

Acronyms and definitions within this application.

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

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

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

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

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

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

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

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

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

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

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

TBD = To be determined.

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

PEI, COMMUNITY PROGRAM PLANNING PROCESS Form No. 2

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

County: Plumas

Date: 1/22/2008

1. The county shall ensure that the Community Program Planning Process is adequately staffed. **Describe which positions and/or units assumed the following responsibilities:**
 - a. **The overall Community Program Planning Process.** The Director of Plumas County Mental Health (PCMH) undertook the planning process with the assignment of a PCMH manager.
 - b. **Coordination and management of the Community Planning Process.** The assigned lead manager (a multi-tasking manager with duties of MHSA Coordination) managed the MHSA PEI planning process with guidance from the Director of Plumas County Mental Health.
 - c. **Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process.** The MHSA Coordinator is responsible for facilitating the stakeholder process.

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

- a. Included representatives of unserved and/or underserved populations and family members of unserved/underserved populations.
- b. Provided opportunities to participate for individuals reflecting the diversity of the demographics of the County, including but not limited to, geographic location, age, gender and race/ethnicity
- c. Included outreach to clients with serious mental illness and/or serious emotional disturbance and their family members, to ensure the opportunity to participate

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

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

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

- i. revisiting the original CSS stakeholder input process from 2005;
- ii. researched the several community prevention plans and strategy plan (for other agencies/programs/coalitions, etc.) that utilized community input; and analyzed the results for strengths, assets, gaps, and un(der)served priorities and needs. Examples of plans, reviewed included: Plumas County System Improvement Plan; Plumas County Child Abuse Prevention Council; Family Violence Prevention Coalition and Juvenile Justice Commission.
- iii. a multiagency discussion regarding meeting the service need(s) identified; and
- iv. evaluation input, from families participating in the pilot run of the family therapy model proposed for PEI service program at PCMH.

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

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

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

Continued on next page.

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3. continued. How stakeholders were included.

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

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

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

No training has been utilized other than the MSHA Coordinator participating in the state supported conference calls from their training and technical assistance contractor. The community has been assessed numerous times since 2004. Since no statistically significant demographic shift has occurred in the community, much of what has been planned for the community remains valid. Since the economy remains limited much of the service priorities and needs remain the same. Thus, no new training was identified as needed or acquired for the processing of this PEI application.

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

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

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

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

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

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

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

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

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

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#4. Continued.

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

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

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

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

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

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

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

There were no substantive recommendations for revisions.

PEI WORKPLAN SUMMARY Form No. 3

Plumas County Mental Health proposes only one PEI project; thus, there is only one completed "form 3" within this application.

County: **Plumas**

Workplan Name: **12-15 session Family Therapy**

Date: 12/28/2007

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 workplan:				
1. Disparities in Access to Mental Health Services				
2. Psycho-Social Impact of Trauma				
3. At-Risk Children, Youth and Young Adult Populations	X	X	N/A	N/A
4. Stigma and Discrimination				
5. Suicide Risk				

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

PEI WORKPLAN SUMMARY Form No. 3

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

Input and Guidance:

PCMH's PEI planning process consisted of eliciting input and guidance with regard to needs, priorities, on going or planned efforts and resources through several meetings from October through December 2007. The following summarizes the process and data relevant to PEI.

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

A recently issued matrix of "strategic prevention plans in Plumas County", collated by the Alcohol & Drug Prevention Community Coalition, records seven (7) prevention coalitions or mission oriented agencies and their efforts across twelve (12) prevention domains. This matrix demonstrates the work being done with parenting skills, child abuse prevention (both curriculum and individual case support), child care enhancement of inclusion and adequacy of community supply, domestic violence prevention, etc.

PEI WORKPLAN SUMMARY Form No. 3

B. continued. Summarize the stakeholder input

Selection of target population:

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

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

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

consistent with feedback from the larger community but resonates with the MHP treatment staff who have repeatedly noted that children and adolescents they serve require more intense and focused family treatment services to function safely and effectively in the community and school. In addition the MHP attained confirmation of consumer support of this type of initiative when it implemented a family treatment group process in 2000. The vast majority of consumers involved in the project strongly advocated it's continuance but the MHP was forced to cut the program due to budget constraints.

