic areas. In focus group discussions, participants reported that older adults were particularly vulnerable to trauma from financial, physical, and emotional scams and abuse. Vulnerability to trauma was coupled with indicators of suicide risk such as feelings of isolation, loneliness, and depression.

Another aspect of Primary Care Services considered by stakeholders to be key to meeting the mental health needs and priority populations discussed above is collaboration, coordination, and communication between primary care and mental health providers. Stakeholders in interviews and focus groups pointed out that a closer working relationship between health and mental health providers would foster distribution of educational materials, targeted screenings and assessments, better patient tracking, comprehensive service plans, increased referrals and referral coordination, and coordinated medication management.

Given the findings discussed above, Primary Care Services was considered to be well-positioned to respond to disparities in access, stigma and discrimination, the psycho-social impact of trauma and suicide risk, and to meet these needs across age groups and underserved cultural populations, such as the Hispanic migrant workers, the deaf and hard of hearing, African Americans, individuals with disabilities, and veterans by:

- Serving as an easily accessible and non-stigmatizing service location for all age groups;
- Serving as a place where early detection of mental health issues can occur;
- Promoting continuity of care;
- Identifying and addressing trauma, depression, and problem behaviors before they lead to negative outcomes;
- Providing the ability to acquire treatment and medication for health and mental health concerns in one location;
- Increasing the level of collaboration, coordination, and communication between health and mental health providers; and,

- Establishing the potential for multi-disciplinary teams that might include law enforcement, Child Protective Services, teachers, among others, in addition to the health and mental health providers.

Using the findings from stakeholder input the PEI Planning Committee Area Work Groups were able to identify the Primary Care Services PEI Project as an appropriate and needed approach to addressing the mental health needs of individuals across age groups. Similarly, the mental health needs that emerged from the findings directly call for interventions focusing on trauma, depression, and providing parents with the skills they need to address disruptive behavior among their children, all of which led to five recommended evidence-based interventions: Depression Treatment Quality Improvement (DTQI), Improving Mood Promoting Access to Collaborative Treatment (IMPACT, specifically designed for older adults), Trauma Focused Cognitive Behavior Therapy (TFCBT), Prolonged Exposure Therapy for PTSD, and Triple P Parenting (PPP). These interventions will be discussed in detail in the following sections.

3. PEI Project Description:

Primary Care Project

The Primary Care Project is specifically responsive to the priority, as identified by the community planning process, to make prevention and early intervention services, targeting individuals of all age groups, readily available and accessible in non-stigmatizing settings. In keeping with the areas of greatest need, this project will primarily support selective prevention and early intervention services targeting depression and trauma experienced across the age span, and secondarily support selective prevention services for children with disruptive behaviors.

Integration with primary care centers was prioritized, based on extensive feedback from participants in the community forums and key informant interviews, because it is viewed as less stigmatizing and more accessible, in particular for individuals and families who have recently emigrated from Mexico, which constitute a significant underserved population in the County. Providing selective prevention and early intervention services in primary care settings is one key strategy, in addition to the work of the community coalitions, to reduce stigma and disparities in access.

Primary Care services will be provided by two teams of practitioners, composed of county and/or private organizational provider(s), dedicated to serving adults/older adults and TAY/children populations, respectively. These teams will be trained in evidence-based intervention models (as described below) and assigned to county and community partner primary care clinics that predominately serve the health needs of low income adults, children and families, and that are located in communities with elevated levels of need.

In every case, the PEI Primary Care service teams will be fully integrated into the primary care clinics, and support a set of interrelated selective prevention and early intervention activities. These activities will be modeled after the Improving Mood, Promoting Access to Collaborative Treatment (IMPACT). This model, which targets depression in older adults,

involves the use of educational materials, screening, assessment, and intervention. In the case of the IMPACT model, educational materials are designed to inform individuals about elder depression, reduce stigma and increase self-referrals. The IMPACT practitioners complete screenings, and when indicated assessment and intervention. Treatment services include an evidence-based cognitive-behavioral intervention for depression specifically designed for older adults coupled with coordinated medication treatment provided by the individual's primary care physician with consultation from the IMPACT practitioners and psychiatrist.

Using the same key elements, the Adult Primary Care Service Team will develop educational materials, and provide screening, assessment and treatment, for adults with depression, and adults and older adults with trauma. Coordination with primary care medical staff will occur as in the IMPACT model. The service team will be cross-trained in IMPACT (for older adult depression), Depression Treatment Quality Improvement—DTQI (for adult depression), and Prolonged Exposure for Therapy for PTSD (for adult and older adult trauma).

The Child Primary Care Service Team will provide educational materials, screening, assessment and coordinated treatment for depression and trauma. The service team will be cross-trained in DTQI (for adolescent depression) and Trauma Focused Cognitive Behavior Therapy—TF-CBT (for child trauma). The child service team will additionally be prepared to provide these services in school settings, in coordination with school staff (described further under the School-Based Project).

Finally, the service team and primary care medical staff will be trained in the use of a brief parenting intervention (Triple P Level 2 which is discussed further under the Parenting Project) targeting mild disruptive behavior concerns in children.

Each of the proposed intervention models is evidence-based, having demonstrated effectiveness in clinical research trials. Brief descriptions of the primary care intervention models are as follows:

Improving Mood, Promoting Access to Collaborative Treatment (IMPACT)
Improving Mood, Promoting Access to Collaborative Treatment (IMPACT)—A selective prevention and early treatment intervention for late-life depression including an educational campaign, screening/assessment, and treatment integrated into primary care settings. Key components include:

- Educational information on late-life depression
- Short assessment
- Behavioral activation therapy
- Antidepressant algorithm (provided by primary care physician with consultation from IMAPCT team psychiatrist)
- Problem Solving Therapy (6-8 sessions in duration)

Depression Treatment Quality Improvement (DTQI)
Depression Treatment Quality Improvement (DTQI)—An intervention model for depression in adolescents and adults that will be enhanced with IMPACT style educational materials and coordination with primary care medical staff. Key components of the DTQI model include:

- Evaluation—screening and assessment of depression and co-morbid conditions and problems
- Psychosocial Treatment—manualized cognitive behavior therapy using individual, group or family-based formats (12-20 sessions in duration)
- Environmental Risk and Protective Factors—adjustments to choice and implementation of treatment strategies based on risk and protective factors
- Symptom and Outcomes Monitoring—ongoing monitoring of symptoms/outcomes to inform treatment delivery
- Crisis Management—management of therapy threatening behaviors including suicidal behavior, cutting, drug and alcohol use, family crisis, removal from home, change in living situation, abuse and victimization
- Relapse Prevention and After Care—development and practice of relapse plans, and development for treatment after CBT is completed
- Coordination with Psychiatry—regular communication with treating psychiatrist, use of current research-based medication practices for treating depression in adolescents and adults

Prolonged Exposure Therapy for PTSD

Prolonged Exposure Therapy for PTSD—An intervention model for adults showing PTSD from single or multiple episode(s) of trauma that will be enhanced with IMPACT style educational materials and coordination with primary care medical staff. Key components of the model include:

- Individual therapy sessions (1-2 contacts per week totaling 8-15 sessions)
- Psycho-education, imaginal exposure and in vivo exposure.

Trauma Focused Cognitive Behavior Therapy (TF-CBT)

Trauma Focused Cognitive Behavior Therapy (TF-CBT)—An intervention model for children (ages 4-18) with difficulties related to traumatic events that will be enhanced with IMPACT style educational materials and coordination with primary care medical staff. Key components include:

- Weekly sessions (12-16 in duration) with child and caregiver individually and together
- Psycho-education
- Relaxation and stress management
- Emotional regulation
- Connecting thoughts-feelings and behaviors
- Gradual in vivo exposure
- Cognitive and affective processing of trauma experiences
- Personal safety and skills training.

The Adult Primary Care Service Team will be composed of 8 clinicians and consulting psychiatrist. The clinicians will be crossed trained in IMPACT, DTQI and Prolonged Exposure Therapy for PTSD and be prepared to work with adults and older adults with depression and/or trauma. The clinicians will work in pairs. Each pair will be responsible for two primary care clinics. In total, PEI Primary Care Services for adults will be available in 8 primary care clinics.

The Child Primary Care Service Team will be composed of 2 clinicians and consulting psychiatrist. The clinicians will be crossed trained in DTQI and TF-CBT and be prepared to work with children and transition age youth with depression and/or trauma. The child clinicians will work in coordination with the adult clinicians and be assigned to the same 8 primary care clinics. In addition, child clinicians will be available to provide these interventions, as needed, in coordination with school-based services (described below).

Selective prevention materials, including brochures, articles for newsletters, and video vignettes will all be available in the lobbies of the 8 primary care clinics. In addition, these materials will be incorporated into the work of the Community Coalitions. It is anticipated that the 8 adult clinicians will provide depression and trauma intervention to about 360 adults and older adults per year, and that the 6 child clinicians will provide depression and trauma intervention to 90 children and transition age youth per year in the primary care clinics (and another 180 children through school based programs).

Clinics will be selected based on level of the unmet need and readiness to support an integrated mental health teams.

