

**Nevada County**

**Mental Health Services Act**

**PREVENTION AND EARLY INTERVENTION COMPONENT**

**Of The**

**COUNTY'S THREE-YEAR PROGRAM AND EXPENDITURE  
PLAN**

**March 2009**

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**PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE  
PLAN FACE SHEET**

Form No. 1

**MENTAL HEALTH SERVICES ACT (MHSA)  
PREVENTION AND EARLY INTERVENTION COMPONENT  
OF THE THREE-YEAR  
PROGRAM AND EXPENDITURE PLAN**

**Fiscal Years 2007-08 and 2008-09**

County Name: Nevada County	Date: March 11, 2009
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**COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):**

<b>County Mental Health Director</b>	<b>Project Lead</b>
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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 Michael J Heggarty 4/15/09  
County Mental Health Director Date

Executed at Grass Valley, California

**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

Michael Heggarty, MFT, Nevada County Behavioral Health Director was responsible for the overall Community Program Planning Process.

- b. Coordination and management of the Community Program Planning Process

Rebecca Slade, MFT, Nevada County Children's Behavioral Health Program Manager and Richard Stone, Nevada County's Mental Health Board Member, National Alliance on Mental Illness (NAMI) member and father of a Transition Age Youth (TAY) mental health consumer coordinated and managed the Community Program Planning Process.

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

Michael Heggarty, MFT, Nevada County Behavioral Health Director, Rebecca Slade, MFT Nevada County Children's Behavioral Health Program Manager and Richard Stone, Nevada County's Mental Health Board Member, NAMI member and father of a TAY mental health consumer ensured that the stakeholders had opportunities to participate in the Community Planning Process.

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

- a. Included representatives of un-served and/or underserved populations and family members of un-served/underserved populations

Nevada County is small rural county north east of Sacramento, California. In 2006 Census, Nevada County was 88.6% Caucasian, persons of Hispanic or Latino decent were 6.9% and 0.9% of Nevada County residents were Native American. There are two agencies that predominately link to the Latino population in Nevada County, The Family Resource Center in Grass Valley, Sierra Nevada Children's Services and the Truckee Family Resource Center in Truckee. These agencies were invited to participate in our Prevention and Early Intervention Committee and were involved in outreach into their respective communities. Twenty-five public meetings and outreach meetings were held in Nevada County, some of those events were conducted in both English and Spanish with simultaneous translation.

We had members from the Gay and Lesbian community that were involved with the PEI committee and helped with our outreach.

We have had a number of discussions with leaders in the Native American community about Prevention and Early Intervention. We invited them to a number of our meetings and offered to join their outreach meetings, but that connection was not made until mid March. The week that our plan was posted for public comment a meeting was organized. In this meeting we explained the PEI guidelines and our plans for this funding. We asked for their feedback and for their involvement. It was also explained how they can provide public comment on the plan. A copy of the plan was also provided. Additionally, a description of our current MHSA services was given and how to access those resources. It is our hope that this is our first step in our continued discussion and connection with Nevada County’s Native American community.

The Prevention and Early Intervention committee conducted outreach, engagement and public meetings with different stake holder groups in different regions of the county. We did this in three different ways. We spoke to leaders of different communities and cultural groups within our county, we held our own meetings and we joined different stakeholder meetings, such as joining the regular Nevada County NAMI or Depression Bipolar Support Alliance (DBSA) meetings. Meetings were held in Truckee, Nevada City, Grass Valley, and North San Juan. These public meetings were advertised in a variety of ways: sending flyers home with school age children, sending out email blasts, advertising in the local paper and/or contacting local stakeholder groups by phone.

Below is a list of all PEI meeting dates, type of meeting, and the stakeholders that participated:

Date	Type of Meeting	Place	Type of Stakeholders
7/18/07	Public Meeting	County Meeting Room	Probation, NCBH, parent of a Transition Age Youth (TAY) consumer, private practice doctor, Truckee family member, Mental Health Board Chair, and private & contracted bi-lingual marriage and family therapist (MFT)
7/31/07	Public Meeting	County Meeting Room	Parent of a TAY consumer, Family Resource Center Director, private & contracted bi-lingual marriage and family therapist (MFT), NCBH, Truckee family member, NAMI, and SPIRIT
8/14/07	Public Meeting	County Meeting Room	Probation, Family Connections: Colaborando, Grass Valley School District (GVSD), Nevada County Superintendent of Schools (NCSOS), Family Resource Center Director, NCBH, Child Protective Services (CPS), First 5 Nevada County (First 5 NC), Nevada County School District (NCSO), KARE Crisis Nursery, Nevada County Health and Human Services Agency (HHSA), Truckee family member, NAMI, parent of a Transition Age Youth (TAY) consumer, and a Child Advocate of Nevada County
8/30/07	Public meeting	County Meeting Room	No sign in sheet
10/26/07	Public Meeting	County Meeting Room	Parent of a TAY Consumer, Nevada County Public Health (NCPH), Northern Sierra Rural Health Network, NAMI, Sierra Family Medical Clinic (SFMC), First 5 NC, Adult Protective Services (APS), In-Home Supportive Services (IHSS), NCBH Friday Night Live, ROP Student, NCSO Big Pal Program, Mental Health Board, NAMI, Probation, NCBH Director

11/05/07	All Superintendent of Schools Meeting	Superintendent of Schools Office	School Superintendents, Principals, School Counselors, Teachers, Nurses, Parents Center, Nevada County Independent Living Program and NCBH-(Representatives from the 13 different school boards in our county)
11/15/09	PEI Committee Meeting	County Meeting Room	Nevada County Schools, Mentoring Program, Nevada County Charter Schools, School Readiness, Soroptomists International, San Juan Ridge Family Resource Center, NAMI Center, Nevada Joint Union High School District and NCBH
12/07/07	Meeting with elder Care providers Coalition	Elder Care providers Coalition	No sign in sheet, attended their regular scheduled meeting
1/9/08	Public meeting organized with the Elder Care Providers Coalition	Del Oro Caregivers	Telecare, Private Therapists, Alzheimer's Outreach Project, Transitions Program, Quail Ridge Senior Living, Adult Protective Services, Dementia Whisperers, Home Instead Senior Care, NAMI, Financial Freedom, Brunswick Senior Village, Independent Elder Care, Retired Senior Volunteer Program Center, Del Oro, Nevada county hearing Aid, Highgate Senior Living, RSVP/Friendly Visitors/Helpline, semi-retired volunteer and NCBH
1/17/08	Truckee Stakeholders	Truckee Family Resource Center	Family Resource Center, Law Enforcement, Truckee Schools, Tahoe Truckee Community Collaborative, NAMI/Mental Health Board, Public Health, Child Welfare, Probation, Tahoe Forest Health System Center, HHSA, and NCBH
2/28/08	Public Meeting organized by the National Alliance on the Mentally Ill	Public Library in Nevada City	Mental Health Consumers and Parents, Family Member of Mental Health Consumers and NCBH
3/27/08	Public Meeting	Family Resource Center of Truckee	Latino Population, Teen Group of Consumers, Transition Age Youth who are consumers, Law Enforcement, Truckee Schools, Family Resource Center, Truckee Collaborative, Nevada County Social Services, Behavioral Health, Public Health, Truckee Woman's Special Friends Program Center and NCBH
4/30/08	Public Meeting in remote area of the county, North San Juan Ridge	North San Juan Ridge Family Resource Center	Fire Department, Schools, Parents, Head Start, Local Therapists, Ananda Retreat Center, Family Resource Center, HHSA, NAMI and NCBH
5/10/08	Public Meeting with the Nevada County Suicide Prevention Task Force	Grass Valley City Hall	Suicide Survivors, Family Members of completed suicides, Therapists, Public Health, Sierra Nevada Memorial Hospital, Probation and Juvenile Hall Superintendent, Anew Day Counseling Service, Grass Valley Fire Department, Nevada County Health and Human Services Agency, NAMI, Nevada County High School District, KARE Crisis Nursery, SPIRIT Center, local Real Estate offices, Chapa De Indian Health Center and NCBH
6/5/08	Public Meeting	Hennessy Elementary School in Grass Valley	Parents, Teachers, Mental Health Consumers, NAMI Center and NCBH
8/16/08	Public Meeting organized with the SPIRIT center	SPIRIT Center	Mental Health Consumers, Mental Health Peer Counselors, Transition Age Youth who are Mental Health Consumers and NCBH
8/21/08	Public Meeting organized by the Depression	First Unitarian Church in Grass Valley	Members of DBSA, SPIRIT Center, local Therapists, local Psychiatrists, Mental Health Consumers and Family Members and NCBH

	Bipolar Support Alliance (DBSA)		
10/3/08	Public Meeting	County Building in Nevada City	Grass Valley Fire Department, DBSA, Public Health, Turning Point, NAMI, Truckee Schools, Sierra Family Services, Adult Protective Services Center and NCBH
10/10/08	Senior Subcommittee	Behavioral Health Office	Friendly Visitor Program, Adult Protective Services, FREED, Adult Behavioral Health, Public Health Center and NCBH
11/04/08	Senior Subcommittee	Behavioral Health Office	Same as above with the addition of NAMI
2/18/09	Public Meeting	County Building	HHSA, NCSD Bid Pal program, Sierra mentoring Partnership, NCSOS Independent Living Program, GVSD, EMQ/Families First, Probation, First 5 NC, FREED, CPS, HHSA, Department of Social Services, Pleasant Valley School District, parent of a TAY consumer, Truckee Family Resource Center, Tahoe-Truckee Truckee Unified School District/First 5, Placer County
2/20/08	Law Enforcement Special Meeting	Wayne Brown Correctional Facility	Nevada County Sheriff, Nevada City Police, Grass Valley Police, Truckee Police, Nevada County Jail, Hospitality House, and NCBH
2/26/09	Western County Latino Outreach	Sierra Nevada Children's Services Family Resource Center	Promotoras, Colaborando en Espanol, Empiezos Maravillosos, Sierra Nevada Children's Services Family Resource Center, Women of Worth and NCBH
3/2/09	Truckee Outreach	County Building in Truckee	Senior Outreach, Family Resource Center of Truckee, Truckee Community Collaborative, Truckee Schools, Nevada County Social Services, Special Friends Program and NCBH.
3/12/09	Native American Outreach	Native TANF Program Office	Native TANF and NCBH

In our public meetings a brief explanation was given of the Prevention and Early Intervention funding, history and guidelines. We created a simple power point presentation in English and Spanish that briefly gave the history of Prop 63, explained the funding, how it came in five different components and how much our county was to receive. The power point described the states definitions of Prevention and Early Intervention and gave examples of programs that could fit those definitions. It also described the resource guide.

In our meetings we made available for people who were interested copies of the PEI guidelines and resource guide. We then asked those attending what they thought was good mental health and what was poor mental health and how could we keep our community in the good mental health arena. We asked for their best ideas on what their community needed and what population was in the most need. Near the end of the meetings we prioritize the ideas by voting.

- 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.

Nevada County is small rural county with a land area of 958 square miles. It is sparsely populated with two major population areas, the Grass Valley/Nevada City area and the Truckee area. The 2006 U.S. Census population estimate for Nevada County was 96,764. The Prevention and Early Intervention committee was responsible for conducting a number

of public meetings in the different geographic areas of the county. Public meetings were held in the Grass Valley/Nevada City area and the Truckee area, with the help of the Family Resource Centers, the public schools, the Public Health Department, DBSA, Gold Country Caregivers, SPIRIT Mental health Peer Empowerment (SPIRIT) Center and NAMI. Additionally, a public outreach meeting was held in the remote area of the county called the North San Juan Ridge with the help of the North San Juan Family Resource Center, the Ananda Retreat Center and the Twin Ridges School District.

Nevada County has a large elder population. The 2006 U.S. Census stated that 17.1% of Nevada County residents were over 65 years old. We had the elder population represented on our Prevention and Early Intervention committee. We had meetings with an organization called the Elder Care Providers Coalition which is an organization of fifty-four different groups that serve the elder and dependent adult population. As a result of these meetings a small sub-committee was formed of elder care providers to make recommendations to the larger committee on how we can serve the elder and dependent adult population.

The 2006 U.S. Census also stated that 18.9% of Nevada County residents were under 18 years old. The First Five Commission, the public schools, Child Welfare, Probation, and the Family Resource Centers were a strong voice for youth on the Prevention and Early Intervention Committee. The Nevada County Superintendent of Schools organized a meeting with all of the school districts in the county. All County Superintendents were represented as well as most of the school principals and many school counselors. Additionally, the Children's System of Care Executive Committee was actively involved in the outreach and decision making process with the Prevention and Early Intervention Committee. This committee includes our Juvenile Judicial Judge, the Directors of Child Welfare, Probation, Mental Health, Social Services, Juvenile Hall, and the Superintendent of Schools.

Nevada County has a Suicide Prevention Task Force. This is a large committee that represents a diverse group of stakeholders, agencies and government departments, including fire departments, schools, faith based organizations, County Coroner, NAMI, SPIRIT Center, Private therapists, Social Services, Public Health, Probation, Behavioral Health, Grass Valley City Council, County Board of Supervisors, Gay and Lesbian community, survivors and family members. This group has been very involved in the PEI committee and strongly advocates preventing suicide for all ages and racial/ethnic and cultural populations.

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

Nevada County is enriched with a strong NAMI support group. NAMI played a strong role in the Prevention and Early Intervention Committee. We did a public meeting with NAMI following the same format as our other public meetings. NAMI family members and consumers gave us feedback on what they believed was effective prevention and early intervention. Nevada County also has a strong DBSA group that was involved in our community outreach. They organized a public meeting for us. The majority of individuals to attend this meeting were mental health consumers and some mental health providers.

Nevada County has a peer empowerment center called SPIRIT Center. This center trains mental health consumers to be peer counselors. They lead groups and help other mental health consumers on a one-on-one basis. SPIRIT Center helped us organize a public meeting at Spirit Center where mental health consumers gave us their ideas and feedback.

Richard Stone one of our co-chairs is a father of a TAY mental health consumer. He also helps to teach the NAMI parenting group. As the Co-Chair of the prevention and Early Intervention Committee he has patiently and gently advocated for the mental health consumers and their families.

The Nevada County Suicide Prevention Task Force has a number of suicide survivors and family members who have lost loved ones to suicide. The Task Force also has first responders and treatment professionals advocating for people with mental illness. This group has participated in our outreach and has given us a lot of feedback during our planning and plan writing phases.

**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 co-chairs of the Prevention and Early Intervention committee identified members from all of the required and recommended sectors and partner organizations and a large committee was formed. All committee members were educated about the Prevention and Early Intervention history and guidelines. They were given copies of the Prevention and Early Intervention guidelines and resource guides. They were shown a power point that described the guidelines. As described earlier the power point briefly gave the history of Prop 63, explained the funding, how it came in five different components and how much our county was to receive. It also described the states definitions of Prevention and Early Intervention and gave examples of programs that could fit those definitions. It described the resource guide. This same group educated other groups of stakeholders and the public in general with the same power point and literature.

- Individuals with serious mental illness and/or serious emotional disturbance and/or their families were represented on the Prevention and Early Intervention committee by the SPIRIT Center a peer run counseling center for mental health consumers, the

NAMI and DBSA. Additionally, the Suicide Prevention Task Force was very involved in outreach and education work. As stated above the committee did public outreach meetings with the SPIRIT Center, NAMI and the DBSA in their regularly scheduled meetings.

- Providers of mental health and/or related services such as physical health care and/or social services were represented on the Prevention and Early Intervention committee by mental health professionals in the community and Nevada County Behavioral Health. Nevada County Public Health, FREED a private non-profit organization representing the disabled was involved, Child Welfare, Probation, Adult Protective Services and Social Services all played an active role on the committee. The committee conducted a large meeting with the Elder Care Providers Coalition which as stated above is an organization of fifty-four different groups that serve the elder and dependent adult population. A small sub-committee was formed of elder care providers to make recommendations to the larger committee on how we can serve the elder and dependent adult population.
- Educators and/or representatives of education were well represented on the Prevention and Early Intervention Committee. The committee did outreach meetings with the superintendent of schools, school principals, counselors, educators and parents. Sub-committees were formed with the school district, school counselors and teachers. First Five has been actively involved in the committee.
- Representatives of law enforcement were invited to a number of meetings but were unable to attend. A special meeting was organized just for them in our county jail. Grass Valley Fire Department was represented and actively involved in the PEI committee.
- Outreach was conducted to our homeless population by having one-on-one conversations with our nomadic homeless shelter's Executive Director. Hospitality House our homeless shelter sent representatives to a couple PEI meetings.

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

A power point was created in both Spanish and English that briefly described the history of the Mental Health Services Act and the state guidelines for Prevention and Early Intervention. At six meetings this was shown and copies of the state guidelines and resource guides were made available. The notes of the meeting were emailed out to all participants who had email addresses with attachments of the PEI guidelines and resource guides.