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B. Summarize the data analysis.

Data analysis:

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

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

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

3. Pei Work Plan Description:

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

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

- a. Conduct the PEI outreach, data capture and analysis, public review and input and submission of the plan to the state department of Mental Health.
- b. Ensure service positions are staffed (with clinical staff that has high availability, one part-time clinician (70%) per every #19 active cases), trained in interpersonal skill interventions (strength-based & solution focused, validation, positive interpretation, reattribution, reframing, and sequencing) and have administrative support (office, computer, furniture, program management, etc).
- c. Set-up the clinical setting(s) for services.
- d. Clinical support team, consists of a small group of clinicians, staff and peers (members of other families when appropriate), to view video and direct observations.
- e. Target outreach to receive referrals for youth ages between 10 and 18 year-olds, all ethnic and cultural groups, from at-risk adolescents and their families. These referrals will be from underserved families with diverse family organization, presenting problems, cultures.
- f. Develop the systematic training, supervision, process, and outcome assessment components.

3. Work Plan Description: continued.

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

Engaging families:

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

Therapeutic Family Sessions (12)

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

3. Work Plan Description: continued.

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

Brokerage and linkages:

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

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

Evaluation:

System outcomes:

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

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

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

PEI WORKPLAN SUMMARY Form No. 3

4. Strategies

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

Notes:

- a. estimating that “families” will consist of 3 individuals (either 2 adults and 1 child or 1 adult and 2 children) on average.
- b. estimated 19 families per 12-15 week sessions with four –series of sessions per year.

PEI WORKPLAN SUMMARY Form No. 3

5. Alternate Strategies

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

PCMH's proposed 12-15 session family therapy program is an adaptation of several strategies identified in the PEI Resource Materials.

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

PCMH has successfully implemented solution-focused therapy for several years with other target populations. Thus, PCMH proposes to utilize universal components of service, from the researched models, and design an adapted program to implement a family therapy model that is suited for this rural, small county. This program will be complementary, not competitive, to any existing services the child and family are participants in. PCMH shall annually evaluate this 12-15 session family treatment model for level of adherence to the framework of the family psychoeducation fidelity scale.

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

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

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

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

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

Outcome of (who/what)	Description of outcome	Method of measure	Periods of evaluation
System outcome	Demographics of participants: <ul style="list-style-type: none"> • Who: • What problem/needs are addressed • Besides family therapy, what service(s) is the family referred to, and how many individuals referred. • Fidelity to family psychoeducation fidelity scale 	Client/family information : <ul style="list-style-type: none"> • age, gender, race/ethnicity and culture • type of problems/needs FPE fidelity Scale, akin to New York State	Intake & ongoing. Semi-annually
System outcome	Assess for barriers and successes	<ul style="list-style-type: none"> • referrals are occurring • therapy timeframe is adequate • family successes • implementation challenges • assessment of the level of extent, quality and nature of collaboration with partner organizations (referring sources) 	Semi-annually
Family outcome	Participating families show fewer negative consequences from emotional and behavioral disturbances	Self-report	Pre and post
Family outcome	Reduce negative communication & develop family focus	Family perspective to clinician	Pre and post
Individual (child) outcome	Reduce the behavior of impulsiveness, related to risk factors. ¹	Short, non-intrusive measures of client perspective and clinical assessments.	Pre and post
Individual(child) outcome	Enhance school attendance behaviors related to protective factors. ²	Short, non-intrusive measures of client perspective and clinical assessments.	Pre and post

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

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

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

Additionally, it is anticipated that PEI will be incorporated into the Plumas County technology component when developed.

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

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

Plumas County has only one proposed PEI program.