Key milestones are as follows:

- Establishing primary care service teams and developing formal collaborative structures with primary care staff
- Developing and implementing educational materials
- Coordinating with Community Coalitions to enhance educational campaign
- Complete training in each of the intervention models for the adult/older adult and child/TAY service teams respectively
- Initiate intervention models

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
IMPACT	Individuals:1,200	Individuals:120	12
DTQI	Individuals:1,650	Individuals: 165	12
Prolonged Exposure Therapy for PTSD	Individuals:1,200	Individuals: 120	12
TF-CBT	Individuals:450	Individuals: 45	12
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 4,500	**Individuals:** 450	

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

Community members receiving PEI services under the Primary Care project will have access to the full array of services available through VCBH. Formal referral channels to the VCBH Mental Health Plan will be established. Moreover, through this project coordination with primary care health services will be greatly enhanced. Finally, the Primary Care service teams will be prepared to provide referrals to formal and/or informal services for mental health or other needed services as indicated.

6. Collaboration and System Enhancements

The Primary Care project is inherently collaborative, building upon and partnering with primary care clinics. In this way, PEI services will be easily accessible, linked with health care, and less stigmatizing. As previously noted, the educational campaign components of the project will be expanded through the work of the Community Coalitions.

VCBH will leverage Medi-Cal and EPSDT funding for Primary Care intervention services when appropriate, which is important for sustaining these activities.

7. Intended Outcomes

Primary Care services are expected to reduce stigma, and increase help seeking and access to early and proven intervention models for depression and trauma across the age span. Specific intended outcomes include:

- Increased access to early intervention services for depression and trauma (all ages_
- Increased interagency collaboration to meet the Prevention and Early Intervention needs of the community (all ages)
- Reduced severity of post traumatic symptoms (all ages)
- Reduced severity of depressive symptoms (transition age youth, adult, older adult)
- Reduced suicide attempts (transition age youth, adult, older adult)
- Improved level of functioning and quality of life (all ages)

8. Coordination with Other MHSA Components

Formal referral structures will be in place to ensure that individuals in need of more extensive treatment level services will have access to Full Service Partnership programs when appropriate

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: **Ventura** Date: **June 9, 2009**

PEI Project Name: **2. Primary Care Services**

Provider Name (if known): **Various (See Below)**

Intended Provider Category: **Primary Health Care**

Proposed Total Number of Individuals to be served:	FY 09-10	450
Total Number of Individuals currently being served:	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	450
Months of Operation:	FY 09-10	12

		Total Program/PEI Project Budget		
Proposed Expenses and Revenues		FY 09-10		Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
Psy Social Worker IV	10.00	$714,630	$0	$714,630
BH Clinic Administrator III	..67	$62,400	$0	$62,400
Office Assistant IV	.67	$29,053	$0	$29,053
b. Benefits and Taxes @ **44%**	**44%**	$358,706	$0	$358,706
c. Total Personnel Expenditures	16.00	$1,164,789	$0	$1,164,789
2. Operating Expenditures				
a. Facility Cost	**8%**	$93,183	$0	$93,183
b. Other Operating Expenses	**49%**	$570,747	$0	$570,747
c. Total Operating Expenses		$663,930	$0	$663,930
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
Initial training of staff on treatment models		$293,333	$0	$293,333
Ongoing training/support to ensure program fidelity		$29,333	$0	$29,333
Contractor - Sr. Psychiatrist (667hrs @ $130)		$86,667	$0	$86,667
Medications		$40,000	$0	$40,000
a. Total Subcontracts		$449,333	$0	$449,333
4. Total Proposed PEI Project Budget		$2,278,053	$0	$2,278,053
B. Revenues (list/itemize by fund source)				
Medi-Cal		$530,624	$0	$530,624
1. Total Revenue **Medi-Cal**		$530,624	$0	$530,624
5. Total Funding Requested for PEI Project		$1,747,429	$0	$1,747,429
6. Total In-Kind Contributions		$0	$0	$0

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

County: Ventura **PEI Project Name:** School Based Services **Date:** June 2009

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

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

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

The recommended PEI Project, School-based Services, is the result of a community-based needs assessment effort spearheaded by the VCBH in collaboration with a 44 member PEI Planning Committee, representative of all PEI sectors and the County. The community-based needs assessment involved stakeholders at multiple levels who were identified to participate in the process based on their geographic representation, and representation within the following MHSA categories: age group, community sector, priority populations, and key PEI community mental health needs. The needs assessment was designed to collect both quantitative and qualitative data from various community sources as well from community stakeholders to inform the identification of PEI Projects. Quantitative data included existing data from multiple sources on key data indicators representative of the MHSA defined priority populations. Qualitative data included direct input from community stakeholders in the form of 1) key individual interviews; 2) focus groups (area-based and countywide groups with specific populations); 3) Area Work Group data review meetings; and, 4) community forums. Please refer to Form #2 for specific details about the needs assessment program planning process.

The focus of this section will be twofold. First to describe the role stakeholders played at multiple levels in the selection of the School-based Services PEI Project; and, second to show how the quantitative and qualitative data collection strategies, analysis, and review process directly informed the selection of the School-Based Services PEI Project as well as the recommended interventions to be implemented as part of the Project.

<u>Stakeholder Input</u>
A countywide grass roots outreach effort was conducted to invite stakeholder participation in the PEI Planning process at multiple levels. The 44 member PEI Planning Committee guided the overall planning process and formed area-based Work Groups responsible for reviewing the quantitative and qualitative data collected through the needs assessment and use those findings to recommend the School-based Services PEI Project and select the evidence-based intervention models corresponding to community needs and populations.

To reach the point at which Work Groups were able to review and use data to make PEI project recommendations, other stakeholder input was gathered through a systematic data collection process. Key individual interviews were conducted across the County with 25 stakeholders who were not only identified to participate in the process based on specific demographic and MHSA categories, but also were knowledgeable about a specific community, issue, or problem related to mental health prevention and early intervention. These individuals were asked to provide input on community and mental health needs, age group priorities and priority populations, existing and needed PEI services, and recommendations for providing effective PEI services.

Focus groups were conducted at two levels: 1) By geographic area of the County (at least two in each area); and, 2) Countywide representing 13 distinct populations: African Americans, Ambulatory Care professionals, Consumers, Deaf and hard of hearing, Developmental disabilities, Pre-K and elementary school students, High school and

college students, Faith-based community members, Immigrants and farm workers, Juvenile probation, Older adults, Transitional-age youth, and Veterans. The purpose of the focus groups was to conduct in-depth discussions with different community leaders, gatekeepers and other community members. Participants were selected because they were knowledgeable about their constituency and had insight into community mental health needs and strategies for PEI.

The PEI Planning Committee members also provided input on the types of key data indicators that would supplement, add to, and validate the qualitative findings from the key individual interviews and focus groups. Quantitative data were compiled on 46 primary indicators representing and categorized by the priority populations. Examples relevant to School-based Services will be provided in the *Data Analysis and Review* section. A complete presentation of the key indicator data compiled can be found in the Key Indicator Data Report in Appendix I.

Once the key indicators and the findings from the key individual interviews and focus groups were compiled, the five PEI Planning Committee Area Work Groups were convened and provided with copies of the Area-based reports along with a presentation of key findings across all three data collection strategies. (Interview and focus group reports are located in Appendix II.) Work groups were asked to react to and comment on the findings presented, as well as asked to use the findings to identify needed PEI services. The needed PEI services identified by each of the five Area Work Groups were compiled and an additional meeting was held with all five Area Work Groups present to review and comment upon the PEI Projects summarized in this report.

One additional level of stakeholder input was sought from community members throughout the County. Three Community Forums were held in one of each of three regions: East County, West County, and Santa Clara Valley. These forums were designed to share the needs assessment findings, present the recommended PEI Projects that emerged from the process, and obtain additional comments and suggestions on the recommended PEI Projects and their corresponding interventions.

The School-based Services Project is one of five PEI Projects recommended as a result of input from stakeholders at multiple levels. The next section describes the community mental health needs, priority populations, and barriers reported by stakeholders that guided the Project selection and recommended interventions.

Data Analysis and Review

Based upon findings across the three data collection strategies—key indicators, key individual interviews, and focus groups—School-based Services emerged as a highly recommended project for Ventura County (see Table 2 in Community Coalitions section). School-based Services are a vital means of addressing the mental health needs and priority populations emphasized by community stakeholders. Key indicator data and interview and focus group discussions in the five geographic regions of Ventura County highlighted the need to reduce disparities in access to mental health services by making prevention and early intervention services available and accessible in non stigmatizing

settings for children and transition-age youth in stressed families, at-risk of school failure and/or at-risk of juvenile justice involvement.

As shown in Table 4 in the Primary Care Services section, the need to reduce disparities in access to mental health services consistently emerged as a top mental health need among interviewees and focus group participants. Specifically, stakeholders emphasized the dearth of services to address the mental health needs of children and transition-age youth in Ventura County. Furthermore, stakeholders noted that those services that do exist do not have the capacity to meet the high demand across the County, which leaves those in need of mental health services vulnerable to escalating and exacerbated mental health issues. According to interviewees and focus group participants, age groups particularly at-risk of exacerbated mental health issues are children and transition-age youth. Stakeholders indicated that "The best prevention is that which comes earlier, especially among school-aged youth."