**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.

Nevada County learned that we needed to have meetings at convenient times for our stakeholders and that it is always welcoming to have some food. We also learned the importance of having literature in Spanish and to have simultaneous Spanish translation. We learned that it is important to have meetings in the geographic location of your stakeholders. We held meetings in our remote areas of the county and in the locations where our stakeholders usually hold their meetings. We learned to join regularly scheduled stakeholder meetings. We learned the importance of well publicized meetings and the importance of public minutes of the meetings.

After the CSS process the stakeholders who represented and/or served the elderly population had felt that they were not well represented. In the PEI outreach a lot of attention was given to outreach to the stakeholders who represented and/or served older adults. We meet with the Elder Caregivers Coalition and created a subcommittee on older adults and people with disabilities. This subcommittee had members from Public Health, Adult Protective Services, and FREED (an Independent Living Resource Center).

Nevada County Behavioral Health was given feedback after the CSS planning process that people were really tired of surveys and that few felt that the surveys had given them a clear opportunity to effectively give their feedback. We choose not to use surveys because of this, instead we meet with different groups, conducted public meetings with citizens and conducted outreach one-on-one with individuals not able to attend meetings. In meetings we created a list of ideas generated on how to best use our PEI money. At the end of the meeting participants were given 10 green dots and with these dots they voted on what they felt were the best ideas. The ideas were then prioritized by the amount of votes they received.

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

Nevada County is enriched to have a private non-profit center, the SPIRIT Center for peer counseling for people with mental illness. The SPIRIT Center has a TAY group and when we did a meeting at the SPIRIT Center this group was invited. A few youth between the ages of 16 and 24 attended this meeting. At our public meetings, particularly the meeting in Truckee we had a large turnout of transition age youth. They added a great deal to the meeting.

Trauma-Exposed individuals were represented by mental health providers, the Suicide Prevention Task Force, Child Welfare workers, Probation Officers, teachers, and school counselors on our committee and in our meetings. In some of our meeting citizens would identify themselves as individuals who had experienced trauma. Many of these people spoke about the need for early screening for trauma and early treatment needs in our community.

Individuals experiencing onset of serious psychiatric illness were represented by the NAMI, The DBSA, SPIRIT Center and the Suicide Prevention Task Force.

Children and Youth in stressed families, at risk for school failure and at risk for juvenile justice involvement were represented by teachers, school counselors, Probation Officers, parents, Child Welfare workers, therapists, drug counselors, public defenders, Juvenile Court Judge and school

administrators. These individuals were on the PEI committee and/or were involved in the public outreach. This community spoke about the need for more psychological education, screening and early intervention with the children in our community.

**Provide the following information about the required county public hearing:**

- a. The date of the public hearing:

April 3, 2009 and April 13, 2009. We scheduled one public hearing on April 3, 2009. This hearing was prior to the close of the 30 day public commit period, so we scheduled a second public hearing on April 13, 2009 after the close of our 30 day public commit period.

- 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.

Our public review and comment period was from March 13, 2009 to April 11, 2009.

The PEI Component of the Three-Year program and Expenditure Plan was made available to the public using the following methods:

- A copy was posted on Nevada County's MHSAs website: <http://www.mynevadacounty.com/mhsa/index.cfm>.
- Electronic mail notification was sent to the Mental Health Board, MHSAs Steering Committee, MHSAs Subcommittees, Behavioral Health contract providers, community based organizations, other County Departments, the Courts, local law enforcement, and other individuals that have requested being on our e-mail list notifying them of the start of the 30-day review period with a link to Nevada County's MHSAs website.
- Hard copies were provided to anyone that request one.
- Hard copies of the plan were provided to organizations that had meetings with the MHSAs Coordinator during the 30-day public commit period.
- Press release were sent to our local media which included:
  - KNCO-radio
  - KVMR-radio
  - The Union-newspaper
  - YubaNet.com-online newspaper
  - Sierra Sun-newspaper
  - Moonshine Inc-Spanish and English newspaper

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

**Attachment 1-NAMI Nevada County Letter Dated April 13, 2009.**

- *Issue 1: Personnel that support the suicide prevention and the forensic liaison programs are considered temporary workers. The facts show that these issues are not temporary problems, We recommend that these positions be permanent, that benefits be available, in order to attract and retain the best candidates and also to increase the likeliness of low staff turnover.*
  - NCBH agrees with NAMI on this issue, but because of economic reasons the Board of Supervisors' and the County Executive Officer are not allowing any new permanent hires. We have to contract out positions or hire temporary workers.
- *Issue 2: Although we respect the need for those with low incomes to be served, we in NAMI know that mental illness knows no income barriers. PEI is not only about those with low incomes. Therefore, we are concerned that services not be limited to those who are on Medi-Cal or are Medi-Cal eligible, especially young people who are at risk for disability from their illness without early intervention.*
  - NCBH also agrees with NAMI on this issue, but because of economic times we had to find a balance between serving Medi-Cal recipients and not. As you can see in our plan we only have one program that is dependent on Medi-Cal. The majority of the programs do not have any requirement to be Medi-Cal eligible.
    - In our Access to Services Project we have no linkage to Medi-Cal to participate in the programs.
    - In our Outreach Project we are targeting low income individuals or underserved population, there is not a requirement to be on Medi-Cal.
    - In our Prevention and Early Intervention for at Risk Children, Youth and Families Project only one project is dependent on Medi-Cal. The only program that depends on Medi-Cal funding is our Early Intervention Program. This program requires short intensive Functional Family and Trauma Focused Cognitive Therapy. To be able to implement this program on a large scale we need to leverage MHSA funds with Medi-Cal funds.
- *Issue 3: We are hopeful that the suicide prevention component will also include the Mental Health First Aid program which provides specific curriculum giving mental health the same parity status with other bodily first aid needs.*
  - As long as funds allow this added feature Nevada County is in support of adding this element to our suicide preventing training.
- *Issue 4: We are still deeply concerned about our community's response to Transitional Aged Youth and the need for better understanding of the spectrum of needs of this age group. The need for stronger coordinated supports for them is critical.*
  - Nevada County agrees with this fact that we need to address TAY in a holistic manner. At this time we do not have enough funds to tackle this issue.
  - We are recommending that this issue be brought up as we start our planning process for innovation funds. We could use innovation funds to create a county wide strategic plan based on a needs analysis, resources analysis, gap analysis and community input.
- *Issue 5: The membership of the Executive Committee on Children's System of Care is listed. It does not include any family or youth representatives.*
  - Members of the PEI subcommittee have brought this fact to the Committees attention, but we have no authority over this committee. At this time they are not

choosing to include family or youth representatives. Our PEI subcommittee member will approach them again.

- *Issue 6: The official name of NAMI was changed. NAMI National Alliance on Mental Illness is the correct designation.*
  - NAMI's name was correct in the document.

**Attachment 2: Depression and Bipolar Support Alliance (DBSA) letter dated March 29, 2009.**

- *Issue 1: The DBSA and other stakeholders would like the Mental Health Board to consider these DBSA peer-led groups: (1) Living Successfully with a Mood Disorder; and (2) Support groups including DBSA Recovery Dialogues; each for various age groups, as a Best Practice model that is a relevant stakeholder priority not identified in the current PEI plan.*
  - Upon reviewing this plan when it was submitted Rebecca Slade Co-Chair of the PEI Subcommittee communicated to DBSA that they would not be funding this project.
  - Per the plan submitted: Educating professionals Plan #1 and Educating Professional and Community Members Plan #2, Nevada County Behavioral Health Department feels these plans would be better fulfilled in our Workforce Education and Training (WET) Plan.
  - Nevada County acknowledges that we need to continue to educate our professionals on best practices pertaining to depression and bipolar disorders. Nevada County has taken its first step in this direction by using MHSA One Time Community Training Funds to send 31 individuals to Dr. Kiki Change training on Comprehensive Treatment of Children & Adolescents with Bipolar Disorder. This training occurred on March 13, 2008. We had a cross section of the community attend- Mental Health Board Member, NAMI, contract providers, a nurse, Children Behavioral Health staff, Juvenile Hall Superintendent, school staff, a Psychiatrist, a Psychologist, Crisis Team staff, Juvenile Hall staff, and Probation Officers.
  - Nevada County has invite DBSA to partner with us as we implement our WET plan.
- *Issue 2: Our final proposal was for a psychosocial and educational therapy group to be co-led by one peer and one licensed professional.*
  - Upon reviewing this plan when it was submitted Rebecca Slade Co-Chair of the PEI Subcommittee communicated to DBSA that they would not be funding this project.
  - Per the plan submitted: Plan for TAY Experiencing or at Risk of Experiencing Onset of Serious Psychiatric Illness; Plan for Older Adults Experiencing or At Risk of Experiencing Onset of Serious Psychiatric Illness; and Plan for Adults Experiencing or At Risk of Experiencing Onset of Serious Psychiatric Illness, Nevada County feels that these plans fit better under our Community Services and Support (CSS) Plan.
  - Nevada County has acknowledged that their first proposal for CSS was not funded and that with funding declining we are not adding any new proposals at this time.

- Nevada County is about to start the CSS Community Planning Process for the 2009/2010 CSS Plan Update.
- Nevada County agrees with DBSA that we need to address TAY. We would like to start in a holistic manner. At this time we do not have enough funds to tackle this issue.
- We are recommending TAY issues be brought up as we start our planning process for innovation funds. We could use innovation funds to create a county wide strategic plan based on a needs analysis, resources analysis, gap analysis and community input.

### **Attachment 3: April 3, 2009 Mental Health Board Public Hearing Meeting Minutes**

- *Issue 1: Concern about the PEI Plan and the use of temporary workers for several key positions.*
  - Michael Heggarty, NCBH Director, shares the same concern.
  - NCBH agree with NAMI on this issue, but because of economic reasons the Board of Supervisors' and the County Executive Officer are not allowing any new permanent hires. We have to contract out positions or hire temporary workers.
- *Issue 2: A number of individuals showed support of our mentoring programs that are in the PEI Plan.*
  - No action needed.
- *Issue 3: At the Public Meeting in August 2007 a number of the plans emphasized TAY for at risk youth and first onset youth is traumatic time for both the individual and family diagnosed with mental illness. It would be good to collaborate in some fashion.*
  - We are recommending that this TAY issues be brought up as we start our planning process for innovation funds. We could use innovation funds to create a county wide strategic plan based on a needs analysis, resources analysis, gap analysis and community input.

### **Attachment 4: April 13, 2009 Mental Health Board Public Hearing Meeting Minutes**

- *Issue 1: DBSA felt that they were not welcomed to participate in the process and thus they did not have the opportunity to provide input and when they provided ideas and input their ideas were turned down. DBSA read Attachment 2.*
  - DBSA is on our mailing e-mail list and have been invited to PEI Meetings and Steering Committee meetings.
  - PEI Committee have accepted their plans, however, they have not been funded to date.
  - See response to Attachment 2.
  - We will continue to work with DBSA to have their area of interest and expertise addressed through the appropriate plan and when funding allows.
- *Issue 2: A number of members of the public expressed support of the Mentoring component of the PEI Plan.*
  - No action taken.
- *Issue 3: NAMI presented Attachment 1 to the Mental Health Board.*
  - Please see response to Attachment 1.

d. The estimated number of participants:

April 3, 2009 we had 19 participants at the Mental Health Board Public Hearing.

- Mental Health Board Members = 5
- NCBH Staff = 4
- Visitors = 10

April 13, 2009 we had 18 participants at the Mental Health Board Public Hearing

- Mental Health Board Members = 5
- NCBH Staff = 4
- Visitors = 9

	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
<p><b>1. PEI Key Community Mental Health Needs</b></p> <p>Select as many as apply to this PEI project:</p> <ol style="list-style-type: none"> <li>Disparities in Access to Mental Health Services</li> <li>Psycho-Social Impact of Trauma</li> <li>At-Risk Children, Youth and Young Adult Populations</li> <li>Stigma and Discrimination</li> <li>Suicide Risk</li> </ol>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>

	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
<p><b>2. PEI Priority Population(s)</b></p> <p><b>Note: All PEI projects must address underserved racial/ethnic and cultural populations.</b></p> <p>A. Select as many as apply to this PEI project:</p> <ol style="list-style-type: none"> <li>Trauma Exposed Individuals</li> <li>Individuals Experiencing Onset of Serious Psychiatric Illness</li> <li>Children and Youth in Stressed Families</li> <li>Children and Youth at Risk for School Failure</li> <li>Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</li> <li>Underserved Cultural Populations</li> </ol>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>

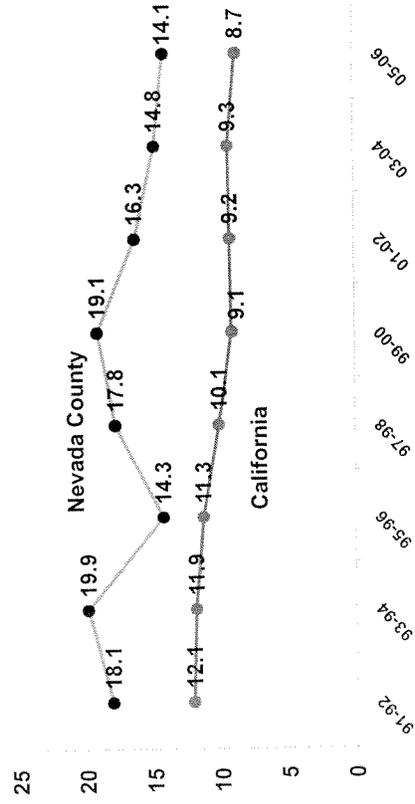
We checked all of the above boxes, because nobody in our community is excluded. Our primary focus is our unserved cultural populations and trauma exposed individual and decreasing disparities in access to resources.

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

In our rural community many people told us accessing services was difficult. We want to increase the community's access to services in our first component of our PEI plan. We have four projects under our Access to Services component: Suicide Prevention Program; Physician Integrative Behavioral Health Training; First Responder Training; and Nevada County 2-1-1.

We chose the Suicide Prevention Program because Nevada County has about one and half to two times the state average of suicides per year and people in the community have expressed a lot of concern about our rates. Please see the table below. Trent Roger, the Chief of the Injury Surveillance and Epidemiology Section in the State Department of Public Health created the following table to show Nevada County suicide rate with the state average rate.

**Figure 2. Suicide deaths, two-year rates per 100,000 population, Nevada County and California residents, 1991-2007**



Source: California Death Statistical Master Files

Prepared by: California Department of Public Health, EPIC Branch

It is further believed that our suicide rate is under reported. Chief Deputy Coroner Cathy Valceschini has stated that if someone commits suicide and there is medical trauma the person is transferred to Placer County Trauma Center and is counted as a Placer

County suicide. Also, there is a bridge just out of the county line that a number of Nevada County citizens have jumped to their deaths. These people are not included in Nevada County statistics.

At a majority of PEI stakeholder meetings concern was expressed about the high suicide rate in our community. At a majority of meetings suicide prevention was listed as one of the top five most important issues to be addressed with PEI funds.

Because of the recent amount of suicides and suicide attempts a Suicide Prevention Task Force was created. This task force has representatives from multiple agencies and organizations, including fire departments, schools, faith based organizations, County Coroner, NAMI, SPIRIT Center, private therapists, Social Services, Public Health, Probation, Behavioral Health, Grass Valley City Council, County Board of Supervisors, survivors and family members. This group has strongly advocated that some of our PEI funds be used to prevent suicide for all ages and racial/ethnic and cultural populations. The Suicide Task Force eloquently argues that suicides/suicide attempts are a public health issue and have become serious enough to be a public safety issues. They believe that suicide prevention is as important as fire, chronic illness or accident prevention. The Suicide Task Force has lead us in the suicide prevention strategic planning process and already has an action plan to prevent suicides. The Suicide Task Force has been very involved in the PEI committee and has really been an adjunct workgroup for the PEI committee.

We chose our Integrative Behavioral Health Training for Physicians because in our outreach to the community it was often said that the real gatekeepers for mental health are our primary care physicians. People said that stigma kept many people from outreaching for help with their mental health problems, but it was permissible to go see your primary care physician. People will go to their primary care physician and address somatic complaints are slow to discuss their psychological pains. The American Association of Suicidology states, “45% of individual who die by suicide made contact with a primary care provider in the month prior to their death and approximately 20% made contact within one day of their death. Primary care has been recognized as the optimal setting within which to identify suicidal individuals and offer early intervention and referral.” At the Elder Care Providers Coalition which is a consortium of 54 providers that serve the elderly in our community many voices stated that for our older generations it was a sign of weakness to admit a psychological need, but it was okay to go to the doctor to ask for help with a somatic complaint. They also said a need in our community was to have physicians screen for depression and anxiety in their population. NAMI and some people at the DBSA meeting also expressed the same need. It is also known that the American Medical Association has said that depression screening is a mandatory part of good health care. It was decided to fund training for primary care physicians on how to address the mental health needs of their clients. Most agreed that this training would be most effective if it was done by another physician.