County Name: Plumas

Date: 1/22/2008

PEI Project Name: 12-15 session family therapy

Provider Name (if known): Plumas County Mental Health

Intended Provider Category: county agency

Proposed Total number of Individuals to be served: FY 07-08 -0- FY 08-09 48

Total Number of Individuals currently being served: FY 07-08 -0- FY 08-09 -0-

Total No. of Indivs. to be served through PEI Expansion: FY 07-08 -0- FY 08-09 48

Months of Operation: FY 07-08 -0- FY 08-09 12

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages			
Therapist II (0.8)		\$52,000	\$52,000
Manager/MHSA Coordinator (0.3)	\$27,000		\$27,000
Fiscal Officer (0.5)	\$4,200		\$4,200
Director (0.25 & 0.5)	\$26,250	\$5,250	\$31,500
b. benefits and taxes	\$38,725	\$28,625	\$67,350
c. Total Personnel Expenditures	\$96,175	\$85,875	\$182,050
2. Operating Expenditures			
a. county overhead	\$2,000	\$11,628	\$13,628
b. other operating expenses	\$1,825	\$2,497	\$4,322
c. Total Operating expenses	\$3,825	\$14,125	\$17,950
3. Subcontracts/Professional Services			
a. Total Subcontracts	\$0	\$0	\$0
4. Total Proposed PEI Project Budget	\$100,000	\$100,000	\$200,000
B. Revenues (list/itemize by fund source)			
Total Revenue			
Total Funding Requested for PEI Project	\$100,000	\$100,000	\$200,000
Total In-Kind contributions			

PEI Revenue and expenditure Worksheet Form No. 4 Narrative

Personnel (county employees):

FY 07/08 funds: Initiating program and hire/assignment of clinician to program. Utilizing 25% of Director @ \$105K; 5% of Fiscal Officer @ \$84K; and 30% of a Manager @ \$90K. FY 08/09 funds: First year start-up of program. Utilizing a Therapist I, 80% @ \$65K; 5% of Director @ \$105K. Benefits in both fiscal years calculated at 50% of wage.

Operating expenses: County A-87 (facility costs): in FY 07/08 3% while in planning; once occupy additional floor space in FY 08/09 then 15%. Office computer software for tracking and quality assurance and consumable supplies.

PEI Administration Budget Worksheet

Form No. 5

County: Plumas County

Date: 1/22/2008

This **form No 5 is not completed for PCMH**, because the **administrative costs are in Form No. 4** as this program is NOT being contracted out and shall be implemented by PCMH with overhead and administrative expenses within the program budget.

	Client & Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 07-08	Budgeted Expenditure FY 08-09	Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator					
b. PEI support staff					
c. Other Personnel					
d. Employee benefits					
e. Total Personnel Expenditures					
2. Operating Expenditures					
a. Facility costs					
b. other operating expenditures					
c. Total Operating expenditures					
3. County Allocated Administration					
a. Total County Administration costs					
4. Total PEI Funding Request for County Administration Budget					
B. Revenue					
1. Total Revenue					
C. Total Funding Requirements					
D. Total In-Kind Contributions					

PREVENTION AND EARLY INTERVENTION BUDGET SUMMARY

Form No. 6								
Instruction: Please provide a listing of all Workplans submitted for which PEI funding is being requested. This form provides a Workplan number and name that will be used consistently on all related workplan documents. It identifies the funding being requested for each workplan from the form No. 4 for each workplan by the age group to be served, and the total PEI funding request. Also insert the Administration funding being requested from Form No.5.								
County: Plumas County								
Date: January 22, 2008								
Fiscal Year				Funds Requested by Age Group				
#	List each Workplan	FY 07/08	FY 08/09	Total	Children, Youth, and their Families	Transition Age Youth	Adult	Older Adult
	12-15 session Family Therapy	\$100,000	\$100,000	\$200,000	\$200,000	\$0	\$0	\$0
	\$0							
	\$0							
	\$0							
	\$0							
	\$0							
	\$0							
	\$0							
Administration is within the program budget, see form No. 4.								
Total PEI Funds Requested:	\$100,000	\$100,000	\$200,000	\$200,000	\$0	\$0	\$0	

Form No. 7 LOCAL EVALUATION OF A WORKPLAN

County: Plumas

Date: 12/28/2007

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

Workplan Name: 12-15 session Family Therapy

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

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

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

3. Table of demographics.

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

5. How will data be collected and analyzed?

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

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

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