Among children and transition-age youth, the two top priority populations identified as needing services were children and youth in stressed families and children at-risk of school failure (see Table 3 in the Community Coalitions section). In addition, children at-risk of juvenile justice involvement, while not among the top three prioritized populations, was considered by stakeholders to be a priority population highly interrelated with the other two; and, as such, would benefit highly from School-based services.

Key indicator data and interview and focus group discussions regarding the mental health needs of stressed families across the five geographic areas of Ventura County show that almost one-third of Ventura County households are living at or below the 200 percent poverty level. These data are corroborated by stakeholder input reporting that families are experiencing economic hardship and at-risk of living in overcrowded and undesirable conditions. In addition, stakeholder input also noted that families are not only stressed economically, but are being affected by substance abuse, violence within the home and in the community, divorce or separation (sometimes due to deportation), unaddressed mental health issues, and an inability to parent their own children. As a result, children and transition-age youth in these families are exhibiting a host of behavioral problems that are placing them at-risk of school failure and juvenile justice involvement. One stakeholder commented that, "We are now seeing mental health issues at a younger age than ever before." Behavioral problems of children and transition-age youth reported by community stakeholders included: depressed mood; thoughts of self harm, such as eating disorders, cutting and/or suicide; poor academic performance and behaviors, such as skipping school, dropping out, and getting suspended or expelled; acting out and disrupting classroom and family life; gang and/or juvenile justice involvement; and, substance abuse.

Key indicator data provide additional supporting evidence that children and transition-age youth in stressed families, at-risk of school failure, and at-risk of juvenile justice involvement are in high need of prevention and early intervention services throughout the County. During the 1st half of the 2008-09 year, these data show that 34 percent of a total of 4,055 children seen for various serious mental illnesses were diagnosed as disruptive; another 18 percent were diagnosed with depression, and another 12 percent were

diagnosed with anxiety. With respect to school behavior and performance, truancy rates in 2007-08 at elementary schools throughout the County ranged from 2 to 60 percent with 10 of 20 elementary schools reporting truancy rates 25 percent or higher. Among 10 high school districts across the five geographic areas of Ventura County, all but two showed a decline in graduation rate between 2004-05 and 2006-07 ranging between 0.3 and 5.9 percentage points. Finally, data indicators representing juvenile justice involvement show that the actual counts of weapons confiscated from students rose from 110 in 2007 to 125 in 2008, a 12 percent increase. While there are a large proportion of documented gang members in one portion of the Ventura County (over 1,500), other areas of Ventura County have between 50 and 1,000.

School-Based Services

Given the key indicator and interview and focus group findings School-based Services was considered a means of providing greater access to prevention and early intervention services for children and transition-age youth. In addition, schools are viewed by interviewees and focus group participants as well as by community members as an existing strength in the community, they represent "service provision in natural community settings." Stakeholders also envisioned school-based services as an opportunity to develop collaborative relationships between school personnel and mental health providers. Overall, schools were considered well-positioned to address the needs of children in stressed families and at risk of school failure and juvenile justice involvement, by:

- Serving as an easily accessible and non-stigmatizing service location for both parents and children;
- Serving as a place where early detection can occur via universal screenings or teacher identification of early signs and symptoms;
- Interfacing collaboratively with school staff and sharing educational materials regarding mental health with school staff
- Offering interventions for children and TAY while simultaneously offering parents intervention services and parenting education; and,
- Identifying and addressing risk factors such as trauma, depression, and problem behaviors that can lead to poor academic outcomes.

Using the findings from stakeholder input and data indicators the PEI Planning Committee Area Work Groups were able to identify School-based Services as an appropriate and needed approach to addressing disparities in access to mental health services for children and transition-age youth in stressed families, at-risk of school failure, and at-risk of juvenile justice involvement. Similarly, the mental health needs that emerged from the findings directly implied the need for interventions focusing on trauma, depression, and behavior problems as well as providing parents with the skills they need to parent resulting in four recommended evidence-based interventions: Strengthening Families Program; Depression Treatment Quality Improvement (DTQI), Trauma Focused Cognitive Behavior Therapy (TFCBT), and Triple P Parenting (PPP).

3. PEI Project Description:

School Based Services

The School Based Services Project is specifically responsive to the priority, as identified by the community planning process, to make prevention and early intervention services, targeting children/TAY in stressed families and at-risk of school failure and/or juvenile justice system involvement, readily available and accessible in non-stigmatizing settings. In keeping with the areas of greatest need, this project will primarily support selective prevention and early intervention services targeting risk factors associated with disruptive behavior problems, school failure, drug use, and juvenile crime.

In addition, interventions for depression and trauma experienced by children/TAY (as described under the Primary Care Services Project) will be available at school sites. Finally, the school based practitioners and school staff will be trained in the use of a brief parenting intervention (Triple P – Level 2 which is discussed further under the Parenting Project) targeting mild disruptive behavior concerns in children.

School Based services will be provided by practitioners, composed of county and/or private organizational provider(s), dedicated to serving children/TAY populations showing (or at-risk of) disruptive behavior, school failure, and/or juvenile crime. These services will be provided on school sites and in close collaboration with school staff, and primarily consist of the evidence-based Strengthening Families Program—SFP (described below). Schools will be identified, from among those that are associated with a Neighborhood for Learning area that is also the target of a Community Coalition, and then based on an elevated level of unmet need and readiness to collaborate and sustain these PEI services.

Strengthening Families Program (SFP)
The Strengthening Families Program (SFP) is a selective prevention and early intervention evidence-based model, having demonstrated effectiveness in clinical research trials, improving school performance and behavior, and diverting youth from substance use and social behavior problems that contribute to risk of juvenile crime. The model is tailored to three age groups (3-5, 6-11 and 12-16 year olds) and is designed to teach child, parent and family skills through a series of child, parenting and family groups.

The intervention consists of fourteen 2-hour group sessions that focus on parent skills (enhancing parent-child bonding, managing anger and family conflict, fostering positive child involvement in family tasks, monitoring compliance and using appropriate consequences, and understanding risk factors for substance abuse), and child skills (communication skills, problem solving, feeling identification, anger management, and resisting peer influences to use substance).

Eight practitioners will be trained in the SFP. It is anticipated that they will work in pairs to conduct 48 SFP groups, serving a total of 350 children/TAY and their families, per year. These eight practitioners will work out of 16 schools (8 elementary, 4 junior and 4 senior high). These school-based practitioners will provide educational material and training for teachers and parents, participate in child study teams and student study teams to facilitate

referrals and coordinate with families and schools. Finally, the school-based program will be coordinated with and supported by the responsible Community Coalition.

Depression and Trauma Intervention (DTQI)
In addition to use of the SFP, the child service teams (described under the Primary Care project) will be additionally assigned to provide depression and trauma intervention at school sites, for children and youth who are identified by school staff, caregivers, or the youth themselves so as to make these early interventions more accessible and less stigmatizing. As noted under the Primary Care Project, the team of 6 Child Primary Care clinicians will be assigned (1-day per week to each of the 14 school sites) to provide depression and trauma intervention services.

Key milestones are as follows:
- Establishing school based assignments and developing formal collaborative structures with school staff
- Sharing educational materials and formal referral structures (teacher, parent, child)
- Participating in child study teams and student study teams
- Completing training in the SFP model
- Initiating SFP services and arranging for school based depression and trauma services (as described under Primary Care project)

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Strengthening Families Program	Individuals:250 Families:250	Individuals: 100 Families: 100	12
DTQI	Individuals:	Individuals:90	12
TF-CBT	Individuals:	Individuals:90	12
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:**250 **Families**: 250	**Individuals:** 380 **Families**:	

5. Linkages to County Mental Health and Providers of Other Needed Services
Community members receiving PEI services under the School Based project will have access to the full array of services available through VCBH. Formal referral channels to the VCBH Mental Health Plan will be established (through the Children's Outreach and Engagement

Project and VCBH's newly established STAR program). Moreover, through this project coordination with schools, and Neighborhood for Learning centers, will be greatly enhanced.

6. Collaboration and System Enhancements

The School Based project is inherently collaborative, building upon and partnering with schools. In this way, PEI services will be easily accessible, linked with school programs and related after school programs, and less stigmatizing. Schools will be providing space and support for SFP services. Moreover, the schools will develop formal referral structures building PEI services into the larger array of school supports for assisting at-risk children and families. Finally, VCBH will leverage Medi-Cal and EPSDT funding for the SFP intervention services when appropriate, which will be important for sustaining these activities.

7. Intended Outcomes

School Based services are expected to reduce stigma, increase help seeking and access to early and proven intervention models for stressed families and children at-risk for school failure and juvenile justice involvement. Specific intended outcomes include:

- Increased access to early intervention services for children showing (or at-risk of) disruptive behaviors, and their families
- Increased interagency collaboration between schools and PEI service providers
- Improved school performance
- Improve child behavior
- Improved family communication and cohesiveness
- Reduced school failure and juvenile justice involvement

8. Coordination with Other MHSA Components

Formal referral structures will be in place to ensure that individuals in need of more extensive treatment level services will have access to Full Service Partnership programs when appropriate.