In our community we have a very special rural community clinic, Sierra Family Medical Clinic. This clinic is part of the Northern Sierra Rural Health Network. This clinic is in a rural part of our county and it has been screening for mental health issues for the past seven years, much the same as they do for blood pressure, with every client who walks in the door. They have created an Integrative

Behavioral Health Care System, which encompasses four different areas. They screen for depression, general anxiety, substance abuse and social anxiety. An example of this practice would be when a client walks in with a complaint about a rash he is still given a brief mental health screening and if he tests high in any of the four areas the primary care physician would address mental health with the client. The physician could also walk this patient over to talk to a social worker.

Over the years Sierra Family Medical Clinic has found that 50% of their patients are depressed. All of these people have been offered services, ideally at the same time they have come to the clinic for their physical health issue. Sierra Family Medical Clinic uses a “secured referral process” or “warm hand off”, where the client is introduced to the mental health provider face to face at the initial appointment. They state that without this “secured referral system” only 50% of people who are referred to a psychiatrist follow through, because of stigmatization. We know that a model where the primary care clinic can introduce the client immediately to a mental health provider increases the number of people who follow through with mental health referrals. This model of a secured referral or a “warm hand off” can be created in a number of different ways. Sierra Family Medical Clinic has found that this screening decreases the amount of time that a physician needs to spend with his clients and decreases the amount of visits that clients ultimately make to their primary care physician. Primary care physicians often do not want to talk to their clients about their mental health issues because of fear that it will take too long.

In our outreach to the community it was also said that our “First Responders” (law enforcement and fire fighters) also need training on mental illness and how to respond to people who appear to be in a mental health crisis. We were asked for this training by some of our Fire Departments, Nevada County Sheriff, our local chapter of NAMI and SPIRIT Center. The Captain of our county jail, Frank Koehler said “twenty years ago we did not know about domestic violence or how to handle it and today I believe we do a good job. We need the same thing to happen on the issue of how to handle the mentally ill.”

When someone experiences a psychiatric crisis and acts out as a result of symptoms of their illness, law enforcement officers are often the first-line responders. Jails and prisons, rather than medical facilities, are increasingly used to house and treat people with mental illnesses. Law enforcement officers report that they spend more time in the disposition of “emotional disturbance” calls, and that they do not feel properly prepared to respond to someone in a psychiatric crisis. Frequently officers may not want to arrest someone who is obviously in need of psychiatric care, but they do not know what treatment options are available, and feel they have few resources to support them and the individual in crisis.

Our Nevada County 2-1-1 project increases the community’s awareness and access to services. Many people in our community are spread apart from one another, we have little public transportation and there has not been a central data source on resources. In our outreach to the public about PEI people would often voice concern that the community was not aware of the resources that we had for help with mental health. Groups like the BPSA, the NAMI parents support group and SPIRIT Center say that people in the

community do not use their services enough because they are not aware of them. Many have said that they would like a central resource guide that would help Nevada County citizens find the mental health services they need. Nevada County 2-1-1 will increase our underserved population's access to mental health services.

Nevada County has an active User Group called the "Community Board" whose goal is to have Nevada County have an active 2-1-1 resource phone line. A website called WWV.Dial211.com has been created with all the resources available to people living in the county on line. Currently mental health is the most searched category of the 11 categories available. Nevada County Behavioral Health is the 3<sup>rd</sup> most searched and viewed site of over 1,200 listed agencies.

Nevada County 2-1-1 is a project to serve a number of underserved communities. In our rural community there are many families without computers. In our vulnerable communities most do not have computer access. Also, in many areas of the county residents only have dial up for an internet connection and the internet is used less frequently because of the slow connection time. Nevada County is hoping to be the first rural county in the state to have a 24 hour phone line where people in the community can call and find resources. This phone service will have access to over one hundred and fifty languages and will have someone who speaks Spanish, so we can serve our emerging Latino population in the county. This line will also accommodate individuals with any disability.

**3. PEI Project Description:**

Nevada County plans with its Suicide Prevention Project to hire a PEI Coordinator/Suicide Prevention Coordinator. This person would use "Living Works" evidence based curriculum to outreach in the community and provide linkage to services. The Coordinator will be trained in "Living Works" curriculum and will be able to lead two and four hour training groups in the community on suicide prevention. They will also be trained in leading two day training seminars in suicide prevention. The coordinator will do these trainings in the schools, in the faith based organizations, businesses, county offices, public health sites, city offices and others that request the training. The high schools have already given an open invitation to this coordinator to lead groups in the high schools for all of their students and teachers. The PEI/Suicide Prevention Coordinator would reach people in the community that ordinarily would not be aware of mental health resources or how to access them. The Coordinator would contribute to the reduction in disparities in access to mental health services.

The main partner in this project is the Nevada County Suicide Prevention Task Force and the Nevada County Behavioral Health Department. The partners will oversee the activities of the PEI/Suicide Prevention Coordinator. The main role of the PEI/Suicide Prevention Coordinator will be to implement the Task Force's newly developed Action Plan. The Coordinator will additionally partner with any organization that is willing to be trained in Suicide Prevention. They will provide outreach and education to all

*racial/ethnic and cultural populations that service providers provide services to in Nevada County. All of the services will be out in the community at service provider sites, community meetings, schools, faith based community programs, health sites, etc.*

The Coordinator will:

- Create a trained volunteer group to help with community outreach. These volunteers will have gone through the two day “Living Works” program and will be able to lead the two and four hour “Living Works” groups.
- Train the Public Health Nurses, Child Welfare Workers, Probation, Law Enforcement, Friendly Visitors volunteers and staff, school teachers, homeless shelter and transitional housing staff.
- Create, maintain and distribute a current list of resources for use by community members.
- Create a referral process that includes electronic, paper and verbal requests.
- Link referrals to appropriate resources. The Coordinator will follow through with referrals to make sure that their needs are met.
- Organize Task Force Meetings and implement their action plan.
- Collect statistical information to establish baseline data and will be responsible for the tracking and collecting suicide data to keep the community informed on any trends.
- Help create, maintain and update the Nevada County Suicide Prevention Website.
- Cross train and coordinate services with other PEI projects, such as the Friendly Visitor Program, Elder Outreach Public Health Nurses, the Mental Health Screeners in the high schools, and the Latino Promotora Programs.

Additionally, PEI will fund a Public Health Educator who is currently using “Living Works.” This person will work with our Suicide Prevention Coordinator helping with all the above tasks. Currently, the Public Health Educator is only doing two “Living Works” seminars yearly and this will increase with the PEI funding.

In our Physician Integrative Behavioral Health Training program the Northern Sierra Rural Health Network will train primary care physicians to screen for mental health issues. We believe that we could prevent and intervene early with many mental health problems if primary care physicians were able to identify and refer people to appropriate resources. This project will decrease the disparities in access to services in our community, by screening all who go to their primary care physician. The Northern Sierra Rural Health Network received a grant of \$10,000 from the California Endowment to partially fund this training. It is planned that Personal Digital Assistants (PDAs) will be bought with the California Endowment funds and loaded with programs for physicians on how to diagnose and treat mental health issues. These PDA’s will be given to the physicians who attend the training.

Sierra Family Medical Clinic will:

- Advertise their training on Integrative Behavioral Health Model

- Offer CEU's for physicians
- Train on a brief mental health screenings that can be used in a primary care physician office
- Train on the time efficacy of mental health screenings for the physician
- Train on the prevalence of mental health issues in the population
- Train on the need to decrease stigma with mental health issues
- Train on the use of the PDA's
- Train on diagnosing and medication management
- Train on referral resources in the community for clients with mental health needs
- Train on the "secured referral" or "warm hand off" model
- Train on how to get consults on psychotropic medication
- Do a pre and post test on information learned in the training

Nevada County will model their "First Responder" training after the national NAMI Crisis Intervention Training. Crisis Intervention Training was started in Memphis, Georgia when a mentally ill man was shot by the police. This training will help officers and fire fighters respond with safety to people with mental illness in crisis. We know that First Responders could often be a gateway into mental health services for people in our community if there was training. This project will decrease the disparity of services for people who may not otherwise get services.

Nevada County currently has a community collaboration group that is called the Forensic Task Force. This group includes the courts, law enforcement, Probation, Behavioral Health, and mental health consumer and family groups. This group examines our local systems to determine the community's need and agrees on strategies for meeting those needs and will help organize the First Responder Training. In Nevada County there are on average seven hundred "5150" evaluations done per year. About one quarter of those evaluations involved Law Enforcement. First Responder Training would make these evaluations and other law enforcement contact with people in a mental health crisis safer and in the long run getting individuals with mental health needs linked to resources.

First Responders will learn in this training:

- That mental illness is a disease of the brain
- The different types of mental illness
- How do they differ
- How do they affect behaviors
- The understanding that behaviors are driven by the illness. The person is often not in control of their behavior.
- To recognize the signs of psychiatric distress

- How to de-escalate a crisis
- How to appropriately engage family members in the situation
- How to avoid officer injuries
- How to avoid consumer deaths
- How to link people with appropriate services
- How to acknowledge that the person needs help and understanding what behaviors on the part of the first responder are most likely to result in a positive outcome

Nevada County 2-1-1 will have a call center that will take calls from people who are looking for help with a wide variety of needs, from looking for shelter, food, or looking for a mental health provider. This is an information and referral service with a personal follow up for callers who need this. For example someone can call who is experiencing social anxiety and is unable to leave their home. This person would receive a follow up call at an agreed upon time and phone number. This follow up call would make sure that they connected to the resources that they requested and see if they needed any additional resources. An additional feature is the 2-1-1 center uses a “warm referral model” because they connect the individual on the phone with resources as they are talking to them. A conference call is created with the caller, the 2-1-1 operator and the service provider. Additionally, this center has access to many languages by being connected to a language service that has approximately one hundred and fifty different languages available. The center has trained information and referral specialists speaking Spanish and who will help our emerging Latino population in finding resources. Caller’s identification is kept confidential.

Information Specialists are trained in screening for mental health needs even when the caller does not identify this need. They are also trained in how to introduce the possibility that the caller may need help with his mental health needs. These callers are offered services for these needs and are followed up with the “warm handoff” to a mental health provider if the caller is receptive.

Nevada County 2-1-1 offers enhanced services during and after a county wide emergency. Information will be provided to the Nevada County 2-1-1 by emergency personnel on the resource available to individuals affected. Nevada County 2-1-1 will help with the immediate needs from county wide emergencies as well as the long term effect of trauma of emergencies, referring callers to mental health treatment. Individuals experiencing trauma could use the call center for finding local mental health services or providers.

The Nevada County 2-1-1 committee, ‘Community Board’ will:

- Continue to meet as a User Work Group.
- Provide information and support to the lead agency Butte County Private Industry Council (PIC).
- Outreach and education about the 2-1-1 resource to all residents in Nevada.

- Continued coordination with Emergency Services in Nevada County and regionally.

The Butte County Private Industry Council (PIC) will:

- Be the lead 2-1-1 agency.
- Provide fiscal oversight.
- Maintain the data base on health and human services available to Nevada County residents: government, nonprofit and essential for-profit services.
- Contract with the twenty-four hour call center in Sacramento.
- Submit a 2-1-1 application to the California Public Utilities Commission.
- Securing usage reports.
- Providing training on Dial2-1-1 data base to 2-1-1 call center.

Sacramento 2-1-1 Call Center will:

- Answer Nevada County residents 2-1-1 calls on a twenty four basis.
- Provide trained Information and Referral professionals, who are trained to identify additional mental health needs that are not disclosed at first contact.
- Will provide follow up calls as required by written protocol by the Alliance Information of Referral Services (AIRS).
- Generate reports on call usage, number of follow ups, demographics and other data.
- Access Nevada County 2-1-1 data base of Nevada County resources.
- Rollover phone calls to other 2-1-1 centers if the necessary in an emergency.
- Provide a warm referral as per the AIRS written protocol requires.
- Provide confidential services.
- Callers will receive services no matter what language is spoken.
- Callers will receive services no matter what the disability.
- There is no charge to caller.
- There is no charge to listed agencies.

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	
<b>Access to Services</b>			
Suicide Prevention Program Prevention is the community training and Early Intervention is the case management of at risk individuals until they receive treatment.	Individuals: 100 Families: 20	Individuals: 20 Families: 5	Nine Months
Physician Integrative Behavioral Health Training Program will train 15 physicians per year. Each physician has about 1,500 clients.	Individuals: 22,500 Families:	Individuals: Families:	Six Months
First Responder Training	Individuals: 100 Families: 20	Individuals: Families:	Six Months
Nevada County 2-1-1 Services	Individuals: 3,000 Families:	Individuals: Families:	Ten Months
<b>TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED</b>	<b>Individuals: 25,700 Families: 40</b>	<b>Individuals: 20 Families: 5</b>	<b>Ten Months</b>

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

This component of our PEI plan is to help people link to the services they need. The four programs in this component will be working together to give people in the community increase knowledge of resources and easier access to these resources.

One of the main tasks of the PEI/Suicide Prevention Coordinator is to connect people in need to mental health resources in the private or the public sector and to follow the individual until they are receiving those services. The Coordinator will become Nevada County's resource guide expert. The Coordinator will be creating a resource guide that will help community members find the help they need. When he/she does trainings in the community he/she will be educating the community about resources we have in our county.

Physicians in the training will be trained on resources in the community for mental health treatment, including Nevada County Behavioral Health. Physicians will be trained on other resources in the community, including Nevada County 2-1-1, and will be given access to the data base that is going to be created by the PEI/Suicide Prevention Coordinator.

Law Enforcement and the Fire Departments will be trained on resources in the community, especially Nevada County Behavioral Health. Our Suicide Prevention Coordinator will be the contact person for Law Enforcement and the Forensic Task Force and will be available to help people connect to these resources. Nevada County also has a program that follows up with people who were not involuntarily placed in a hospital on a 5150 evaluation. This program is called COPE and is funded using MHSA CSS funds. In this program people who did not meet 5150 criteria are visited by a nurse who connects consumers to mental health treatment resources. First Responders will be trained on this resource as well.

The Information and Referral Specialists on the Nevada County 2-1-1 service will be trained in all of the resources, including mental health resources in our community and will refer callers to those services in the “warm referral system” as described above. They will refer clients to County Behavioral Health and any of its contractors, if appropriate for the caller. Our Nevada County 2-1-1 will be an important part of linking our citizens with needed mental health services in the community.

**6. Collaboration and System Enhancements**

All four of our Access to Services programs will collaborate and enhance our current mental health system. The PEI/Suicide Prevention Coordinator will collaborate with a multitude of agencies, businesses, and stake holders. The Coordinator will offer trainings in any arena that will open their doors to the training. The Coordinator will work with the Suicide Prevention Task force which as stated above is a task force that has representatives from many agencies, faith based groups, businesses, government groups and consumers and family members. The Coordinator and people on the Suicide Task Force will be involved in the creation and ongoing maintenance of the Suicide Prevention Website and the list of resources for suicide prevention. The Coordinator will be the central hub for this system collaboration

Physician Integrative Behavioral Health Training program will occur because of collaboration with the Northern Sierra Rural Health Network, The California Endowment, Sierra Family Medical Clinic and Behavioral Health. This training will enhance Nevada County resident’s ability to receive mental health treatment in the early stages of their illness. This training will create a safety network for our community. Northern Sierra Rural Health will collaborate with the hospital, and primary physicians. Nevada County Behavioral Health will be involved in helping to set up the training and will make available our PEI/Suicide Prevention Coordinator for resources and information.

Our “First Responder” training will be done in collaboration with Nevada County Behavioral Health, Law Enforcement, Fire Departments, Probation, NAMI, Spirit Center, Courts, Mental Health Consumers and Family Members. The training will be overseen by the Forensic Task Force which is a collaborative effort of all the above groups.

The Nevada County 2-1-1 project involves many agencies working collaborating. Nevada County 2-1-1 committee consists of the following agencies, FREED, First 5 Nevada County, Nevada County In Home Support Services, Truckee Family Resource Center, Nevada County Superintendent Schools of Office, Nevada County Department of Social Services, Community Collaborative Truckee Tahoe, Adult & Family Services Commission, HelpLine, and Area 4 Area of Aging. Behavioral Health is collaborating by helping to expand this service from a web based service to a twenty-four hour phone referral service.

## **7. Intended Outcomes**

Our desired outcomes for the Suicide Prevention Program will be:

- Twelve “Living Works” trainings done in the community in a year.
- All high school students will have a two hour “Living Works” curriculum training.
- Eighty percent of referred individuals are connected to resources.
- One hundred percent of referred clients will have follow up by the Program Coordinator.