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: **Ventura** Date: June 9, 2009

PEI Project Name: **3. School Based Services**

Provider Name (if known): **Various (See below)**

Intended Provider Category: **Mental Health Treatment/Service Provider**

Proposed Total Number of Individuals to be served:	FY 09-10	530
Total Number of Individuals currently being served:	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	530
Months of Operation:	FY 09-10	12

		Total Program/PEI Project Budget		
Proposed Expenses and Revenues		FY 09-10		Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
Psy Social Worker IV	8.00	$571,704	$0	$571,704
BH Clinic Administrator III	0.58	$54,600	$0	$54,600
Office Assistant IV	0.58	$25,422	$0	$25,422
b. Benefits and Taxes @ **44%**	**44%**	$290,017	$0	$290,017
c. Total Personnel Expenditures	9.17	$941,743	$0	$941,743
2. Operating Expenditures				
a. Facility Cost	**8%**	$75,339	$0	$75,339
b. Other Operating Expenses	**49%**	$461,454	$0	$461,454
c. Total Operating Expenses		$536,793	$0	$536,793
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
Initial training of staff on treatment models		$186,667	$0	$186,667
Ongoing training/support to ensure program fidelity		$25,667	$0	$25,667
Contractor - Sr. Psychiatrist (333hrs @ $130)		$43,333	$0	$43,333
Medications		$20,000	$0	$20,000
a. Total Subcontracts		$275,667	$0	$275,667
4. Total Proposed PEI Project Budget		$1,754,203	$0	$1,754,203
B. Revenues (list/itemize by fund source)				
Medi-Cal		$670,122	$0	$670,122
1. Total Revenue **Medi-Cal**		$670,122	$0	$670,122
5. Total Funding Requested for PEI Project		$1,084,081	$0	$1,084,081
6. Total In-Kind Contributions		$0	$0	$0

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

County: Ventura **PEI Project Name:** Parenting **Date:** June 2009

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

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

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

The recommended PEI Project, Parenting, is the result of a community-based needs assessment effort spearheaded by the Ventura County Behavioral Health Department in collaboration with a 44 member PEI Planning Committee, representative of all PEI sectors and the County. The community-based needs assessment involved stakeholders at multiple levels who were identified to participate in the process based on their geographic representation, and representation within the following MHSA categories: age group, community sector, priority populations, and key PEI community mental health needs. The needs assessment was designed to collect both quantitative and qualitative data from various community sources as well from community stakeholders to inform the identification of PEI Projects. Quantitative data included existing data from multiple sources on key data indicators representative of the MHSA defined priority populations. Qualitative data included direct input from community stakeholders in the form of 1) key individual interviews; 2) focus groups (area-based and countywide groups with specific populations); 3) Area Work Group data review meetings; and, 4) community forums. Please refer to Form #2 for specific details about the needs assessment program planning process.

The focus of this section will be twofold. First to describe the role stakeholders played at multiple levels in the selection of the Parenting PEI Project; and, second to show how the quantitative and qualitative data collection strategies, analysis, and review process directly informed the selection of the Parenting PEI Project as well as the recommended interventions to be implemented as part of the Project.

Stakeholder Input

A countywide grass roots outreach effort was conducted to invite stakeholder participation in the PEI Planning process at multiple levels. The 44 member PEI Planning Committee guided the overall planning process and formed area-based Work Groups responsible for reviewing the quantitative and qualitative data collected through the needs assessment and use those findings to recommend the Parenting PEI Project and select the evidence-based intervention models corresponding to community needs and populations.

To reach the point at which Work Groups were able to review and use data to make PEI project recommendations, other stakeholder input was gathered through a systematic data collection process. Key individual interviews were conducted across the County with 25 stakeholders who were not only identified to participate in the process based on specific demographic and MHSA categories, but also were knowledgeable about a specific community, issue, or problem related to mental health prevention and early intervention. These individuals were asked to provide input on community and mental health needs, age group priorities and priority populations, existing and needed PEI services, and recommendations for providing effective PEI services.

Focus groups were conducted at two levels: 1) By geographic area of the County (at least two in each area); and, 2) Countywide representing 13 distinct populations: African Americans, Ambulatory Care professionals, Consumers, Deaf and hard of hearing, Developmental disabilities, Pre-K and elementary school students, High school and

college students, Faith-based community members, Immigrants and farm workers, Juvenile probation, Older adults, Transitional-age youth, and Veterans. The purpose of the focus groups was to conduct in-depth discussions with different community leaders, gatekeepers and other community members. Participants were selected because they were knowledgeable about their constituency and had insight into community mental health needs and strategies for PEI.

The PEI Planning Committee members also provided input on the types of key data indicators that would supplement, add to, and validate the qualitative findings from the key individual interviews and focus groups. Quantitative data were compiled on 46 primary indicators representing and categorized by the priority populations. Examples relevant to the Parenting Project will be provided in the *Data Analysis and Review* section. A complete presentation of the key indicator data compiled can be found in the Key Indicator Data Report in Appendix I.

Once the key indicators and the findings from the key individual interviews and focus groups were compiled, the five PEI Planning Committee Area Work Groups were convened and provided with copies of the Area-based reports along with a presentation of key findings across all three data collection strategies. (Interview and focus group reports are located in Appendix II.) Work groups were asked to react to and comment on the findings presented, as well as asked to use the findings to identify needed PEI services. The needed PEI services identified by each of the five Area Work Groups were compiled and an additional meeting was held with all five Area Work Groups present to review and comment upon the PEI Projects summarized in this report.

One additional level of stakeholder input was sought from community members throughout the County. Three Community Forums were held in one of each of three regions: East County, West County, and Santa Clara Valley. These forums were designed to share the needs assessment findings, present the recommended PEI Projects that emerged from the process, and obtain additional comments and suggestions on the recommended PEI Projects and their corresponding interventions.

The Parenting PEI Project is one of five PEI Projects recommended as a result of input from stakeholders at multiple levels. The next section describes the community mental health needs, priority populations, and barriers reported by stakeholders that guided the Project selection and recommended interventions.

Data Analysis, Review, and Implications

Analysis of input across the three data collection strategies—key indicators, key individual interviews, and focus groups—reveals how Parenting arose as one of the needed PEI projects. Key indicator data and interview and focus group discussions regarding the mental health needs in the five geographic regions of Ventura pointed to a significant concern for stressed families, and the impact those stressors have on parenting and outcomes in children and youth. Accordingly, parent/family education, training, and services was one of the top six recommended prevention and early intervention strategies by stakeholders as shown on Table 2 in the Community Coalitions section.

Across interviews and focus groups, children and youth in stressed families, underserved cultural populations, and children at-risk of school failure were among the top three prioritized populations (see Table 3 in the Community Coalitions section). Similarly, disparities in access to services and at-risk children, youth, and young adult populations were the top two prioritized mental health needs in both interviews and focus groups (see Table 4 in the Primary Care Services section). While discussing the top priority populations and mental health needs, stakeholders emphasized that prevention and early intervention services for at-risk children and youth must include their parents and families in order to be effective. One stakeholder stated, "If the child needs help, so do the parents."

Along with underserved cultural populations, families with single parents and both parents in the workforce were also cited as overwhelmed, stressed, and in need of parenting interventions. According to the 2000 Census, 15% of families are headed by single mothers and 53% of families have both parents in the workforce across the County. Input from stakeholders indicates that these numbers may have increased in the past nine years. They reported that many parents need to work multiple jobs, leaving insufficient time for involvement in their children's lives; this was particularly pervasive among underserved cultural populations. Stakeholders discussed how immigration concerns, economic stressors, demanding work schedules, and the breakdown of family structures all contribute to the inability of many parents to supervise, communicate with, emotionally support, and effectively parent their children.

The lack of positive parenting skills described by stakeholders is made evident in indicator data on child abuse and foster care placements in Ventura County. In the 2007-08 fiscal year there were 8,139 child abuse referrals in the County, with 314 children removed from their homes. During that time, 605 children were placed in foster care as of December 2008. In both interviews and focus groups, stakeholders discussed the increased child neglect, child abuse, familial violence repeated over generations, and substance abuse in homes seen across the County, as well as the affect these parental behaviors had on children and youth.

When looking at the impact on children and youth in stressed families, stakeholders were overwhelmingly concerned about negative social, emotional, and behavioral outcomes. They reported children acting out as early as elementary school, lacking coping and communication skills, and exhibiting disruptive and violent behaviors. Parents were seen as unequipped to manage their children's communicative and behavioral issues.

Being in stressed families also put children and youth at-risk of school failure. When there are tensions at home and their basic needs are not being met, children's abilities to learn and get along with others are negatively affected. Stakeholders also cited increased school failure, suspensions and expulsions, and drop outs at earlier ages as a result of family stressors. Furthermore, stakeholders discussed increased alcohol and drug use, gang involvement, and criminal activity, all at earlier ages among children and youth. Key indicators support stakeholder input. Averaged across all school districts in the County, suspension and expulsion rates have steadily increased in the past 3 years, particularly suspensions and expulsions related to violence and/or alcohol and drug usage.

Accordingly, stakeholders prioritized prevention and early intervention services for youth and their parents and families. However, they were concerned that the stigma associated with mental health would hamper access to these services. In both interviews and focus groups, stakeholders reported that parents often refuse to follow through with referrals made for their children due to stigma. Some parents tend to deny and minimize their children's mental health issues, and/or prefer to deal with their children's issues within their familial and cultural support system instead of seeking assistance from others outside their culture, particularly in underserved populations. Therefore, stakeholders emphasized the need for an educational campaign targeted to parents in order to overcome stigma and encourage positive parenting and help seeking behaviors. They recommended that educational materials be provided in multiple languages to reach underserved populations in the County, especially Spanish-speaking and Mixteco communities.

In order to address the mental health needs of at-risk children and youth and the stigmas limiting access to mental health services, stakeholders identified a number of needed prevention and early intervention strategies. Parent education, training, and early intervention services emerged as one of the top strategies in interviews and focus groups. In addition, stakeholders emphasized that parenting education and supports should be provided in collaboration with other community organizations and services in non-stigmatizing locations such as schools, primary care settings, family resource centers, faith-based organizations and in home settings.

Overall, the Parenting PEI Project was considered well suited to address the impact of stressed families and reported lack of parenting skills placing children and youth at-risk. At the same time, this PEI Project is well positioned to raise parental awareness about mental health issues, reduce the stigma surrounding mental health, and increase access to mental health services for children and families. Specifically, this PEI Project has the ability to:

- Increase awareness of positive parenting strategies through a broad media campaign;
- Educate parents and families on various topics such as nutrition, life skills, coping skills, and parenting skills in non-stigmatizing locations such as churches, schools, local clinics, and resource centers at convenient days and times for working parents;
- Improve child behaviors and school performance;
- Improve child-parent communications and family cohesiveness;
- Train parents how to identify mental health issues, navigate the system, access services, and support children with mental health issues; and,
- Provide parenting training and other early intervention services for at-risk families in order to reduce child abuse and other negative outcomes.

Using the findings from stakeholder input the PEI Planning Committee Area Work Groups were able to identify the Parenting PEI Project as an appropriate and needed approach to addressing the mental health needs of children and their parents and families. Similarly, the mental health needs that emerged from the findings directly implied the need for parenting education and interventions available in homes, schools, primary care, and community-based settings, as well as a universal public education campaign. These findings led to the two

recommended evidence-based interventions: Strengthening Families Program (incorporated in the School Based Project) and Triple P Parenting (PPP).

3. PEI Project Description:

Parenting Project

The Parenting Project is specifically responsive to the priority, as identified by the community planning process, to support a broad multilevel prevention and parenting intervention targeting children in stressed families and at-risk of school failure. This project primarily involves implementation of the Triple P Parenting model, targeting communities showing elevated child risk factors, with a special focus on underserved populations.

The Triple P Parenting model is ideally suited to advance Ventura County's interest in providing parenting supports and preventing child behavior problems and school failure. This model has been subject to random clinical trials and found to be effective in improving parenting, child behavior and parent-child interactions, and decreasing child maltreatment and child behavior problems.

Triple P Parenting

Specifically, Triple P Parenting is a multi-level, parenting and family support strategy that aims to prevent severe behavioral, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents. This tiered multi-level strategy recognizes that parents have differing needs and desires regarding the type, intensity and mode of assistance they may require, as such it is designed to reduce stigma and overcome access barriers, particularly for underserved populations.

The Triple P system is designed to maximize efficiency, contain costs and ensure the program has wide reach in the community. The program targets five different developmental periods from infancy to adolescence. Within each developmental period the reach of the intervention can vary from being very broad (targeting an entire population) to quite narrow (targeting only high-risk children). The model consists of five levels as follows:

- **Level 1**—is a universal prevention parent information strategy, provides parents with access to information about parenting through a coordinated media and promotional campaign using print and electronic media. This level of intervention aims to increase community awareness of parenting resources, to encourage parents to participate in programs, and to create a sense of optimism by depicting solutions to common behavioral and developmental concerns. This component will be coordinated with all Community Coalitions and have a countywide reach. Materials will be developed in English and Spanish, including special design elements specific to Spanish speaking families, migrant farm workers, and Mixteco families.
- **Level 2**—is a brief, 1 or 2-session primary health care intervention providing anticipatory developmental guidance to parents of children with mild behavior difficulties, with the aid of user-friendly parenting tip sheets and videotapes that demonstrate specific parenting strategies.
- **Level 3**—is a 4-session primary care intervention, targeting children with mild to moderate behavior difficulties and includes active skills training for parents. Training

and materials will be provided for primary care clinics and schools sites that are involved in the other PEI projects for both levels 2 and 3. In addition, the Neighborhood for Learning resource centers will be invited to provide Level 2/3 services.

- **Level 4**—is an intensive 8 to 10-session individual, group or self-help parenting program for parents of children with more severe behavior difficulties.
- **Level 5**—is an enhanced behavioral family intervention program for families where parenting difficulties are complicated by other sources of family distress (e.g. relationship conflict, parental depression or high levels of stress). Levels 4 and 5 can be provided in-home, reducing access barriers for underserved populations.

Level 1 (universal prevention education campaign including—flyers, newsletters, newspaper articles, radio and televisions spots, and bus placards) will be supported in coordination with Community Coalitions (as previously described). Moreover, Level 2/3 (brief intervention) will be provided by primary care and school staff (as noted in the Primary Care and School Based projects). In addition, staff from the Neighborhood for Learning resource centers, and child care programs will be provided Level 2/3 training and materials so that these selective prevention activities can be readily available in multiple settings through the targeted communities.

Finally, a team of 4 full-time practitioners, from county and private organizational providers, will be trained in the use of Levels 4 and 5 (full early intervention parenting curriculum) that can be provided individually (in-home) or in a group format (in schools, churches, community organizations).

Level 2/3 and Level 4/5 activities will be primarily available in the communities supported by the primary care and/or school based services projects. It is anticipated that about 24,000 families will be influenced by a Triple P Level 1 public marketing message, and that 750 families will participate in a Level 2/3 selective prevention activity (in a primary care or school site), and that 240 families will participate in a Level 4/5 parenting early intervention (in home).

Key milestones are as follows:

- Establishing Triple P intervention teams and collaboration with primary care centers, schools, and resource centers around use of Level 2/3
- Completing Triple P training (Levels 2-5)
- Initiating Triple P Level 2-5 activities
- Developing and implementing Level 1 educational materials

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
Triple P Parenting	Families:24,000	Families: 240	12
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Families**: **24,000**	**Families**: **240**	

5. Linkages to County Mental Health and Providers of Other Needed Services
Through this project coordination with primary care health services, school sites, and Neighborhoods for Learning will all be enhanced. Moreover, formal referral channels to the VCBH Mental Health Plan will be established.

6. Collaboration and System Enhancements
The Parenting project (though the Triple P Parenting model) builds upon and enhances community efforts to provide parenting supports. Level 1 is a multifaceted public media campaign that will be assisted by the Community Coalitions project and community volunteerism.

Level 2/3 involves coordination and collaboration among a host of formal and informal systems including primary care centers, schools, resources centers, and others as interested, who together provide brief parenting guidance and facilitate referral to other needed services when indicated. PEI will fund the Level 2/3 training and materials, but the collaborating agencies will provide their staff (as in kind support) when they make use of the Level 2/3 activities for parents. Finally, VCBH will leverage Medi-Cal and EPSDT funding for the Triple P Level 4/5 services when appropriate, which will be important for sustaining these activities.

7. Intended Outcomes
Parenting (Triple P Parenting) activities are expected to reduce stigma, increase help seeking and access to early and proven parenting supports for stressed families and children at-risk for school failure. Specific intended outcomes include:

- Positive parenting media campaign
- Increased access to parenting supports for children with behavior problems
- Increased interagency collaboration between primary care clinics, schools, resource centers, and Triple P providers
- Improved child behavior
- Improved family communication and cohesiveness

- Improved school performance
- Reduced child maltreatment and school failure

8. Coordination with Other MHSA Components

Formal referral structures will be in place to ensure that individuals in need of more extensive treatment level services will have access to Full Service Partnership programs when appropriate.