Key Milestones for the Suicide Prevention Program will be:

- Have a person trained in training “Living Works” curriculum.
- Have a trained pool of 20 volunteers who can do the two and four hour “Living Works” Suicide Prevention training.
- List of resources created and distributed to community members.
- Referral process is in place and functioning that includes electronic, paper, and verbal requests.
- Baseline statistics of suicides is established and suicide data is collected monthly and shared with the Suicide Prevention Task Force.
- Suicide Prevention Task Force action plan is being implemented

Timelines for the Suicide Prevention Project

Task	07/09	08/09	09/09	10/09	11/09	12/09	01/10	02/10	03/10	04/10	05/10	06/10
Hire Coordinator/ contract												
Train Coordinator												
Create resource guide and maintain												
Create referral process												
Implement referral process												
Organize training plan												
Implement training plan												
Task Force Leadership												
Create and maintain Website												
Create the volunteer program												
Collect baseline data and evaluate data												

The desired outcomes for the Physician Integrative Behavioral Health Training Program

- Nevada County physicians will screen for mental health issues in their clients as part of their routine care.
- Nevada County physicians will participate in Integrative Behavioral Health training.
- Physicians will have received training on the use of the PDF and information on diagnosing psychotropic medication.
- Two trainings will occur in our community per year.
- Sixty percent of our primary care physicians will be trained in this model within three years.
- After attending this training physicians will:
  - Understand the need for mental health screening
  - Know the prevalence of mental health issues in the population they serve
  - Understand that mental health screening is a time saver for physicians and their staff
  - Understand how mental health stigmatization stops people from getting the help they need
  - Know how to use the PDA with psychological information
  - Be comfortable prescribing psychotropic medication
  - Be aware of mental health resources in the community
  - Be aware of how to get consultations on psychotropic medication
- Fifty percent of trained physicians will use a mental health screening tool in their offices.
- Fifty percent of trained physicians will develop a protocol on how to find a client mental health services if they are needed.

Key Milestones for the Physician Integrative Behavioral Health Program will be:

- Training is advertised to physicians in our community
- CEU's offered
- Two trainings will occur in our community per year.

The timelines for the Physician Integrative Behavioral Health Training Program

Task	07/09	08/09	09/09	10/09	11/09	12/09	01/10	02/10	03/10	04/10	05/10	06/10
Create Training Curriculum												
Create Training Plan												
Advertise training												
Conduct Training												
Report results to Nevada County Behavioral Health												

The Nevada County 2-1-1 Outcomes will be:

- Callers requesting mental health services are being connected to service providers or agencies to meet their needs.
- Information Specialists screen for mental health problems even if the caller does not at first identify that need.
- Gaps in services will be identified and brought to the attention of Nevada County Behavioral Health.

Key Milestones for the Nevada County 2-1-1 Program will be:

- The user group meets monthly.
- Butte County PIC contract with Sacramento 2-1-1 Call Center.
- Approved application by the California Public Utilities Commission.
- All of the Information and Referral Specialist are trained in Nevada County resources.
- Nevada County 2-1-1 Call Center will go live.
- Contact calls are tracked and reports generated.
- Gaps in services will be identified.
- Callers requesting mental health services are being connected to service providers or agencies to meet their needs.

The timelines for the Nevada County 2-1-1 Project

Task	07/09	08/09	09/09	10/09	11/09	12/09	01/10	02/10	03/10	04/10	05/10	06/10
Contract with Butte County PIC												
Approved by Public Utilities Commission												
Referral Specialists trained												
Nevada County 2-1-1 taking calls												
Calls tracked and reports generated												
Gaps in Service identified												

The First Responder trainings Outcomes will be:

First Responders will:

- Learn the basics of mental illness
- Recognize the signs of psychiatric distress
- Have more skills in de-escalating a crisis
- Learn how to appropriately engage family members in the situation
- Avoid officer injuries
- Avoid consumer deaths
- Link people with appropriate services

Key Milestones for the First Responder trainings will be:

- Two First Responder trainings will occur in the first year at the workplaces of Police, Fire and Ambulance personnel
- The Forensic Task Force will be involved in the planning of the trainings
- Nevada County Behavioral Health will
  - Create a system of referrals for Law Enforcement clients
  - Have the COPE team follow up on appropriate referrals
  - Have the PEI/Suicide Prevention Coordinator follow up on other referrals

The timelines for the First Responder Training

Task	07/09	08/09	09/09	10/09	11/09	12/09	01/10	02/10	03/10	04/10	05/10	06/10
Task Force organize training												
Training completed												
Evaluation of Training												

**8. Coordination with Other MHSA Components**

All four programs of the Access to Services Project will be trained in accessing our MHSA CSS programs. The PEI/Suicide Prevention Coordinator will provide training to all staff involved in the other MHSA components. The Coordinator will train individuals implementing CSS and other PEI components about suicide prevention and be available as a resource on an as needed basis. The Coordinator will train those involved in our Full Service Partnerships, School Mental Health Program, Elder and Disabled Adult Outreach Program, Latino Outreach Program, Homeless Outreach Program, Forensic Liaison Program, and our Prevention and Early Intervention for at Risk Children, Youth and Families Project, Law Enforcement, the Fire Departments and primary care physicians. Nevada County 2-1-1 will know of the Coordinator and make appropriate referrals to the Coordinator.

The Integrative Behavioral Health training for physicians will coordinate with other MHSA programs. Physicians will be made aware of the County Behavioral Health services and the expansion that the MHSA programs provide. They will be educated on how to refer clients to these services. They will be educated on the PEI/Suicide Prevention Coordinator, the Law Enforcement Liaison, and the Older and Disabled Adult Outreach Program so they can refer their clients to the appropriate needed resource.

First Responders can come from all areas of our county and will be trained on the mental health treatment resources we have in the community. Clients that the First Responders serve could be referred to our CSS Assertive Community Teams intensive services, network providers or Behavioral Health. These clients could be referred to our COPE (a MHSA CSS program) program for a follow up with a nurse, or they could be referred to Nevada County Behavioral Health for treatment. They could also be to a Full Service Partnership that was created using MHSA CSS funds. Individuals could also be followed by our new PEI Suicide Prevention Coordinator who will assist the consumer in finding some treatment for their mental health issues.

All other MHSA components will be made aware when the Nevada County 2-1-1 call center starts to take calls. The Nevada County 2-1-1 call center will have listed all of the MHSA resources in their directory. Their Referral Specialists will be trained in the different MHSA resources available in Nevada County.

County: Nevada

PEI Project Name: Outreach Project

Date: March 1, 2009

	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
<p><b>1. PEI Key Community Mental Health Needs</b></p> <p>Select as many as apply to this PEI project:</p> <ol style="list-style-type: none"> <li>1. Disparities in Access to Mental Health Services</li> <li>2. Psycho-Social Impact of Trauma</li> <li>3. At-Risk Children, Youth and Young Adult Populations</li> <li>4. Stigma and Discrimination</li> <li>5. Suicide Risk</li> </ol>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
<p><b>2. PEI Priority Population(s)</b></p> <p><b>Note: All PEI projects must address underserved racial/ethnic and cultural populations.</b></p> <p>B. Select as many as apply to this PEI project:</p> <ol style="list-style-type: none"> <li>1. Trauma Exposed Individuals</li> <li>2. Individuals Experiencing Onset of Serious Psychiatric Illness</li> <li>3. Children and Youth in Stressed Families</li> <li>4. Children and Youth at Risk for School Failure</li> <li>5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</li> <li>6. Underserved Cultural Populations</li> </ol>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>

We checked all of the above boxes, because nobody in our community is excluded. Our primary focus is our un-served cultural populations and trauma exposed individual and decreasing disparities in access to resources.

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

In our outreach to the community many voices were concerned about groups of people that did not have equal access to mental health services. The groups that were most identified were the Older and Disabled Homebound adults, the Latino Population, the Homeless population and the people involved in the Justice System. Nevada County has a large elder population. The 2006 U.S. Census stated that of Nevada County residents, 17.1% were over 65 years old. We had the elder population represented on our Prevention and Early Intervention committee. The PEI committee received a lot of feedback in many of our meetings that the community was concerned about our elderly and disabled population that were homebound. In our rural community there are not a lot of resources for this population for transportation and outreach to resources. Concerns were expressed for older adults and disabled adults being depressed and going unnoticed by the community. We had meetings with an organization called the Elder Care Providers Coalition which is an organization of fifty-four different groups that serve the elder and dependent adult population. A small sub-committee was formed of elder care providers to make recommendations to the larger committee on how we can serve the elder and disabled adult population. Many of our stakeholders who represented the older and disabled population stated that we needed home visitors to outreach to the homebound older and disabled adult. They stated that volunteers and nurses would be best received. They felt that this population values their independence and frequently comes from a generation that does not value mental health workers.

In Nevada County we have two areas where the Latino population is growing. We believe that this population is underserved, in accessing Spanish speaking resources. One of these areas is the Truckee Tahoe Basin which has about one fifth of Nevada County residents. The primary industry is recreation sports and the tourism industry to support the sports enthusiasts. The area has many homes that are second homes for wealthier county residents. It is also an area where there is a growing Latino population that serve the recreational areas and people who come to vacation. The 2006 U.S. Census said that 12 % of Truckee is Latino. Adela Valle, the Director of the Truckee Family Resource Center said that 50% of their kindergarten and first graders were students whose first language was Spanish. Our second area where there is a growing Latino population is Grass Valley. The elementary school that serves the Grass Valley area states that about 10% of their children come from homes where Spanish is the primary language.

We held three meetings in the Truckee area and many voices said that the Truckee Latino population was much underserved. There were issues of not enough professionals who spoke Spanish, transportation issues and not enough infrastructures in creating networking opportunities for Latino families. It was also stated that there is a lot of stigma and fear in the Latino population about reaching out for help with mental health issues. Some of the Latino population stated it was shameful to be “mentally weak.” It was also stated that many of Truckee’s Latino population are fearful of seeking services, because not all of their family members are legal citizens. We held a meeting in Spanish and English at the Family Resource Center in Truckee. It was stated that there is a large group of Latino families where depression is going untreated. They are particularly concerned about new mothers, especially in the winter.

The winter weather in the Truckee Tahoe region can be very confining and long; many of these new parents are separated from their natural family supports and have little connection to outside community.

Nevada County has small Promotores programs in the Truckee and Grass Valley areas. This is a program where bi-cultural and bilingual paraprofessionals help Latino families connect to resources mostly for physical health care in the community. They work out of the Family Resource Centers and generally the programs are small and underfunded.

We also spoke to the Promotores that work in the Grass Valley area and they echoed many of the same concerns. These Promotores work for the Family Resource Centers in Grass Valley (El Colaborando en Espanol) and Truckee (Empiezos Maravillosos).

Nevada County homeless frequently live in the woods or by one of our many rivers and lakes. We recently did a homeless count and found about 300 individuals living in tents or different temporary shelters in the woods, in emergency shelters, transition houses, couch surfing, or in facilities not fit for habitation. Our homeless community represents all ages and ethnic backgrounds. Many of our homeless are chronically and severely mentally ill. Additionally, many of our homeless are people who mistrust government and government services.

Nevada County has limited resources to house our homeless population. We have one family transitional housing facility, Booth Center. This facility can house nine families per night. The only emergency homeless shelter we have provides shelter and food to singles and families, but only has a capacity of 40 individuals per night. This shelter is a nomadic homeless shelter. This means that each night the homeless sleep in a different location. An agency called "Hospitality House" hosts and organizes this operation. Hospitality House works with a consortium of faith communities that open up their sanctuaries at night. People check in between 1:00 and 4:00 PM at the Hospitality House Welcome Center in downtown Grass Valley where they are served lunch, can shower and do laundry, received case management services, and are used to the church that is hosting the shelter that night. At the host facility participants are served an evening meal and breakfast by one of 25 participating faith communities. This overnight shelter program runs from October 15 through April 30. In the summer months Hospitality House operates as a daytime drop in center Monday through Friday from noon until 4 PM. Additionally, some of our chronically and severely mentally ill homeless population receives services from SPIRIT Center our Peer to Peer counseling center.

In our PEI outreach and education to the community we received feedback that the community is worried about our homeless population and their lack of resources for mental health treatment. People in all areas of our county expressed this concern. The Latino population in the Truckee area expressed concern about the homeless. SPIRIT Center and Hospitality House have asked for help getting their chronically and severely mentally ill participants into services.

Our Law Enforcement agencies and our local jail officers have told us that they constantly deal with citizens who are struggling with mental health issues. They say they do not feel equipped to handle these people and feel that the mental health system is not adequately helping them. Many of these people have never had any mental health treatment. They state there is a need for someone to help people in the justice system access mental health resources. They also state there is a need for parenting, anger management groups and general mental health groups in the jail. They believe that these groups could prevent violence in and out of jail and recidivism. Our local NAMI chapter is also concerned that the justice system is often where people end up who really need mental health treatment. Our local homeless shelter has also stated that they see many people who are involved in the justice system that could be better served in the mental health system.

When someone experiences a psychiatric crisis and acts out as a result of symptoms of their illness, law enforcement officers are often the first-line responders. Jails and prisons, rather than medical facilities, are increasingly used to house and treat people with mental illnesses. Once incarcerated, people with mental illnesses do not receive the services that they need, are vulnerable to abuse, and have difficulty reconnecting with services on release. The result, for many, is years of cycling between prisons and jails, shelters, and emergency rooms. This cycle is costly for communities, a burden on law enforcement and corrections, and tragic for people with mental illnesses. People with serious mental illnesses create a financial burden on law enforcement and corrections -- money that would be better spent maintaining public safety and getting people with mental illnesses the treatment they need before they encounter law enforcement. Law enforcement officers report that they spend more time in the disposition of “emotional disturbance” calls, and that they do not feel properly prepared to respond to someone in a psychiatric crisis. Frequently officers may not want to arrest someone who is obviously in need of psychiatric care, but they do not know what treatment options are available, and feel they have little choice.

### **PEI Project Description:**

It was decided to create a program where homebound disabled and older adults could be seen in their home and screened for mental health issues. All areas of the county will be served as well as all racial, ethnic and cultural populations. We would have trained volunteers visit this population with a backup system of using our Senior Outreach Public Health Nurses. The Senior Outreach Public Health Nurses would also take referrals for homebound disabled and older adults. These referrals could come from the “Friendly Visitor” program volunteers or from anyone in the county. The Senior Outreach Public Health Nurses and volunteers would assess for depression using the Beck’s Depression scale or a similar tool and would refer consumers to their primary care physicians.

Additionally, we plan to double our “Friendly Visitor Program.” This is a current program that has trained senior or adult volunteers to visit home bound adults. The “Friendly Visitor Program” is currently located in an agency that supports independent living for

*adults with disabilities and older adults.* Our current “Friendly Visitors” does not have a program director because of lack of funding. We would hire a part time Program Director whose goal would be to increase the number of trained volunteers and maintain the volunteer pool. These volunteers or “Friendly Visitors would be assigned consumers and would see these people on a regular basis. This program would be housed in an agency that provides services to disabled and older adults.

Our part time Director of the “Friendly Visitor Program” would

- Be a part of the User Task Force.
- Create a referral system for homebound disabled and older adults.
- Advertise their services.
- Recruit volunteers.
- Train volunteers.
- Serve as a backup to volunteers.
- Take referrals from the community on homebound disabled or older adults.
- If necessary “cold call” these referrals, introducing themselves and asking if they could come by and visit.
- Attempt to connect the consumer with other resources and/or family.
- Connect the disabled or older adult with his or her primary care physician.

Our Friendly Visitors would:

- Would be volunteers.
- Be trained in mental health screening.
- Would be able to use the Beck’s Depression or similar inventory.
- Take referrals from the community on homebound disabled or older adults.
- If necessary “cold call” these referrals, introducing themselves and asking if they could come by and visit.
- Visit the homebound disabled or older adults.
- Set up a regular visitation schedule with homebound disabled or older adults.
- Refer the homebound disabled or older adults to the Senior Public Health Nurse if they thought that the consumer needed some further intervention.
- Support the homebound disabled or older adults to seek outside treatment for their mental health needs.
- Attempt to connect the consumer with other resources and/or family.

We would also increase our Senior Outreach Public Health Nurses by .5 FTE. This Senior Outreach Public Health Nurse would be stationed with Adult Protective Services and would serve referred older and disabled adults who were in need of mental health

services. Our Senior Outreach Public Health Nurses currently take referrals for consumers who have concerns about their physical health. Assessing for mental health is a new job duty for these nurses, as well is the increased 0.5 FTE job position.