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: **Ventura** Date: June 9, 2009

PEI Project Name: **4. Parenting**

Provider Name (if known): **Various (See Below)**

Intended Provider Category: **Mental Health Treatment/Service Provider**

Proposed Total Number of Individuals to be served:	FY 09-10	240
Total Number of Individuals currently being served:	FY 09-10	0
Total Number of Individuals to be served through PEI Expansion:	FY 09-10	240
Months of Operation:	FY 09-10	12

		Total Program/PEI Project Budget		
Proposed Expenses and Revenues		FY 09-10		Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
Psy Social Worker IV	2.00	$142,926	$0	$142,926
MHA - Unlicensed	2.00	$95,308	$0	$95,308
BH Clinic Administrator III	0.25	$23,400	$0	$23,400
Office Assistant IV	0.25	$10,895	$0	$10,895
b. Benefits and Taxes @ **44%**	**44%**	$121,275	$0	$121,275
c. Total Personnel Expenditures	4.50	$393,804	$0	$393,804
2. Operating Expenditures				
a. Facility Cost	**8%**	$31,504	$0	$31,504
b. Other Operating Expenses	**49%**	$192,964	$0	$192,964
c. Total Operating Expenses		$224,468	$0	$224,468
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
Initial training of staff on treatment models		$80,000	$0	$80,000
Ongoing training/support to ensure program fidelity		$11,000	$0	$11,000
a. Total Subcontracts		$91,000	$0	$91,000
4. Total Proposed PEI Project Budget		$709,272	$0	$709,272
B. Revenues (list/itemize by fund source)				
Medi-Cal		$269,013	$0	$269,013
1. Total Revenue **Medi-Cal**		$269,013	$0	$269,013
5. Total Funding Requested for PEI Project		$440,259	$0	$440,259
6. Total In-Kind Contributions		$0	$0	$0

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

County: Ventura **PEI Project Name: Early Signs of Psychosis Intervention** **Date: June 2009**

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

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

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

The recommended PEI Project, Early Psychosis Intervention, is the result of a community-based needs assessment effort spearheaded by the VCBH in collaboration with a 44 member PEI Planning Committee, representative of all PEI sectors and the County. The community-based needs assessment involved stakeholders at multiple levels who were identified to participate in the process based on their geographic representation, and representation within the following MHSA categories: age group, community sector, priority populations, and key PEI community mental health needs. The needs assessment was designed to collect both quantitative and qualitative data from various community sources as well from community stakeholders to inform the identification of PEI Projects. Quantitative data included existing data from multiple sources on key data indicators representative of the MHSA defined priority populations. Qualitative data included direct input from community stakeholders in the form of 1) key individual interviews; 2) focus groups (area-based and countywide groups with specific populations); 3) Area Work Group data review meetings; and, 4) community forums. Please refer to Form #2 for specific details about the needs assessment program planning process.

The focus of this section will be twofold. First to describe the role stakeholders played at multiple levels in the selection of the Early Signs of Psychosis Intervention PEI Project; and, second to show how the quantitative and qualitative data collection strategies, analysis, and review process directly informed the selection of the Early Signs of Psychosis Intervention PEI Project as well as the recommended interventions to be implemented as part of the Project.

<u>Stakeholder Input</u>
A countywide grass roots outreach effort was conducted to invite stakeholder participation in the PEI Planning process at multiple levels. The 44 member PEI Planning Committee guided the overall planning process and formed area-based Work Groups responsible for reviewing the quantitative and qualitative data collected through the needs assessment and use those findings to recommend the Early Signs of Psychosis Intervention PEI Project and select the evidence-based intervention models corresponding to community needs and populations.

To reach the point at which Work Groups were able to review and use data to make PEI project recommendations, other stakeholder input was gathered through a systematic data collection process. Key individual interviews were conducted across the County with 25 stakeholders who were not only identified to participate in the process based on specific demographic and MHSA categories, but also were knowledgeable about a specific community, issue, or problem related to mental health prevention and early intervention. These individuals were asked to provide input on community and mental health needs, age group priorities and priority populations, existing and needed PEI services, and recommendations for providing effective PEI services.

Focus groups were conducted at two levels: 1) By geographic area of the County (at least two in each area); and, 2) Countywide representing 13 distinct populations: African Americans, Ambulatory Care professionals, Consumers, Deaf and hard of hearing,

developmental disabilities, Pre-K and elementary school students, High school and college students, Faith-based community members, Immigrants and farm workers, Juvenile probation, Older adults, Transitional-age youth, and Veterans. The purpose of the focus groups was to conduct in-depth discussions with different community leaders, gatekeepers and other community members. Participants were selected because they were knowledgeable about their constituency and had insight into community mental health needs and strategies for PEI.

The PEI Planning Committee members also provided input on the types of key data indicators that would supplement, add to, and validate the qualitative findings from the key individual interviews and focus groups. Quantitative data were compiled on 46 primary indicators representing and categorized by the priority populations. Examples relevant to Early Signs of Psychosis Intervention will be provided in the *Data Analysis and Review* section. A complete presentation of the key indicator data compiled can be found in the Key Indicator Data Report in Appendix I.

Once the key indicators and the findings from the key individual interviews and focus groups were compiled, the five PEI Planning Committee Area Work Groups were convened and provided with copies of the Area-based reports along with a presentation of key findings across all three data collection strategies. (Interview and focus group reports are located in Appendix II.) Work groups were asked to react to and comment on the findings presented, as well as asked to use the findings to identify needed PEI services. The needed PEI services identified by each of the five Area Work Groups were compiled and an additional meeting was held with all five Area Work Groups present to review and comment upon the PEI Projects summarized in this report.

One additional level of stakeholder input was sought from community members throughout the County. Three Community Forums were held in one of each of three regions: East County, West County, and Santa Clara Valley. These forums were designed to share the needs assessment findings, present the recommended PEI Projects that emerged from the process, and obtain additional comments and suggestions on the recommended PEI Projects and their corresponding interventions.

The Early Psychosis Intervention PEI Project is one of five PEI Projects recommended as a result of input from stakeholders at multiple levels. The next section describes the community mental health needs, priority populations, and barriers reported by stakeholders that guided the Project selection and recommended interventions.

Data Analysis and Review

Based upon findings across the three data collection strategies—key indicators, key individual interviews, and focus groups—Early Psychosis Intervention arose as one of the needed PEI projects. Interviewees noted that the rate of unidentified and/or unaddressed mental health issues is increasing, resulting in exacerbated symptoms, with individuals reaching a state of crisis before receiving any form of intervention. Concomitantly, interviewees and focus group participants noted that mental health issues are left undetected and unaddressed because community members lack the ability to recognize

the signs and symptoms of mental illness. As a result, there is a high need across Ventura County to address disparities in access to mental health services.

Stakeholders in interviews and focus groups reported that more and more transition-age youth are experiencing psychotic breaks, with some seeking services for co-occurring disorders because the first disorder went undetected and untreated. According to stakeholders, the onset of serious psychiatric illness among at-risk transition-age youth may be left undetected for two key reasons: 1) once youth become 18 they are legally independent and not required to seek help; or, 2) they do not know what services are available to them or how to access them. Furthermore, stakeholders reported that parents, as well as community members who come in contact with transition-age youth on a regular basis, lack the ability to identify the signs and symptoms of mental health issues. Those key points of contact are critical to the early identification of serious mental illness and include family members, teachers, primary care physicians, faith-based professionals, landlords, social service agency representatives, and police officers—all identified by interviewees and focus group participants.

Consequently, stakeholders across interviews and focus groups emphasized a high need to incorporate outreach strategies to reach families, service providers, and community members about the prodromal symptoms of mental illness as a means of reducing disparities to access among transition-age youth. Recommended strategies included media campaigns in various forms, as well as formal education for parents and service providers—those key points of contact mentioned above. Successfully implemented community outreach efforts along these lines are needed in order to promote early detection and intervention, and thereby reduce or prevent the incidents of psychotic breaks and chronic, long-term mental illness.

Overall, the Early Psychosis Intervention Project was considered best suited to address the lack of early detection and intervention services for transition-age youth at-risk of serious mental illness. At the same time, this Project is well positioned to reduce the disparities in access to mental health by raising awareness about early onset of serious mental illness and educating individuals who interact frequently with transition-age youth. Specifically, this PEI Project has the ability to:

- Increase awareness and early identification of the onset of serious mental illness, particularly among transition-age youth;
- Address signs and symptoms of mental illness before they escalate, become long-term, persistent, and more difficult to manage;
- Educate parents on how to identify someone who is showing signs of poor mental health; and,
- Educate and train those who serve as key points of contact for young adults—teachers, physicians, landlords, police officers, social service agency representatives, and faith-based professionals—to be able to identify the prodromal signs of the early onset of mental illness.

Using the findings from stakeholder input, the PEI Planning Committee Area Work Groups were able to identify the Early Psychosis Intervention Project as an appropriate and needed approach to raising awareness of the early signs and symptoms of mental health

issues and promoting screening, early identification, and early intervention among transition-age youth. This includes educating teachers, doctors, clergy, social service agency representatives, landlords, and police officers, as well as other key providers, in addition to parents as a means of increasing community capacity to catch mental health issues early on and prevent them from becoming exacerbated and full-blown serious mental illnesses. These findings led to the recommendation to implement the promising practice Early Detection and Intervention for the Prevention of Psychosis (EDIPP), as the primary service for this PEI Project. The applicability and benefits of the EDIPP for Ventura County will be discussed in detail in the following sections.

3. PEI Project Description:

Early Psychosis Intervention Project

The Early Psychosis Intervention Project is specifically responsive to the priority, as identified by the community planning process, to support a broad multilevel selective prevention and early intervention response targeting Transition Age Youth (TAY) showing the early signs of psychosis. This project primarily involves implementation of the Early Detection and Intervention for Prevention of Psychosis (EDIPP) model, targeting the entire county.

The early psychosis prevention and early intervention (EDIPP) team will be responsible (in coordination with all of the Community Coalitions) for an education/training campaign directed at high school and college teachers, primary care staff, and law enforcement. Moreover, this team will be mobile, providing screening/assessment and when indicated early intervention services that are home and community based. Formal linkages to the county's FSP and related supports (e.g. TAY Tunnel Wellness and Recovery Center) will be established.

The EDIPP model is specifically designed to advance Ventura County's interest in supporting the early identification and intervention of early psychosis. This is a promising model that is currently the subject of effectiveness research. The early findings are very promising in regards to forestalling or limiting the impact of psychotic disorders.

Specifically, the model focuses on the pre-illness (prodromal) phase of a developing psychotic process, which is a time when psychotic disorders are highly treatable and interventions may set the foundations for an unusually good outcome and long-term prognosis. This model includes early identification of those individuals with prodromal and active symptoms, as well as early intervention that is designed to continue, perhaps in a less intense form, for as long as the person remains vulnerable.

Adolescents and young adults between the ages of 15 and 25 will be the target population for this project. Youth/young adults showing possible signs of early psychosis will be referred (typically by trained school, primary care, or law enforcement staff) for assessment (using the Structured Interview for Prodromal Syndromes).

The early psychosis team will consist of a full-time social worker, full-time nurse, half-time occupational therapist, half-time education/employment specialist, and consulting psychiatrist. The team will be mobile, working countywide, providing early intervention when

early psychosis is confirmed. The team will have the capacity to support 20 youth/young adults per year. Key components of the program will include community outreach, assessment and intervention, as follows:

Community Outreach—The goal of community outreach is to reach those school and healthcare professionals and community members, such as families and youth workers, who interact frequently with young people. Those community members are in a key position to detect early changes in an adolescent's or young adult's functioning and behaviors, and once given appropriate information about early signs of psychosis, they can intervene on that young person's behalf.

The early intervention team will (1) Educate and train the provider community, particularly school-based professionals, primary care physicians and law enforcement, about the early warning signs of severe mental illness; (2) Teach community members (families, clergy, youth workers, students) how to identify young people who are manifesting prodromal or active symptoms of major psychotic disorders; and (3) Establish a community wide system of early detection and intervention of youth and young adults at-risk for prodromal psychosis. The outreach and education work will be coordinated with all Community Coalitions, and offered to all county high schools, Ventura County Community College, Cal State Channel Islands, and primary care clinics.

Assessment—The intervention team will respond to referrals from throughout the county. Standardized measures specific and sensitive to early psychosis will be used. Early intervention services, provided by the team, will be offered if early psychosis is confirmed. Other referrals will be offered, including linkages to VCBH Mental Health Plan and FSP programs, when mental health needs, other than early psychosis, are identified during the assessment.

Early Intervention—Early intervention will involve a combination of pharmacologic and psychosocial interventions to promote functioning including: (1) Family psychoeducation; (2) Family-aided assertive community treatment; (3) Supported education/employment; and (4) Low-dose medication, as indicated.

In sum, this project will promote awareness and education concerning the onset of serious mental illness, with the goal of early identification leading to more effective and accessible intervention. The core intervention will be an educational campaign that will leverage the efforts and resources of schools, notably high schools and community colleges as forums for education and outreach concerning the onset of serious mental illness. Staff in academic and other community institutions will be trained to identify signs of possible prodromal signs of psychosis. When individuals are identified, they will be referred to a mobile screening and assessment team, made up of clinicians from county and/or organizational providers. Upon confirmation of early psychosis, individuals will be offered corresponding intervention services.

Individuals, who demonstrate a need for services beyond the scope of PEI activities, will be linked to VCBH FSP programs.

Key milestones are as follows:

- Establish the early psychosis intervention (EDIPP) team and collaboration with primary care centers, schools, colleges and law enforcement
- Conduct and coordinate education and outreach activities with the Community Coalitions
- Complete EDIPP training
- Initiate EDIPP screening/assessment and early intervention activities
- Developing formal linkages with FSP and related programs

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2010 by type		Number of months in operation through June 2010
	Prevention	Early Intervention	
EDIPP	Individuals:1,000	Individuals: 20	12
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** 1,000	**Individuals: 20**	

5. Linkages to County Mental Health and Providers of Other Needed Services
Community members receiving PEI services under the Early Psychosis Intervention project will have access to the full array of services available through VCBH. Moreover, formal referral channels FSP programs will be established.

6. Collaboration and System Enhancements
The Early Psychosis Intervention project (though the EDIPP model) builds upon and enhances community efforts to respond to the needs of youth/young adults at-risk of serious mental illness. This initiative includes an innovative education and training component for schools, colleges, primary care centers and law enforcement. PEI will fund the training; however, early identification and referral is sustained through the in-kind efforts of the collaborating agencies.

Again, formal linkages with the counties Mental Health Plan and FSP programs will be established for those individuals who show a need for assistance beyond the PEI episode. Finally, VCBH will leverage Medi-Cal and EPSDT funding for the EDIPP intervention services when appropriate, which will be important for sustaining these activities.

7. Intended Outcomes

Early Psychosis Intervention activities are expected to reduce stigma, increase early identification and access to proven interventions for early psychosis experienced by transition age youth. Specific intended outcomes include:

- Education and training of key stakeholders
- Establishing formal referral channels
- Increased identification of early psychosis
- Improved educational/vocational performance
- Improved quality of life
- Reduced need for inpatient treatment

8. Coordination with Other MHSA Components

Formal referral structures will be in place to ensure that individuals in need of more extensive treatment level services will have access to Full Service Partnership programs when appropriate.

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

County Name: **Ventura** Date: June 9, 2009

PEI Project Name: **5. Early Signs of Psychosis Intervention**

Provider Name (if known): **Various (See Below)**

Intended Provider Category: **Mental Health Treatment/Service Provider**

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

		Total Program/PEI Project Budget		
Proposed Expenses and Revenues		FY 09-10		Total
A. Expenditure				
1. Personnel (list classifications and FTEs)				
a. Salaries, Wages				
b. Benefits and Taxes @ %	44%	$0	$0	$0
c. Total Personnel Expenditures	0.00	$0	$0	$0
2. Operating Expenditures				
a. Facility Cost		$0	$0	$0
b. Other Operating Expenses		$0	$0	$0
c. Total Operating Expenses		$0	$0	$0
3. Subcontracts/Professional Services (list/itemize all subcontracts)				
TBD		$220,000	$0	$220,000
Initial training of staff on treatment models		$80,000	$0	$80,000
Ongoing training/support to ensure program fidelity		$22,000	$0	$22,000
			$0	$0
a. Total Subcontracts		$322,000	$0	$322,000
4. Total Proposed PEI Project Budget		$322,000	$0	$322,000
B. Revenues (list/itemize by fund source)				
Medi-Cal		$103,455	$0	$103,455
1. Total Revenue	**Medi-Cal**	$103,455	$0	$103,455
5. Total Funding Requested for PEI Project		$218,545	$0	$218,545
6. Total In-Kind Contributions		$0	$0	$0

FORM No. 7 – Local Evaluation of a PEI Project

County: Ventura Date: June 15, 2009

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

PEI Project Name:

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

VCBH proposes to evaluate its PEI Parenting Project (Triple P Parenting program).

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

The Parenting Project was selected due to its breadth and anticipated impact. It is a multilevel initiative involving a broad universal prevention public media campaign, a selective prevention component that will be available at numerous schools, primary care clinics and resource centers, and an early intervention parenting course.

In a recent random clinical trial of the Triple P Parenting model, conducted in South Carolina with support from the Centers for Disease Control, community level outcomes including reduced child maltreatment and injury rates, and as well as reduced need for group home care was demonstrated. There is strong interest in evaluating the program/system and individual/family impact of this project in reducing risk factors experienced by stressed families.

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

Expected person/family-level outcome include:

- Improved child behavior
- Improved school performance
- Reduced incidences of disruptive behavior in school
- Reduced child maltreatment and school failure
- Reduced family stress

Expected program/system-level outcomes include:

- Positive parenting media campaign
- Increased interagency collaboration between primary care clinics, schools, resource centers, and Triple P providers

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

PERSONS TO RECEIVE INTERVENTION

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/ DISCRIMINATION
ETHNICITY/ CULTURE							
African American			15%	15%			
Asian Pacific Islander			5%	5%			
Latino			60%	60%			
Native American							
Caucasian			20%	20%			
Other (Indicate if possible)							
AGE GROUPS							
Children & Youth (0-17)			24,000[1] 750 240	24,000 750 240			
Transition Age Youth (16-25)							
Adult (18-59)							
Older Adult (>60)							
TOTAL							
Total PEI project estimated ***unduplicated*** count of individuals to be served 24,000							

[1] The Parenting Project is expected to encompass in excess of 24,000 families with its public media campaign, 750 families with its selective prevention (brief) parenting guidance, and 240 families with its early intervention parenting course.