Senior Outreach Public Health Nurse would:

- Create a referral system where anyone in the community can refer disabled or older adults.
- Create and publicize a phone line for referrals.
- Advertise their service.
- Do home visits to disabled and older, home bound adults
- Assess the consumer's mental health using the Beck's Depression Inventory or another tool.
- Educate the consumer about depression and suicidality.
- Connect the consumer with their primary care physician and if necessary Adult Protective Services.

The partners on this project would be Elder Care Provider agencies, Adult Protective Services, Public Health and a group of trained volunteers.

Actions to be preformed to carry out to create Older and Disabled Adult Outreach:

- Create a User Task Force that includes all partners.
- Create a referral system.
- Create a dedicated phone line for the Senior Outreach Public Health Nurses.
- Advertise the phone line.
- Create Procedures and Policies on Disabled and Older Adult Outreach, where roles and partnerships are clearly stated with the "Friendly Visitor Program" and the Senior Outreach Public Health Nurses.
- Create a support structure for the Senior Friendly Visitor Volunteers.
- Hire/ Contract a half time Director of the Senior Friendly Visitor Program.
- Advertise the Friendly Visitor Program.
- Have 50 volunteer "Friendly Visitors" within one year.
- Connect "Friendly Visitor" Volunteers with at least one home bound disabled or older adult within two month of finishing training.
- Train all nurses and volunteers in the use of depression scales and suicidality.
- Train all nurses and volunteers in the two day "Living Works" workshop on Suicide Prevention.
- Give the Beck's Depression or similar inventory at the beginning of the Disabled and Older Adult Outreach and within two months of services.

- Create data base and keep statistics on outreach.

Nevada County would like to serve our Latino population by increasing the “Promotores Program” where the Promotores will conduct outreach, psycho-educational groups for Latino families in Spanish. It would be a six week group that would be offered two times per year. The psycho-education group will educate people attending about mental health and attempt to decrease stigma about reaching out for help with mental health issues. Childcare will be offered.

The Promotores would:

- Increase their hours with the Family Resource Centers.
- Be trained on mental health education.
- Be trained on “Living Works” Suicide Prevention.
- Be trained on the Beck’s Depression or similar Inventory tool.
- Create a curriculum with a licensed therapist for the psycho-educational groups.
- Obtain supervision from a licensed therapist.
- Advertise group and do outreach.
- Conduct two, six week psycho-educational groups yearly at the Family Resource Center of Truckee and Grass Valley in Spanish.
- Educate the Truckee Latino population on mental health.
- Reduce stigma about reaching out for help with mental health issues.
- Organize Childcare for the Psycho-educational Groups.
- Give the Beck’s Depression or similar Inventory to individuals who they are concerned about.
- Refer clients to the bi-lingual, bi-cultural therapist.
- If necessary, accompany clients to their first appointment with the therapist.

Nevada County will serve the Latino population by partnering with Placer County and hiring a bi-lingual therapist who would take referrals from the Family Resource Centers (FRC), the local Promotores Programs and the Woman Infant Child (WIC) Program. The referral sources would be trained in using the Beck’s Depression or similar Inventory. Individuals who scored high on this tool would be referred to a bilingual therapist that both Placer and Nevada County have hired. This therapist would be doing early short term intervention with individuals whose mental illness has recently manifested. This therapy would occur in the Family Resource Centers or in the family’s home. This therapist would be trained in Cognitive Therapy for depression. The therapist could have up to ten sessions with a referred consumer, and would serve clients all over the county.

*This bi-lingual, bi-cultural therapist would:*

- Be trained in short term Cognitive Therapy for depression.
- Be trained in “Living Works” suicide prevention.
- Regularly consult with the Promotores.
- Be involved in the creation of the Psycho education groups done in the FRC’s by the Promotores.
- Attend some of the psycho-educational groups.
- Treat referred clients with up to ten sessions.

*Actions to be taken to start this project:*

- Create a User Task Force that would include Placer County, Nevada County, The FRCs, WIC and any other group identified by the above listed members.
- Increase Promotores’ hours worked.
- Hire/contract a bi-lingual, bi-cultural therapist.
- Train bi-lingual, bi-cultural therapist in short term Cognitive Therapy for depression.
- Train the Promotores on Mental Health Education and resource materials.
- Train the Promotores, the Family Resource Centers, the WIC centers and other task force members on the use of Beck’s Depression Scale or similar tool.
- Train the Promotores and the bi-lingual, bi-cultural therapist on Suicide Prevention using the “Living Works” materials.
- Create an ongoing consultant group of the therapist and the Promotores.
- Create a referral system to the bi-lingual, bi-cultural therapist.
- Create a curriculum for the Psycho-education group.
- Advertise psycho-education group.
- Conduct two six-week psycho-education groups throughout the year.

In our Homeless Outreach Project we will hire a part time case manager to go to the where homeless people are and attempt to build connections and trust, help individuals get benefits they are entitled to, and assist in connecting them to treatment services. This case manager will go to Hospitality House every afternoon when people gather. The case manager will be on call and go to the SPIRIT Center, Booth Center, Truckee or other outlying areas on an as needed basis. The case manager will start the intake process for Adult Behavioral Health, refer and help connect individuals to drug treatment and help people apply for Social Security Income. A team of service providers: Social Services, Public Health and Behavioral Health; will be created to collectively case manage this homeless population.

The case manager will:

- Go to where homeless people can be found.
- Be at Hospitality House daily.
- Go to Booth Center on a weekly basis.
- Go to SPIRIT Center on as needed basis.
- Go to remote outlying areas as needed.
- Ask the homeless individuals what services they need.
- Educate the homeless on mental health and substance abuse issues.
- Start the Behavioral Health intake process for the chronically and severely mentally ill homeless population.
- Help clients with their first appointments with physicians or other providers.
- Help appropriate clients apply for Social Security Income and other benefits.
- Help clients connect to low income housing.
- Help clients to connect to the CalWORKs one stop office.
- Refer appropriate clients to our Access team.
- Start a data base of the outreach services.
- Compile data on outreach services.

Actions to be taken to start Nevada County Behavioral Health's Homeless Outreach:

- Create a Homeless Outreach User Task Force, including Hospitality House, Booth Center, SPIRIT Center, Truckee Health and Human Services, Public Health, Social Services, CalWORKs One Stop Shop, Behavioral Health, mental health consumers, family members and others.
- Create a team of people who will be responsible to help the homeless individuals that are discovered in this outreach.
- Train case manager on homeless issues.
- Train case manager on Suicide Prevention.
- Train case manager on mental health screening.
- Create a referral process.

In our Forensic Liaison Program We decided to fund a half time position called a Forensic Liaison. This person will serve as a Liaison with Law Enforcement and Nevada County Behavioral Health. They will serve people who are involved in the justice system and are not getting mental health services or need help re-instating those services. The Forensic Liaison's purpose will be prevention of further justice involvement and early intervention on mental health issues so people involved in the Justice system could lead more productive lives.

The Forensic Liaison will:

- Outreach to the Law Enforcement community and to the County Jail and offer their resources
- Create a referral system for clients who are involved with the justice system who need mental health resource
- Link referred people to mental health services in the private or public sector
- Help referred people get Social Security benefits if they qualified
- Conduct psycho-education groups in the jail
- Assess people in the jails if the Jail Commander requests
- Be available to help de-escalate inmates in the jail that appear to be having a mental health crisis

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
<b>Outreach Project</b>	Prevention	Early Intervention	
Older and Disabled Adults	Individuals: 60 Families: 15	Individuals: Families:	Nine Months
Latino Outreach: The Psycho-educational groups are Prevention and the short term Cognitive therapy is Intervention.	Individuals: 35 Families: 20	Individuals: 10 Families:	Six Months
Homeless Outreach	Individuals:30 Families: 10	Individuals: Families:	Nine Months
Forensic Liaison	Individuals:70 Families:	Individuals:10 Families:	Seven Months
<b>TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED</b>	<b>Individuals: 195 Families: 45</b>	<b>Individuals: 20 Families:</b>	<b>Nine Months</b>

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

All of our Outreach Project components will be trained in linking to Nevada County Behavioral Health and providers of other services. Our Older and Dependent Adult Outreach is linking a number of different providers and agencies. Adult Protective Services, Public Health, Behavioral Health, and the Elder Care Providers Coalition will be working together to create a system that

will effectively serve this population. The Elder Care Providers Coalition has many providers of needed services and will be part of the resources for served clients.

In the Latino Outreach Project the Family Resource Centers will link the individuals and families that they serve under this project to needed services in the community. They will link families to County Behavioral Health if they think that they need this level of service. The Promotores will provide the language link if necessary for individuals and families to get other services in the community.

In order for our community to solve the problem of homelessness we need to all collaborate together. In our Homeless Outreach project Nevada County Social Services, CalWORKs One Stop Shop, Public Health, service providers and Behavioral Health will create a Homeless Outreach Team. This team will provide support to the Homeless Outreach Case Manager. The Homeless Outreach case manager will need to constantly link their clients to other needed services and will need to create a system where this can happen easily. This Homeless Outreach Case Manager will lead this linkage.

In the Forensic Liaison Project the primary jobs will be to connect referred people to appropriate resources, especially Nevada County Behavioral Health. This Liaison will assess referred people's mental health needs and other immediate needs and find resources for people in our community that would meet these needs. The Liaison will increase the communication and partnership with Law Enforcement, the County Jail and County Behavioral Health. This Liaison will be part of our Forensic Task Force whose members are the Courts, Probation, Law Enforcement, NAMI, mental health consumers and family members, SPIRIT Center and Nevada County Behavioral Health.

## **6. Collaboration and System Enhancements**

In our Older and Disabled Outreach Program Adult Protective Services, Public Health, Behavioral Health, FREED (an organization supporting the independence of disabled adults and the Elder Care Providers Coalition will collaborate on increasing our outreach to older and disabled adults. The increased outreach to homebound people with the intent of screening for mental health issues is an enhancement of our current system.

The two Family Resource Centers that serve the Latino population will collaborate together along with Nevada and Placer County Behavioral Health to create enhanced outreach and serves to the Latino population. A Promotores mental health education and supervision group will be created enabling these paraprofessionals to help decrease mental health stigma and enable the Latino population to receive needed mental health services.

Our homeless shelters, Hospitality House and the Booth Family Center along with Nevada County Social Services, CalWORKs One Stop Shop, Public Health, Behavioral Health and the Family Resource Centers will all collaborate to create a system where it will be easier for homeless individuals to access mental health and other resources. The Homeless Outreach Case Manager will enhance this collaboration by being the central organizer for this work.

The Forensic Liaison would increase the collaboration with Law Enforcement, the County Jail, the Courts and County Behavioral Health. As stated above the Forensic Liaison would be an important part of the Forensic Task Force a collaboration of a number of different agencies and stake holders that meets monthly.

## **7. Intended Outcomes**

Our Outcomes of the Disabled and Older Adult Outreach will be:

- Increase the amount of volunteers for the “Friendly Visitor” program to 50 people within one year of receiving funding.
- Connect “Friendly Visitor” with at least one homebound disabled or older adult within two months of training the volunteer, in the first year.
- Visit homebound disabled or older adults at least once per month.
- Assess the Disabled or Older Adults mental health status
- Obtain mental health treatment for 80% of individuals who need it.
- Decrease scores on the Beck’s Depression index for consumers who score high, within six months by 20%.

Key Milestones for the Disabled and Older Adult Outreach will be:

- A User Task Force would create and maintain a referral process for beginning the Disabled and Older Adult Outreach within two months of receiving funding. This task force will represent all areas of the county.
- The User Task Force would create and maintain policy and procedure on Disabled and Older Adult Outreach within two month of receiving funding.
- Hire/contract a part time Director of the “Friendly Visitor” program within three months of receiving funding.
- Increase the hours of the Senior Public Health Nurses within one month of receiving funding.
- Create and advertise a phone line for community members to call when concerned about a disabled or older adult within two months of receiving funding.
- Train all nurses and volunteers in the use of depression scales and suicidality by October 2009.
- Train all nurses and volunteers in the two day “Living Works” workshop on Suicide Prevention by January 2010.
- Newly hired Senior Nurse visits at least 30 new clients the first year.

- Create Data base

Timelines for the Older and Disabled Adult Outreach Project

Task	07/09	08/09	09/09	10/09	11/09	12/09	01/10	02/10	03/10	04/10	05/10	06/10
User Task Force created												
Hire a Director												
Hire .5 FTE nurse												
Create Policy & Procedure												
Phone line installed and operational												
Recruit Volunteers												
Home Visits are occurring												
Depression screening training												
Living Works Training												
Data Base												

Outcomes to be achieved by the Latino Outreach Project

- Bi-lingual therapist treats 15 consumers by June 2010.
- Treated consumer's depression scale score will increase by 20%.
- Curriculum is created for Psycho-educational group with the consulting therapist and the Promotores by December 2009.
- Twenty families have received education on mental health issues and know how to access resources for help.

Key Milestones for the Latino Outreach Project will be:

- User Task Force created.
- Promotores hours increased.
- Promotores educated on mental health issues.
- Promotores educated in the use of the Beck's Depression Inventory or similar tool.
- Bi-lingual therapist hired.
- Promotores and the bi-lingual therapist are educated in Suicide Prevention by using the "Living Works" curriculum.
- Referral system is created to refer consumers to the bi-lingual therapist.
- Group is advertised.
- One six week session of psycho-educational will have occurred.

- Create data base.
- Data is reported monthly to the User Task Force.

Timelines for the Latino Outreach

Task	07/09	08/09	09/09	10/09	11/09	12/09	01/10	02/10	03/10	04/10	05/10	06/10
User Task Force												
Increase Promotores time												
Hire therapist												
Train therapist												
Tram Promotores												
Create consultant group												
Create referral system												
Group Curriculum created												
Advertise group												
Conduct one six week group												
Therapist seeing referred clients												
Data base created												

Outcomes to be achieved by the Homeless Outreach will be:

- 90% of chronically and severely mentally ill clients will be referred to the County person who helps people apply for Social Security Income.
- 90% of chronically and severely mentally ill clients will be offered psychiatric services.
- 70% of clients with a drug problem will be offered drug treatment services.
- Enroll 10 clients in the first year into Behavioral Health Services.
- Decrease the homeless population by 5% the first year.

Key Milestones for the Homeless Outreach will be:

- User Task Force created.
- Referral Process created.
- Homeless team created with Social Services, Public Health, CalWORKS, Behavioral Health, Hospitality House, Booth Center, SPIRIT Center, service providers, consumers, family members and others that will be collectively responsible to connect the homeless client with services in the community.

The timelines for the Homeless Outreach

Task	07/09	08/09	09/09	10/09	11/09	12/09	01/10	02/10	03/10	04/10	05/10	06/10
User Task Force Created												
Hire Case Manager												
Referral Process Created and Implemented												
Action Team Formed												
Training												
Data base created												

The Intended Outcomes for the Forensic Liaison Program are:

- Connect 80% of referred clients to mental health services and/or other benefits
- Connect 100% of referred homeless clients to the Homeless Outreach Coordinator
- Conduct psycho-educational groups at the county jail

Key Milestones for the Homeless Outreach will be:

- Multi-agency Task Force create job description and policy and procedure around Law Enforcement Forensic Liaison position
- Law Enforcement Forensic Liaison hired/contracted
- Law Enforcement Forensic Liaison will:
  - a. Be out stationed at Law Enforcement headquarters or county jail
  - b. Educate and outreach to all Law Enforcement agencies and Fire Departments in the area
  - c. Create a referral process
  - d. Create and maintain date base

The timelines for the Forensic Liaison Program

Task	07/09	08/09	09/09	10/09	11/09	12/09	01/10	02/10	03/10	04/10	05/10	06/10
Task Force create Policy and Procedure												
Hire/Contract Liaison												
Create referral process												
Case manage referral clients												
Conduct psycho-educational groups in the jail												
Data base												

## **9. Coordination with Other MHSA Components**

The Older and Disable Adult outreach component will work closely with the Suicide Prevention Coordinator to receive training and have access to resources. It can also refer clients to our Full Service Partnerships if they qualify for this level of treatment. Generally this population will be referred to their primary care physicians for treatment if any mental health issues are found. It is hoped that these physicians will be trained by our PEI Physician Integrative Behavioral Health training. The Older and Disabled Adults will also be referred to Nevada County Behavioral Health or to a private sector therapist if there is a need.

The Latino Outreach Program will be coordinated with a number of different MHSA projects. The Suicide Prevention Coordinator will help train and educate the Promotes and will do trainings for the Latino population. The Promotores and the Family Resource Center can refer clients to the Suicide Prevention Coordinator for resources and treatment if necessary. They can also ask for help with the Law Enforcement Liaison if one of their clients is involved in the Justice System. Latino children will receive psycho-educational groups under the PEI “Teaching Pro-Social Skills in the Schools” and Spanish speaking parenting classes will be offered under this project as well. The Family Resource Centers already refer clients to our CSS Full Service Partnerships.