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

Person/family-level outcomes will be measured using a combination of approaches as follows:

- Improved child behavior will be measured using a standardized measure of child behavior (Eyberg Child Behavior Inventory) completed prior to and immediately following a course of Level 4 or 5 intervention
- Family stress levels will be measured using a standardized measure (Parenting Stress Index or other measure) completed prior to and immediately following a course of Level 4 or 5 intervention
- Improved school performance will be measured comparing STAR scores between schools district who have received Triple P Levels 2/3 and 4/5 services and those that do not, collected annually
- Similarly, incidences of suspensions and expulsions will be tracked, and comparison with participating and non-participating schools compared, collected annually
- Child maltreatment rates will be measured using county child welfare data for allegations and substantiated incidences (as reported in the CWS/CMS data system) comparing participating and non-participating communities, collected annually

Program/system-level outcomes include:

- Number public media activities (television and radio spots, newsletters, newspaper articles, community fairs, and so forth) per year
- Interagency collaboration will be measured using number of Level 2/3 contacts and Level 4/5 referrals, collected annually

5. How will data be collected and analyzed?

VCBH intends to subcontract for evaluation supports including data collection, analysis and reporting as follows:

- Person/family-level outcome data that involve pre- and post-measures will be collected by the practitioners as the intervention is starting and ending. The completed measures will be sent to the designated VCBH evaluator.

- Person/family-level school data will be gathered, by the VCBH evaluator, annually from participating and select non-participating school districts from existing databases used for tracking STAR test scores and suspensions/expulsions.

- Person/family-level child maltreatment data will be gathered, by the VCBH evaluator, annually from the statewide CWS/CMS database.

- Program/system data involving public media events will be tracked by the Community Coalitions and Triple P Level 1 providers on a monthly log submitted to the VCBH evaluator.

- Program/system data involving Level 2/3 contacts and Level 4/5 referrals will be tracked by the participating schools, primary care clinics and resource centers using a monthly log submitted to the VCBH evaluator.

Three types of analysis will be conducted as follows:

- Descriptive/qualitative analyses of program/system data including public media activities and Level 2/3 contacts and Level 4/5 referrals.

- Quantitative analyses of pre- post- measures (child behavior and family stress) associated with Level 4/5 interventions.

- Quantitative analyses comparing school performance and maltreatment rates between schools and communities receiving Triple P interventions and those that do not.

Quantitative analyses will include tests of statistical significance.

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

Triple P Parenting, by virtue of its multilevel and flexible components, is expected to be successful with diverse ethnic and culturally groups. To test this, the qualitative analyses will examine the degree to which the public media campaign is tailored to each ethnic/cultural group. Moreover, for the Level 2/3 activities, Level 4/5 referrals, and Level 4/5 interventions, participation rates, and level of improvement (as measured by the individual/family outcomes) will be examined for differences across gender and ethnicities. Any differences will be explored and adjustments to the program tried to improve cultural sensitivity of the project. Outcomes of particular relevance to one or more cultural groups will be incorporated as appropriate.

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

All Level 2/3 and 4/5 practitioners will complete the full Triple P Parenting training protocol as required by the national training center. Adherence to the model is promoted through a certification process and will be monitored using “dashboard” program performance reports, completed twice annually, that summarize indicators of program activity and outcomes. Any departure from expected levels of achievement will be investigated and additional training or supervision provided to improve adherence to the program.

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

Annual evaluation reports, and bi-annual “dashboard” reports, will be broadly disseminated to all participating schools, primary care centers, and resource centers. In addition, they will be shared with the Community Coalitions, and posted on the VCBH website for review by the community at large.

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

Administration Budget Worksheet

Form No. 5

County: **Ventura** Date: June 9, 2009

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2009-10		Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator **(BH Manager I)**		**1.00**	**$83,101**		**$83,101**
b. PEI Support Staff **(Management Assistant II)**		**1.00**	**$44,160**		**$44,160**
c. Other Personnel (list all classifications)					**$0**
					$0
					$0
					$0
					$0
d. Employee Benefits **44%**			**$56,631**		**$56,631**
e. Total Personnel Expenditures			**$183,892**	**$0**	**$183,892**
2. Operating Expenditures					
a. Facility Costs **8%**			**$14,711**		**$14,711**
b. Other Operating Expenditures **49%**			**$90,107**		**$90,107**
c. Total Operating Expenditures			**$104,818**	**$0**	**$104,818**
3.County Allocated Administration					
a. Total County Administration Cost **A-87**			**$564,119**	**$0**	**$564,119**
4. Total PEI Funding Request for County Administration Budget			**$852,829**	**$0**	**$852,829**
B. Revenue					
1 Total Revenue **FFP**			**$191,886**	**$0**	**$191,886**
C. Total Funding Requirements			**$660,943**	**$0**	**$660,943**
D. Total In-Kind Contributions			**$0**	**$0**	**$0**

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

Exhibit E-4 PEI Funding Request

FY 2009/10 Mental Health Services Act
PEI Component Plan Funding Request

County: **VENTURA** Date: **6/9/2009**

PEI Work Plans			FY 09/10 Required MHSA Funding	Estimated MHSA Funds by Type of Intervention			Estimated MHSA Funds by Age Group			
	No.	Name		Universal Prevention	Selected/ Indicated Prevention	Early Intervention	Children, Youth, and Their Families	Transition Age Youth	Adult	Older Adult
1.	**1**	Community Coalitions	$622,000	$373,179	$248,821		$285,500	$100,500	$153,000	$83,000
2.	**2**	Primary Care	$1,747,429		$247,565	$1,499,864	$290,988		$970,961	$485,480
3.	**3**	School Based	$1,084,081		$162,612	$921,469	$1,084,081			
4.	**4**	Parenting	$440,259	$66,039	$44,026	$330,194	$440,259			
5.	**5**	Early Psychosis	$218,545			$218,545		$218,545		
6.										
7.										
8.										
9.										
10.										
11.										
26.	**Subtotal: Work Plans**[a/]		**$4,112,314**	$439,218	$703,024	$2,970,072	$2,100,828	$319,045	$1,123,961	$568,480
27.	**Plus County Administration**		**$660,943**							
28.	**Plus Optional 10% Operating Reserve**		**$477,326**							
31.	**Total MHSA Funds Required for PEI**		**$5,250,583**							

a/ Majority of funds must be directed towards individuals under age 25--children, youth and their families and transition age youth.
Percent of Funds directed towards those under 25 years= 59%

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

FY 2009/10 Mental Health Services Act
EXHIBIT E - Summary Funding Request

County: **VENTURA** Date: **June 11, 2009**

	MHSA Component				
	CSS	**CFTN**	**WET**	**PEI**	**Inn**
A. FY 2009/10 Planning Estimates					
1. Published Planning Estimate[a/]				$6,889,700	
2. Transfers[b/]					
3. Adjusted Planning Estimates	$0	$0	$0	$6,889,700	$0
B. FY 2009/10 Funding Request					
1. Required Funding in FY 2009/10[c/]				$5,250,583	
2. Net Available Unspent Funds					
a. Unspent FY 2007/08 Funds[d/]				$474,249	
b. Adjustment for FY 2008/09[e/]					
c. Total Net Available Unspent Funds	$0	$0	$0	$474,249	$0
3. Total FY 2009/10 Funding Request	**$0**	**$0**	**$0**	**$4,776,334**	**$0**
C. Funding					
1. Unapproved FY 06/07 Planning Estimates					
2. Unapproved FY 07/08 Planning Estimates				**$1,409,700**	
3. Unapproved FY 08/09 Planning Estimates				$3,366,634	
4. Unapproved FY 09/10 Planning Estimates					
5. Total Funding[f/]	**$0**	**$0**	**$0**	**$4,776,334**	**$0**

a/ Published in DMH Information Notices
b/ CSS funds may be transferred to CFTN, WET and Prudent Reserve up to the limits specified in WIC 5892b.
c/ From Total Required Funding line of Exhibit E for each component
d/ From FY 2007/08 MHSA Revenue and Expenditure Report
e/ Adjustments for FY 2008/09 additional expenditures and/or lower revenues than budgeted
f/ Must equal line B.3., Total FY 2009/10 Funding Request, for each component

Ventura County Behavioral Health Department
PREVENTION AND EARLY INTERVENTION COMPONENT PLAN

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

Date: June 15, 2009	County Name: Ventura
Amount Requested for FY 2008/09: $125,300	**Amount Requested for FY 2009/10: 125,300**

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

Ventura County Behavioral Health Department will work with a contractor that we have yet to identify that has the demonstrated ability and experience to develop projects that provide statewide training, technical assistance, and capacity building programs in partnership with local and community partners. The contractor will identify and link us with other counties that have similar training and capacity building needs and will partner with local and community partners via sub-contracts or other arrangements in order to help assure the appropriate provision of prevention and early intervention activities in our local communities. The contractor will use training methods that have demonstrated capacity to increase skills and promote positive outcomes consistent with the MHSA and PEI proposed guidelines.

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)