The clients served with the Homeless Outreach component would be referred to Nevada County Behavioral Health for mental health services. These services could be coordinated with the CSS Full Service Partnerships. Appropriate clients can be referred to our Assertive Community Team which could give these people intensive services. Families could be referred to our children’s wraparound program for intensive services. These homeless clients could be served by the PEI Suicide Prevention Coordinator or the Law Enforcement Liaison, if these serves were needed.

The Law Enforcement Liaison will coordinate services for people involved in the juvenile justice system that need mental health services. S/he will be aware of all of the MHSA programs in the county that could serve this population. People could be referred to our CSS Community Assertive teams, to the PEI Suicide Prevention Coordinator, the PEI Homeless Outreach Case Manager and/or The Early Intervention Team.

County: Nevada  
 PEI Project Name: Prevention and Early Intervention for at Risk Children, Youth and Families.  
 Date: March 13, 2009

	Age Group		
	Children and Youth	Transition-Age Youth	Adult Older Adult
<b>1. PEI Key Community Mental Health Needs</b>  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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

	Age Group		
	Children and Youth	Transition-Age Youth	Adult Older Adult
<b>2. PEI Priority Population(s)</b> <b>Note: All PEI projects must address underserved racial/ethnic and cultural populations.</b>  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 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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

In our PEI for at Risk Children, Youth and Families we are teaching pro-social skills, increasing screening, increasing our mentoring programs and creating short term early intervention therapeutic programs for at risk youth. At all of our meetings people spoke about the need for more screening and services for children and youth. Many Nevada County residents told us in our meetings that they thought students in our schools should be educated about mental health, social skills and violence prevention. Most thought this should be done at an early age. They thought education about mental health would reduce stigma, decrease bullying and make it easier for children to learn in school. They were concerned that children were not tolerant of differences or students who were emotionally fragile and that there was a lot of bullying in the schools and children with mental health issues often became the target. When we met with the school administrators they also voiced the above concerns. They said that they would like to include in their curriculum teaching social skills, emotional management, problem solving and cooperation. All hoped teaching pro-social skills would make the classroom a better place to learn and that the teachers would have to spend less time on discipline. It was also believed that if we give our children the tools to handle conflict and emotions we would see less violence and school disruption throughout the child's life.

In our outreach to our community we also heard many different stakeholder groups shared their concerns about youth needing treatment and going unnoticed. All expressed a hope that we as a community could identify our young who are struggling with poor mental health and get them early intervention. The Nevada County Superintendent of Schools expressed a desire to identify children and youth and get them treatment early in hopes that these children could be successful in school. Parents, teachers, principals, and school counselors have stated the need for better screening and referral processes in their schools. The Children's System of Care Executive Committee concurred with this hope. At one of our outreach meetings in Truckee the Latino population made an emotional plea for help with their teens, stating the need for early identification and intervention. At our meetings with members of NAMI many people said what would have helped them or their family members was to have their loved one's illness identified earlier. NAMI has written a statement on how they would like to see PEI funds spent in the community and they have supported the idea of mental health screening in the middle and high schools.

At every meeting we held in our community people spoke about the need to mentor children and youth. Our community is concerned about children who do not have a strong adult in their lives. At the same time it was said that giving our adolescents leadership roles and opportunities to give back to the community is preventative factor in these young adult's lives. In our communities there are a number of different mentoring programs; in some of these programs the mentoring take place in the community and in others the mentoring takes place in the schools. Our school based mentoring programs connect older teens to mentor young children in the schools or have a trained aid that connects with the child. In our community a couple of the school based programs are losing funding.

We have been asked by a number of people in the community to help continue and expand these programs; because these programs help children build resilience, feel safe and connected at school.

We also heard at every meeting that the community was concerned about youth who were starting to use drugs, not doing well in school, and getting in trouble in and out of school. At the same time the community expressed concerns about children and youth who are being neglected and abused and come into contact with the Child Welfare system. Most of the concerned people felt we did not have enough services for children in these situations. Many asked if there was something that could be done early in order to help these children walk down a different path and live in a safe situation. At every meeting there were concerned parents who said we needed more programs for youth at risk. All areas of the county and all ethnicities presented with these concerns, many using the analogy that we needed to go up stream to pull our children out of trouble before they had a serious drug problem and/or were in the county juvenile hall or jail. It seemed widely accepted that increases in delinquency are rooted in a number of interrelated social problems in our community, i.e., child abuse and neglect, alcohol and drug abuse and that it originates within the family structure. Probation has asked for a program where they could send their youth that they just identified as beginning to get into trouble. Child Welfare has asked that we find a program that could help the children they encounter who are starting to get into trouble because of poor parenting at home. The schools have said that they often know youth who are going to end up in Juvenile Hall, in the Probation system and/or using drugs and they asked for a program to serve these children. Child Welfare has said that they get hotline referrals for children that do not rise to the level of court intervention, but there is a need for early intervention to stop further referrals.

### **3. PEI Project Description:**

Nevada County PEI committee has decided to fund four programs of the Prevention and Early Intervention for at Risk Children, Youth and their Families. These components are (1) Teaching Pro-social skills in the schools, (2) Mental Health Screening in the Schools, (3) Child and Youth mentoring, and (4) Early Intervention for Referred Children and Youth. The Teaching Pro-social Skills component will increase the SECOND STEP program in the schools. The Mental Health Screening component will offer parents of middle or high school youth the opportunity to have their children screened for depression and anxiety. The screening tool we plan on using is called “Columbia Teen Screen.” We want to increase the school mentoring we have in our county. Lastly we want to create a team of therapists who would do short term intervention, using “Functional Family Therapy’ and “Trauma Focused Cognitive Behavioral Therapy” for children found to be at risk.

SECOND STEP will be implemented in the elementary and pre-schools and is in the SAMHSA National Registry of Evidence-based Programs and Practices. It is a classroom based social skill program that teaches socio-emotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. The program builds on cognitive behavioral intervention models integrated with social learning theory, empathy research and social information processing theories. Each curriculum contains five

teaching kits that build sequentially and cover empathy, impulse control and anger management in developmentally and age appropriate ways. An estimated 27,000 schools across the United States have implemented SECOND STEP since the program's inception in 1987. Since 2000, nearly 12 million students and 3 million adults have participated in SECOND STEP. Different studies have shown an increase in pro-social skills, fewer anti-social behaviors, reduced physical aggression in the classroom and heightened feelings of inclusiveness and respect. We currently have a few schools and preschools that are using SECOND STEP and we would like to increase the number of students exposed to this curriculum using PEI funds. It was decided with the Nevada County Superintendent of Schools, the First Five Commission, the thirteen different school districts and many school principals that we would implement the SECOND STEP curriculum from pre-schools through the fifth grade and in some schools up to eighth grade.

Our local First Five commission, First Five Nevada County will oversee the expansion for all of Nevada County pre-school program. In Nevada County we currently have 135 licensed childcare/preschool providers. The Superintendent of Schools in Nevada City and in Truckee will oversee the expansion of SECOND STEP in the elementary schools.

First Five Nevada County will:

- Give onsite training to twelve pre-schools and/or childcare providers each year. Preschool teachers and childcare providers cannot come to trainings off site, because they do not have substitutes and typically work very long days. First Five Nevada County has found what works is taking the training to the preschool teachers at their own site.
- The trainer will do six weekly sessions with the teacher in the classroom.
- The trainer will come back twice over the next 12 weeks to observe the teacher and provide support and guidance.
- Purchasing for the schools and regional parent training in six week sessions in Spanish and English would be provided to each pre-school and childcare provider.
- Track changes in children's social emotional development using the Desired Results Developmental Profile (DRDP).
- Track changes in parent's understanding and self reported behavior using parent evaluation from SECOND STEP.

Our expansion of the SECOND STEP program to elementary age children will be done in partnership with Superintendent of Schools.

Nevada County Superintendent of Schools will:

- Identify trainers for each school district.
- Host training where SECOND STEP personnel will train trainers on using their curriculum.
- Each school district will use these trainers to train Kindergarten to Fifth grade teachers and some school districts will train sixth through eighth grade teachers on SECOND STEP.
- Implement SECOND STEP.

Nevada County is planning on starting a new program that would involve screening youth using the “Columbia Teen Screen” in the middle schools and the high schools. The Columbia Teen Screen involves active consent from the parent and the youth. We would offer the opportunity to screen youth to all parents with children in our middle and/or high schools. Our initial pilot project will begin in the alternative schools. Screening will be made available in English and Spanish. We will hire one and half full time equivalent staff to do this job. One of these people will be a licensed clinician and the other a bachelor’s level case manager.

Columbia Teen Staff will:

- Organize screening process with the school.
- Obtain active assent from the youth and his/her parents or guardians.
- Conduct screening in a private way.
- Interview youth independently if they score negatively on the screening tool.
- Triage youth if necessary.
- Contact all parents within 24 hours if youth scores high on the screening tool.
- Contact the family weekly until the youth is in treatment.
- Help the family find treatment resource for the child.
- Disseminate materials about depression and suicide to the family.
- Continue to case manage the family until the youth has seen a treatment provider for three sessions.
- Follow up with the youth and family to determine if the youth is out of the high risk range.
- Conduct a Cognitive Behavioral Group in the schools for youth that do not have the resources to find outside therapy.
- Provide case management for high risk youth identified by the screening tool.

Actions to be performed to carry out the School Mental Health Screening Program:

- Hire and have contracts in place for services to be provided.
- Create User Task Force to plan and implement the “Columbia Teen Screen” in the middle and high schools. Task Force will include parents, youth, teachers, school counselors, principals and school superintendents.
- Contract with “Columbia Teen Screen” to use their tool.
- Train the staff on “Columbia Teen Screen.”
- Train the staff on Cognitive Behavioral Therapy for youth depression.
- Create resource guide.
- Create a referral process.
- Offer universal screening to middle and high school students.
- Connect with 100% of the parents of youth who have scored negatively on the screening tool.

- Follow youth until they have been seen by an outside professional for three sessions, before closing case.
- Re-interview youth and their parents or guardians to see if there has been improvement in their mood and suicide risk.
- Start a Cognitive Behavioral group for youth who do not have any health insurance and have scored high on the “Columbia Teen Screen.”
- Create data base and evaluate data.

Our implementation partners are the Nevada County Superintendent of Schools, high school and middle school principals, counselors, nurses and teachers. This screening will be done in the schools.

Our in school mentoring programs are a well accepted part of our community and the community’s goals have been to expand these programs. These programs help to increase children’s self esteem, the sense of community and connectedness. The Mentoring programs that use adolescents as mentors have the same result for the adolescent mentor. These children and youth will be more successful with their school work with this connection. The Prevention and Early Intervention committee would like to fund mentoring programs that take place in the schools. These programs connect a teen with an elementary school child or they connect a caring adult with the child. The mentor comes to the child’s school and visits with him for 45 minutes per week. During these visits, they can do some academic work and also play together. These weekly meetings continue throughout the school year.

Lastly a team of early intervention therapists would be created who would use “Functional Family Therapy” and “Trauma Based Cognitive Therapy” and they would take referrals from Probation, Child Welfare, Schools, the courts, the SMART (Special Multi Agency Resource Team) team, STAR team (committee of high school counselors who identify youth at risk) and the Community. This team would treat youth who have just been identified as having an early stage substance abuse problem or were just starting to get into trouble in school or in the community. The team would be out-stationed in our Family Resource Centers and schools. The team would screen all referred children and decide what modality to use with the child and family.

Thirty years of clinical research indicate the Functional Family Therapy can prevent the onset of delinquency. This team would target youth ages 11-19 from a variety of ethnic and cultural groups. Functional Family Therapy is a short term intervention, using 8-12 sessions for mild cases and up to 30 hours of direct services. In most cases sessions are spread out over a three month period. In the long run the Functional Family Therapy philosophy leads to greater self sufficiency, fewer total treatment needs and considerable lower costs.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) targets symptoms of posttraumatic stress disorder (PTSD), which often co-occurs with depression and behavior problems. The intervention also addresses issues commonly experienced by traumatized children, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use. A

parent treatment component is an integral part of this treatment model. It parallels the interventions used with the child so that parents are aware of the content covered with the child and are prepared to reinforce or discuss this material with the child between treatment sessions and after treatment has ended. There are approximately 12 to 16 sessions for children and for parents, three of which are joint sessions. Children receiving TF-CBT experienced significantly greater improvement in depressive symptoms, significantly greater improvement in social competence, and maintained these differential improvements over the year after treatment ended.

The Early Intervention Team would consist of up to eight individuals who would have half their case loads be families and youth they are treating using Functional Family Therapy and would use Trauma Focused Cognitive Therapy with children who were suffering from trauma. Both of these modalities are short term early interventions that will be used for youth and children who have just been identified as needing help. These individuals would be trained and certified in Functional Family Therapy and Trauma Based Cognitive Therapy and will meet all the requirements of the model.

The Early Intervention Team will:

- Create a referral process for youth who are just getting into trouble in school or in the community and/or are appearing to be in the early stages of substance abuse.
- Create a referral process for children who have been involved in a child abuse investigation and will not get services in other capacities.
- Outreach and educate the community about this resource.
- Be trained on “Functional Family Therapy.”
- Be trained on “Trauma Focused Cognitive Therapy.”
- Choose a lead practitioner to lead the group.
- Create a clinical supervision group.
- See at least five youth with their family weekly in the family home (each practitioner).
- Use this treatment modality as a short term intervention
- Use the Functional Family Therapy data and monitoring system.
- Use the Functional Family Therapy outcome and accountability system.
- Use Trauma Focused Cognitive Therapy data and monitoring system.
- Report the results of the above data, outcome and monitoring systems to the User Work Group and the Children’s System of Care Executive Committee.

Actions Needed to Start Youth at Risk and Early Intervention:

- Create a User Work Group.

- Identify the Early Intervention Team of up to eight individuals.
- Hire/Contract the Early Intervention Team.
- Train the Early Intervention Team.
- Create the referral process for youth who are just getting into trouble in school or in the community and/or are appearing to be in the early stages of substance abuse.
- Create a referral process with Child Welfare for children who are not served in other capacities.
- Outreach and educate the community about this resource.
- Organize the Functional Family and Trauma Focused Cognitive Therapy Data Base.

#### 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 201-
	Prevention	Early Intervention	
<b>Prevention and Early Intervention for at Risk Children, Youth and Families.</b>	Individuals: 1,750 Families: 50	Individuals: Families:	Ten Months
Teaching Pro-Social Skills in the Schools	Individuals: 300 Families:	Individuals: Families:	Five Months
School Mental Health Screening	Individuals: 150 Families:	Individuals: Families:	Nine Months
Child and Youth Mentoring	Individuals: Families:	Individuals: Families: 40	Six Months
Early Intervention for Youth	<b>Individuals: 2,200</b> <b>Families: 50</b>	<b>Individuals: 40</b> <b>Families: 40</b>	<b>Ten Months</b>
<b>TOTAL PEI PROJECT ESTIMATED UNDUPLICATED COUNT OF INDIVIDUALS TO BE SERVED</b>			

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

All components of the Prevention and Early Intervention for at Risk Children, Youth and Families will be trained on how to link these children and families to more services. In this SECOND STEP expansion, when a child or family is identified as needing more mental health services, the First Five and Superintendent of Schools will refer these children and families to County Behavioral Health or to

the private sector. First Five and the Superintendent of Schools have a list of resources that is updated of mental health providers in the community as well as providers of other services. The First Five and the elementary school SECOND STEP trainers will train their teachers on accessing resources in the community. Nevada County Behavioral Health will be involved in the training of trainers and will educate the trainers on the programs available for children's mental health.

First Five currently funds a parenting class for children under six at the Nevada County Children's Behavioral Health facility. They also, currently fund an outreach that is conducted by Nevada County Children's Behavioral Health to our homeless shelters, Domestic Violence Shelters and residential drug treatment centers. In this outreach on site parenting is taught and one-on-one consultation occurs. First Five and the pre-schools they support frequently refer children and families to our parenting classes, shelter outreach, Parent Child Interactive Therapy and regular therapy. First Five is linked to our public health nurses and the Family Resource Centers. The children and families they serve are often referred to the above services.

Nevada County Schools refer children and families in need of mental health treatment to Nevada County Children's Behavioral Health. Nevada County has a SMART team (Special Multi Agency Resource Team) which is a team of Probation, Child Welfare, Public Health, the schools, Nevada County Superintendent of Schools, Behavioral Health and our Full Service Partnership providers to review children and families that are in need of services. Children and families are frequently referred for mental health services through Nevada County Behavioral Health or one of its contractors.

Youth who have been identified as needing mental health treatment will be linked to this County Behavioral Health or to the private sector. Youth who need other services, such as health care will also be linked to those needed services.

The Early Intervention Team will refer their clients to other needed services such as public health, housing resources, psychiatric resources, drug treatment, school resources, Adult Behavioral Health, etc. They will help the youth and families they serve negotiate those systems until they get the service they need. If the youth and their family need longer and more intense therapy they will refer these children to Nevada County Behavioral Health for further evaluations and treatment. If these children need more system coordination to create a safe home and school environment they will be referred to our multi-agency SMART (Special Multi Agency Resource Team) for further evaluation for treatment. They will also be referred to Children's Wraparound Services if they need this level of care.

**6. Collaboration and System Enhancements**

All components of the Prevention and Early Intervention for at Risk Children, Youth and Families will collaborate with Nevada County Behavioral Health. In the SECOND STEP component, Nevada County Behavioral Health will work closely with both First

Five and the Superintendent of Schools. The School Mental Health Screening will be done by collaborating with the schools, County Behavioral Health, parents and youth. How the screening is implemented and maintained will be decided by a Task Force that will include all of the above stakeholders. Youth and children will be better served by this collaboration. Nevada County has a newly formed Sierra Mentoring Partnership, where all mentoring program will be partners and will work together on training, resource finding, and developing evaluation metrics for the children and youth involved in the program. The in school mentoring programs will be a part of the Sierra Mentoring Partnership. The Sierra Mentoring Partnership hopes to expand all of its programs and to actively recruit more mentors for all of their programs. Local service clubs such as Kiwanis, Rotary and Soroptimist assist with financial support for the program. Other local agencies collaborate and support the mentoring programs through referrals and shared programs. The mentoring programs have partnered with the Friday Night Live Program, the Friendship Club, Tobacco Prevention Program, Foster Youth Program, Child Abuse Prevention in Nevada County Schools (CAPINCS), Big Brothers/Big Sisters, and Child Abuse Prevention Council (CAPC). The Early Intervention team will collaborate with Nevada County Behavioral Health, Probation, Child Welfare, our local drug treatment organizations, and the Schools. The team will be a part of our Children's System of Care All Staff and will meet regularly with them. The team will collaborate with all of the above agencies and take referrals from the SMART team, from the STAR team (committee of high school counselors who identify youth at risk). This team will enhance our Children's System of Care in Nevada County by taking youth who are at the early stages of their mental health needs and stop these children and youth from entering the Probation, Child Welfare system or Behavioral Health system further.

## **7. Intended Outcomes**

The Intended Outcomes for the Teaching Pro-social Skills in the Schools are:

- Twenty Percent decrease in disciplinary referrals.
- Thirty percent of children will have an increase in social emotional development using the Desired Results Developmental Profile (DRDP) or the SECOND STEP Knowledge Assessments.
- Thirty percent of parents will show an increase in understanding and self reported behavior using parent evaluation from SECOND STEP.

Key Program Milestones for the Teaching Pro-social Skills in the Schools are:

- Second Step curriculum bought for the elementary schools; one set per two classrooms.
- One Second Step curriculum bought for each of the participating Pre-Schools and Day Care Centers in the county.
- Curricula in English will be purchased for the schools, preschools and child care providers in English and Spanish for the parent training program.
- SECOND STEP trainer trains local trainers from each school district interested in participating in the program.
- SECOND STEP trainers have trained Kindergarten through Fifth grade teachers.

- SECOND STEP trainers have gone to the twelve pre-schools per year and have trained pre-school teachers in their classroom.
- The SECOND STEP pre-school trainer does six weekly sessions with the teacher in the classroom.
- The SECOND STEP pre-school trainer comes back twice over the next 12 weeks to observe the teacher and provide support and guidance.
- SECOND STEP parenting classes will be taught in English and in Spanish (6-week sessions) six times a year, one in English and one in Spanish in Truckee and three English and one Spanish in western county.
- Track changes in children’s social emotional development using the Desired Results Developmental Profile (DRDP) or the SECOND STEP Knowledge Assessments.
- Track changes in parent’s understanding and self reported behavior using parent evaluation from SECOND STEP.
- Track changes in the number of disciplinary referrals since the inception of SECOND STEP
- Report outcomes to Nevada County Behavioral Health yearly.

The timelines for teaching pro-social skills

Task	07/09	08/09	09/09	10/09	11/09	12/09	01/10	02/10	03/10	04/10	05/10	06/10
SECOND STEP curriculum bought												
Training for trainers is conducted												
Teachers trained												
SECOND STEP Implemented												
Track changes												
Report Outcomes												

The Intended Outcomes for School Mental Health Screening

- Offer universal screening in both Spanish and English in pilot schools
- Obtain active assent from parents and youth to screen.
- Connect with 100% of all parents or guardians of youth who score negatively on the screening tool. Have the ability to connect with parents or guardians in Spanish.
- Help families connect at least 80% of youth who scored negatively to a treatment provider.
- Follow youth until they have been seen by an outside professional for three sessions, before closing case.
- Re-interview youth and their parents or guardians to see if there has been improvement in their mood and suicide risk.

Key Program Milestones for the School Mental Health Screening are

- A User Task Force is created and implemented within three months of our PEI plan approval.

- Contract with “Columbia Teen Screen.”
- Train staff on Columbia Teen Screen and train staff on Cognitive Behavioral Group therapy in the schools.
- Create a resource guide.
- Create referral process.
- Start a Cognitive Behavioral Therapy Group in each school where the tool is being used. This group will be for youth who do not have any outside resources for treatment.
- Create data base and evaluate data.

The timelines for School Mental Health Screening

Task	07/09	08/09	09/09	10/09	11/09	12/09	01/10	02/10	03/10	04/10	05/10	06/10
Hire staff												
Obtain contract with Columbia Teen Screen												
Create User Task Force												
Train												
Create and Maintain Resource Guide												
Create and Market Referral Process												
Active Assent												
Initiate Pilot screening process												
Case Manage for outside treatment												
Conduct Cognitive Behavioral Groups												
Create data base												
Assess improvement in youth												

The Intended Outcomes for School mentoring program will be:

- Decrease of disciplinary referrals by 30% for referred children
- Increase by 20% referred children’s school scores

Key Program Milestones for the School Mentoring program will be:

- Recruit teens from the high school to be “Big Pals” who will mentor children at the elementary schools
- Recruit adults to be mentors for children in schools
- Take referrals for high risk children from the elementary schools

- Train mentors
- Match mentors and high risk children
- Supervise Mentors
- Develop evaluation metrics
- Report evaluations to Nevada County Behavioral Health

The timelines for School Mentoring

Task	07/09	08/09	09/09	10/09	11/09	12/09	01/10	02/10	03/10	04/10	05/10	06/10
Recruit teens												
Recruit Adults												
Implement referral form in elementary schools												
Train mentors												
Match mentors and children												
Supervise mentors												
Develop evaluation metrics												
Evaluate program												
Report findings												

The Intended Outcomes for Early Intervention for Youth at Risk:

- Treated youth will decrease their substance abuse by 30%.
- Treated youth will decrease their re-arrest rate by 20%.

Key Program Milestones for the for Early Intervention for Youth at Risk will be:

- Youth at Risk Task Force created.
- Early Intervention Team hired.
- Early Intervention Team completed training.
- Early Intervention Team will have a lead practitioner.
- Each early intervention practitioner will see at least eight youth and their families the first year.
- Each early intervention practitioner will see youth and families for up to 15 weeks.
- Treated youth will decrease their substance abuse by 30%.
- Treated youth will decrease their re-arrest rate by 20%.
- Data base created using Functional Family Therapy guidelines.

- Data base created using Trauma Focused Cognitive Behavioral Therapy.

The timelines for the Early Intervention for Youth at Risk

Task	07/09	08/09	09/09	10/09	11/09	12/09	01/10	02/10	03/10	04/10	05/10	06/10
User Task Force Created												
Intervention Team hired												
Team trained												
Referral Process Created and Implemented												
Lead chosen												
Data base created												

**8. Coordination with Other MHSA Components**

All components of the Prevention and Early Intervention for at Risk Children, Youth and Families will be trained on the other MHSA programs and how to access these programs for the children and families they serve if they think they are needed. Nevada County Behavioral Health and its Full Service Partnership contractors will be invited to the training done by the SECOND STEP trainers, so they can be aware of the curriculum that the schools are teaching. It is hoped that these mental health providers can tie their work in with the curriculum. The elementary and pre-schools will be aware of resources in the community for mental health treatment because of outreach done by Nevada County Children’s Behavioral Health Department. The mental health screener in the middle and/or high schools will coordinate with a number of other MHSA components. They will coordinate with the PEI Suicide Prevention Coordinator in finding resources for youth and families and in educating youth and families about mental health and suicide. The screeners will coordinate with the PEI Early Intervention Children Team to refer youth who are who need the treatment that the team will offer. The screeners will also coordinate with our MHSA full service partnerships if they think a child needs that level of treatment or is already receiving that treatment. Our Mentoring Programs will coordinate with some of the other MHSA programs if a child needs more mental health treatment. Mentor coordinators will be aware of the County Behavioral Health services and the expansion that the MHSA programs provide. They will be educated on how to refer clients to these services. They will be educated on the PEI SECOND STEP curriculum, Children’s Wraparound and the Suicide Prevention coordinator. They will know that they can refer a child to the SMART team if they feel the child needs further services. The Early Intervention team will coordinate with all parts of the Nevada County Children’s System of Care, including the MHSA components. They will coordinate with the MHSA Children’s Full Service Partnerships if they think a child needs that increased level of care or they will coordinate and treat the siblings of a child who is involved in children’s wraparound or assertive community treatment teams.

**PEI Revenue and Expenditure Budget Worksheet**

Form No. 4

County Name: **Nevada**

Date: 3/10/09

PEI Project Name: **Access to Services**

Provider Name (if known): **Not known at this time**

Intended Provider Category: County, Health Clinic, and Other

Proposed Total Number of Individuals to be served:                      FY 08/09 0      FY 09/10 25,700

Total Number of Individuals currently being served:                      FY 08/09 0      FY 09/10 0

Total Number of Individuals to be served through PEI Expansion:      FY 08/09 0      FY 09/10 25,700

Months of Operation:      FY 08/09 0      FY 09/10 10 Months

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 09-10	Total
<b>A. Expenditure</b>			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages: 1 FTE BH Health Tech III Temp	\$0	\$77,786	\$77,786
b. Benefits and Taxes @        %	\$0	\$0	\$0
<b>c. Total Personnel Expenditures</b>	<b>\$0</b>	<b>\$77,786</b>	<b>\$77,786</b>
2. Operating Expenditures			
a. Facility Cost	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$104,115	\$104,115
<b>c. Total Operating Expenses</b>	<b>\$0</b>	<b>\$104,115</b>	<b>\$104,115</b>
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Suicide Prevention Trainer Contract	\$0	\$49,889	\$49,889
Physician Trainer Contract	\$0	\$48,346	\$48,346
NC 2-1-1 Contract	\$0	\$43,951	\$43,951
<b>a. Total Subcontracts</b>	<b>\$0</b>	<b>\$142,186</b>	<b>\$142,186</b>
4. Total Proposed PEI Project Budget	\$0	\$324,087	\$324,087
<b>B. Revenues (list/itemize by fund source)</b>			0
	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$0	\$324,087	\$324,087
6. Total In-Kind Contributions	\$0	\$10,000	\$10,000

## **Budget Narrative for: Access to Services**

### **A. Expenditure**

#### **1. Personnel**

##### **a Salaries, Wages:**

Nevada County will hire 1 FTE Behavioral Health Technician III Temporary worker. Nevada County is requesting \$77,786 for this position. Nevada County's Behavioral Health Salary Planner was used to determine the salary amount. This will be a new temporary position that will be advertised and we will encourage clients and family members to apply. The Behavioral Health Technician III will be our PEI/Suicide Prevention Coordinator for the county. This individual will provide community outreach by training a volunteer group of trainers in "Living Works." The PEI/Suicide Prevention Coordinator with the trained volunteers and contracted trainer will conduct trainings to government, community based and private organization and agencies. The Coordinator will also create, maintain and distribute a list of resources for use by community members. Additionally, this individual will create, maintain and communicate a referral process to the community. The Coordinator will cross train and coordinate services with other MHSA Prevention and Early Intervention projects and programs.

##### **b Benefits and Taxes:**

Because Nevada County is hiring a temporary employee benefits and taxes do not apply.

#### **2. Operation Expenditures**

##### **a Facility Cost**

Facility Cost are part of our A-87 costs which are included under Other Operating Expenses.

##### **b Other Operating Expenses**

Nevada County is requesting \$104,115 in Other Operating Expenses. These expenses come from our A-87 cost allocation methodology for employees from the Salary Planer, from quotes from suppliers, and from information provided to us by our community based partners. This includes training costs of \$34,699, material costs of \$10,603, other costs of \$30,749 for items like travel, mileage, office supplies, printer/copier, phone, cell phone, food for meetings, and incentives, and other operating costs associated with this program, indirect administration cost of \$28,064 for rent, utilities, Health and Human Serves Agency support, and A-87 charges and other indirect costs allocated to the program.

##### **c Total Operating Expenses**

Nevada County is requesting \$104,115 in operation expenditures to run our Suicide Prevention Program, Physician Integrative Behavioral Health Training Program, Train our First Responder Program and our Nevada County 2-1-1 Program.

#### **3. Subcontracts/Professional Services**

- Suicide Prevention Trainer Contract: Nevada County is requesting \$49,889 to fund a contracted "Living Works" trainer out of the Nevada County Public Health

Department. This individual is already trained in “Living Works.” The cost includes salary and benefits and other expenses related to the trainer.

- Physician Integrative Behavioral Health Training Contract: Nevada County is requesting \$48,346 to fund a contract to train local primary care physicians to screen for mental health issues. The contract may also fund creating training curriculum, advertising, travel, mileage, office supplies, training, food, and other costs pertaining to the trainings and indirect costs.
- Nevada County 2-1-1 Contract: Nevada County is requesting \$43,951 for start-up and ongoing cost for Nevada 2-1-1 system. The start-up and ongoing cost include set-up charges at Sacramento 2-1-1, telephone switching with phone company, 800 number roll-over charges set-up, call center staff training, application copy charges, postage, advertisement, outreach, and charges for 2-1-1 usage.

**a Total Subcontracts**

The total Nevada County subcontractor’s funds we are requesting is \$142,186.

**4. Total Proposed PEI Project Budget**

The total proposed budget for the Nevada County Access to Services Project is \$324,087.

**B. Revenues**

**1. Total Revenue**

We have no proposed revenues supporting this project besides MHSA funds.

**C. Total Funding Requested for PEI**

The total proposed budget for the Nevada County Access to Services Project is \$324,087.

**D. Total In-Kind Contributions**

In our Physician Integrative Behavioral Health Training Program the Northern Sierra Rural Health Network will train primary care physicians to screen for mental health issues. The Northern Sierra Rural Health Network received a grant of \$10,000 from the California Endowment to partially fund this training. It is planned that Personal Digital Assistants (PDAs) will be bought with the California Endowment funds and loaded with programs for physicians on how to diagnose and treat mental health issues. These PDA’s will be given to the physicians who attend trainings.

**PEI Revenue and Expenditure Budget Worksheet**

Form No. 4

County Name: **Nevada**

Date: 3/10/09

PEI Project Name: **Outreach Project**

Provider Name (if known): **Not known at this time**

Intended Provider Category: **County, Family Resource Center, Older Adult Services, Other**

Proposed Total Number of Individuals to be served:      FY 08-09 0    FY 09-10 195

Total Number of Individuals currently being served:      FY 08-09 0    FY 09-10 0

Total Number of Individuals to be served through PEI Expansion:      FY 08-09 0    FY 09-10 195

Months of Operation:      FY 08-09 0    FY 09-10 9 Months

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 09-10	Total
<b>A. Expenditure</b>			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	\$0	\$0	\$0
0.5 FTE Therapist-Temp	\$0	\$68,889	\$68,889
	\$0	\$0	\$0
b. Benefits and Taxes @      %	\$0	\$0	\$0
<b>c. Total Personnel Expenditures</b>	<b>\$0</b>	<b>\$68,889</b>	<b>\$68,889</b>
2. Operating Expenditures			
a. Facility Cost	\$0		\$0
b. Other Operating Expenses	\$0	\$20,163	\$20,163
<b>c. Total Operating Expenses</b>	<b>\$0</b>	<b>\$20,163</b>	<b>\$20,163</b>
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Older and Disabled Adult Outreach Contract	\$0	\$211,323	\$211,323
Latino Outreach Contract	\$0	\$141,362	\$141,362
Homeless Outreach Contract	\$0	\$68,288	\$68,288
<b>a. Total Subcontracts</b>	<b>\$0</b>	<b>\$420,973</b>	<b>\$420,973</b>
4. Total Proposed PEI Project Budget	<b>\$0</b>	<b>\$510,025</b>	<b>\$510,025</b>
<b>B. Revenues (list/itemize by fund source)</b>			0
	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0
<b>5. Total Funding Requested for PEI Project</b>	<b>\$0</b>	<b>\$510,025</b>	<b>\$510,025</b>
<b>6. Total In-Kind Contributions</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

## **Budget Narrative for: Outreach Project**

### **A. Expenditure**

#### **1. Personnel**

##### **a Salaries, Wages:**

Nevada County will hire 0.5 FTE Behavioral Health Therapist Temporary worker. Nevada County is requesting \$68,889 for this position. Nevada County's Behavioral Health Salary Planner was used to determine the salary amount. The Behavioral Health Therapist will outreach to the Law Enforcement community, the County jail, Probation and the Courts. They will create, maintain and communicate a referral system for individual who are involved with the justice system who may need mental health resources. They will help to link these individuals to mental health services in the private or public sector and when appropriate conduct psycho-education groups in the jail.

##### **b Benefits and Taxes:**

Because Nevada County is hiring a temporary employee benefits and taxes do not apply.

#### **2. Operation Expenditures**

##### **a Facility Cost**

Facility Cost are part of our A-87 costs which are included under Other Operating Expenses.

##### **b Other Operating Expenses**

Nevada County is requesting \$20,163 in Other Operating Expenses. These expenses come from our A-87 cost allocation methodology for employees from the Salary Planner, from quotes from suppliers, and from information provided to us by our community based partners. This includes material costs of \$2,137, other costs of \$6,411 for items like travel, mileage, office supplies, printer/copier, phone, cell phone, food for meetings, and incentives, and other operating costs associated with this program, and indirect administration cost of \$11,615 for rent, utilities, Health and Human Services Agency support, and A-87 charges and other indirect costs allocated to the program.

##### **c Total Operating Expenses**

Nevada County is requesting \$20,163 in operation expenditures to run our Older and Disabled Adult Outreach Program, the Latino Outreach Program, the Homeless Outreach Program and the Forensic Liaison Program.

#### **3. Subcontracts/Professional Services**

- Older and Disabled Adult Outreach Contract: Nevada County is requesting \$211,323 to fund the contract. The contract will include a 0.5 FTE Senior Health Nurse and a 0.5 FTE Program Director for our Friendly Visitor Program. The Senior Health Nurse, Program Director and volunteers of the Friendly Visitor Program will be trained in mental health screening and will refer clients for mental health support and treatment. This contract may also include training,

materials, advertising, food, travel, mileage, office supplies, printers/copier, phones, other operating costs associated with the program, and indirect costs.

- **Latino Outreach Contract:** Nevada County is requesting \$141,362 to fund a contract to outreach to our Latino population by increasing the “Promotores Program” through Family Resource Centers. The Promotores will conduct outreach, psycho-education, and recreation groups for Latino families in Spanish. The funds will be used to expand the Promotores hours, provide child care, and may also include training, materials, travel, phones, advertising, office supplies, other operating costs associated with the program, and indirect costs. Additionally these funds will be used to fund a 0.5 FTE bi-lingual therapist who will collaborate with the Family Resource Centers and Promotores to provide Cognitive Therapy for depression, attend psycho-education groups, provide treatment for referred clients, and provide consultation to the Family Resource Centers and the Promotores.
- **Homeless Outreach Contract:** Nevada County is requesting \$68,288. The contract will include a 0.5 FTE Case manager to outreach to the homeless to build connections and trust to help individuals get their basic needs met including mental health needs. The Case Manager will be out stationed at our one emergency shelter, but will be on call to other agencies and organizations that are providing services to the homeless. This contract may also include training, materials, advertising, food, travel, mileage, office supplies, printers/copier, phones, other operating costs associated with the program, and indirect costs.

**a Total Subcontracts**

The total Nevada County subcontractor’s funds Nevada County is requesting is \$420,973.

**4. Total Proposed PEI Project Budget**

The total proposed budget for the Nevada County Outreach Project is \$510,025.

**B. Revenues**

**1. Total Revenue**

We have no proposed revenues supporting this project besides MHSA funds.

**C. Total Funding Requested for PEI**

The total proposed budget for the Nevada County Outreach Project is \$510,025.

**D. Total In-Kind Contributions**

No in-kind contributions were plan.

## PEI Revenue and Expenditure Budget Worksheet

Form No. 4

County Name: **Nevada**

Date: 3/10/09

PEI Project Name: **Prevention and Early intervention for at Risk Children, Youth and Families Project**

Provider Name (if known): **Not Know at this time.**

Intended Provider Category: **County, Pre K-12 School, Other**

Proposed Total Number of Individuals to be served:      FY 08-09 0    FY 09-10 2,350

Total Number of Individuals currently being served:      FY 08-09 0    FY 09-10 0

Total Number of Individuals to be served through PEI Expansion:      FY 08-09 0    FY 09-10 2,350

Months of Operation:      FY 08-09 0    FY 09-10 10 Months

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 09-10	Total
<b>A. Expenditure</b>			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	\$0	\$0	\$0
0.5 FTE Licensed Clinician, LPHA- Temp	\$0	\$62,727	\$62,727
2-.05 FTE Licensed Clinician, LPHA = .1 FTE LPHA	\$0	\$9,329	\$9,329
b. Benefits and Taxes @ 33 % of .1 FTE LPHA	\$0	\$4,595	\$4,595
<b>c. Total Personnel Expenditures</b>	<b>\$0</b>	<b>\$76,651</b>	<b>\$76,651</b>
2. Operating Expenditures			
a. Facility Cost	\$0	\$0	\$0
b. Other Operating Expenses	\$0	\$192,741	\$192,741
<b>c. Total Operating Expenses</b>	<b>\$0</b>	<b>\$192,741</b>	<b>\$192,741</b>
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
School Mental Health Needs: Columbia Teen Screening Contract	\$0	\$94,174	\$94,174
Early Intervention for at Risk Youth Contract		\$48,173	\$48,173
Second Step Contract	\$0	\$87,446	\$87,446
Mentoring Contract	\$0	\$72,518	\$72,518
<b>a. Total Subcontracts</b>	<b>\$0</b>	<b>\$302,311</b>	<b>\$302,311</b>
4. Total Proposed PEI Project Budget	<b>\$0</b>	<b>\$571,703</b>	<b>\$571,703</b>
<b>B. Revenues (list/itemize by fund source)</b>			
	\$0	\$0	\$0
1. Total Revenue (Medi-Cal)	\$0	\$709,004	\$709,004
<b>5. Total Funding Requested for PEI Project</b>	<b>\$0</b>	<b>\$571,703</b>	<b>\$571,703</b>
<b>6. Total In-Kind Contributions</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

## **Budget Narrative for: Prevention and Early Intervention for at Risk Children, Youth and Families**

### **A. Expenditure**

#### **1. Personnel**

##### **a Salaries, Wages:**

Nevada County is requesting \$72,056 in Salaries and Wages to support Nevada County's Prevention and Early Intervention for at Risk Children, Youth, and Families Project. Nevada County will hire two new clinicians to be a part of the team that provides Functional Family Therapy and Trauma Based Cognitive Therapy. All costs for the two clinicians will be covered by Medi-cal except five percent of each of their salary and benefits. We are requesting the funds to pay for five percent of each of their salaries. Additionally, Nevada County will hire a 0.5 FTE Licensed Clinician, Licensed Practitioner of the Healing Arts (LPHA) temporary worker to be assigned to the School Mental Health Needs Screening Program. Nevada County's Behavioral Health Salary Planner was used to determine salary amount. The 0.5 FTE Licensed Clinician, LPHA will be a new temporary position.

##### **b Benefits and Taxes:**

Nevada County is requesting \$4,595 for Benefits and Taxes for the .two .05 FTE Licensed Clinician. Benefits were calculated at 49 percent of salary. This information was provided in the County's Salary Planner. Benefits include retirement benefits, other post employment benefits, and health benefits.

#### **2. Operation Expenditures**

##### **a Facility Cost**

Facility Cost are part of our A-87 costs which are included under Other Operating Expenses.

##### **b Other Operating Expenses**

Nevada County is requesting \$192,741 in Other Operating Expenses. These expenses come from our A-87 cost allocation methodology for employees from the Salary Planner, from quotes from suppliers, and from information provided to us by our community based partners. This includes training costs of \$147,595, material costs of \$9,729, other costs of \$10,927 for items like travel, mileage, office supplies, printer/copier, phone, cell phone, food for meetings, and incentives, other operating costs associated with this program, and indirect administration cost of \$24,490 for rent, utilities, Health and Human Services Agency support, and A-87 charges and other indirect costs allocated to the program.

##### **c Total Operating Expenses**

Nevada County is requesting \$192,741 in operation expenditures to run our School Mental Health Needs: Columbia Teen Screening Program, Early Intervention for at Risk Youth Program, Second Step Program, and Mentoring Program.

#### **3. Subcontracts/Professional Services**

- School Mental Health Needs: Columbia Teen Screening Contract: Nevada County is requesting \$94,174 to fund a contracted to offer parents

of middle or high school youth the opportunity to have their children screened for depression and anxiety. The screening tool we plan on using is called “Columbia Teen Screen.” The contract will include a full time Case Manager who will work with the Clinician. The contract may also include travel, materials, mileage, office supplies, printer/copier, phone, cell phone, food for meetings, incentives, other operating costs associated with the program, and indirect costs.

- Early Intervention for at Risk Youth Contract: Nevada County is requesting \$48,173 to fund this contract. The contract will fund up to six clinicians to be a part of the team that provides Functional Family Therapy and Trauma Based Cognitive Therapy. All cost for the clinicians will be covered by Medi-Cal except five percent of each of their salary. We are requesting the funds to pay for five percent of each of their salaries. The contract may also fund advertising, materials, travel, mileage, office supplies, training, printer/copier, phone, cell phone, food, incentives, other operating costs associated with the program, and indirect costs.
- Second Step Contract: Nevada County is requesting \$87,446 for start-up and ongoing cost for the implementation of the Second Step Program. The Second Step Program will be implemented in elementary and pre-schools. First 5 Nevada County will implement this contract. First 5 Nevada County will provide Second Step training to 12 pre-schools and/or childcare each year. Additionally, trainings will occur in elementary schools in each of our school districts in grades Kindergarten to Fifth grade.
- Mentoring Contract: Nevada County is requesting \$72,518 for our Mentoring Program. This contract will include the cost to hire staff and indirect costs.

**a Total Subcontracts**

The total Nevada County subcontractor’s funds we are requesting is \$302,311.

**4. Total Proposed PEI Project Budget**

The total proposed budget for the Nevada County Prevention and Early Intervention for at Risk Children, Youth, and Families Project is \$571,703.

**B. Revenues**

**1. Total Revenue**

We anticipate \$709,004 in Medi-Cal funding. This funding will be generated by the Early Intervention for at Risk Youth Therapist Team of eight providers. We only included in our PEI budget the portion of the therapist time that is not covered by Medi-Cal reimbursement.

**C. Total Funding Requested for PEI**

The total proposed budget for the Nevada County Access to Services Project is \$571,703.

**D. Total In-Kind Contributions**

No in-kind contributions were plan.

PEI Administration Budget Worksheet

Form No. 5

County: Nevada

Date: 3/10/2009

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2008-09	Budgeted Expenditure FY 2009-10	Total
<b>A. Expenditures</b>					
<b>1. Personnel Expenditures</b>					
a. PEI Coordinator (Program Manager)		0.25	\$0	\$44,487	\$44,487
b. PEI Support Staff (Health Technician)		0.25	\$0	\$18,401	\$18,401
c. Other Personnel (list all classifications)					\$0
Behavioral Health Director		0.05	\$0	\$14,725	\$14,725
Clinical Supervisor		0.2	\$0	\$28,512	\$28,512
Administrative Service Officer		0.05	\$0	\$7,855	\$7,855
Accountant		0.05	\$0	\$4,779	\$4,779
d. Employee Benefits @ 49 %			\$0	\$58,192	\$58,192
e. Total Personnel Expenditures			\$0	\$176,951	\$176,951
<b>2. Operating Expenditures</b>					
a. Facility Costs			\$0	\$0	\$0
b. Other Operating Expenditures			\$0	\$7,605	\$7,605
c. Total Operating Expenditures			\$0	\$7,605	\$7,605
<b>3. County Allocated Administration</b>					
a. Total County Administration Cost			\$0	\$63,529	\$63,529
<b>4. Total PEI Funding Request for County Admin. Budget</b>			\$0	\$248,085	\$248,085
<b>B. Revenue</b>					
1 Total Revenue			\$0	\$0	\$0
<b>C. Total Funding Requirements</b>			\$0	\$248,085	\$248,085
<b>D. Total In-Kind Contributions</b>			\$0	\$0	\$0

## **PEI Administration Budget Narrative**

### **E. Expenditure**

#### **1. Personnel**

##### **a Salaries, Wages:**

Nevada County is requesting \$118,759 for salaries of personnel that will be administering the PEI projects. The staff dedicated to this project is: Behavioral Health Director, Children's Program Manager, Clinical Supervisor, the Behavioral Health Administrative Service Officer, Accountant, and Health Technician. Nevada County's Behavioral Health Salary Planner was used to determine the salary amount. The above staff will be responsible for writing contracts, contract management, project implementation, project evaluation, budget management, and MHPA reporting requirements.

##### **b Benefits and Taxes:**

Nevada County is asking for \$58,192 for benefits and taxes. Benefits and taxes were calculated at 49%. The benefits include retirement benefits, other post employment benefits, and health insurance.

#### **2. Operation Expenditures**

##### **a Facility Cost**

Facility Cost are part of our A-87 costs which are included under County Allocated Administration.

##### **b Other Operating Expenses**

Nevada County is requesting \$7,605 in Other Operating Expenses. These expenses come from our A-87 cost and allocation methodology for employees from the Salary Planner. These funds will be used for items like travel, mileage, office supplies, printer/copier, phone, cell phone, food for meetings, other operating costs associated with the program.

##### **c Total Operating Expenses**

Nevada County is requesting \$7,605 in operation expenditures to administer the PEI projects and programs.

#### **3. County Allocated Administration**

##### **a Total County Administration Cost**

The total Nevada County Administration funds requested is \$63,529. These funds will be used to cover our indirect costs like rent, utilities, Health and Human Services Agency support, and A-87 costs and other indirect costs allocated to the program.

#### **4. Total Proposed PEI Project Budget**

The total proposed budget for Administration for PEI is \$248,085.

### **F. Revenues**

#### **1. Total Revenue**

We have no proposed revenues supporting this project besides MHPA funds.

### **G. Total Funding Requested for PEI**

The total proposed budget for the Nevada County PEI Administration is \$248,085.

### **H. Total In-Kind Contributions**

No in-kind contributions at this time.

Prevention and Early Intervention Budget Summary

Form No. 6

<b>County:</b>	Nevada County
<b>Date:</b>	March 13, 2009

#	List each PEI Project	Fiscal Year			Funds Requested by Age Group			
		FY 08/09	FY 0910	Total	*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
1	Access to Services Project	\$0	\$324,087	\$324,087	\$29,087	\$75,000	\$110,000	\$110,000
2	Outreach Project	\$0	\$510,025	\$510,025	\$62,000	\$62,000	\$190,000	\$196,025
3	Prevention and Early Intervention for at Risk Children, Youth and Families Project	\$0	\$571,703	\$571,703	\$421,703	\$100,000	\$50,000	\$-
4	Administration	\$0	\$248,085	\$248,085	\$90,495	\$41,820	\$61,770	\$54,000
	<b>Total PEI Funds Requested:</b>	\$0	\$1,653,900	\$1,653,900	\$603,285	\$278,820	\$411,770	\$360,025

Nevada County is requesting the following funds:

	FY 07/08	FY 08/09	FY 09/10	Total
Remaining Unapproved PEI Funds				
Planning	\$ 187,600	\$ 441,500	\$ 738,900	\$ 1,368,000
Planning additions		\$ 86,500		\$ 86,500
<b>Total Unapproved Planning PEI</b>	<b>\$ 187,600</b>	<b>\$ 528,000</b>	<b>\$ 738,900</b>	<b>\$ 1,454,500</b>
Other PEI Unapproved PEI Funds				
State Administered Projects		\$ 86,500	\$ 86,500	\$ 173,000
Training, Technical Assistance & Capacity Building		\$ 13,200	\$ 13,200	\$ 26,400
<b>Total Other PEI Unapproved PEI Funds</b>	<b>\$ -</b>	<b>\$ 99,700</b>	<b>\$ 99,700</b>	<b>\$ 199,400</b>
<b>Total: PEI Remaining Unapproved Amounts</b>	<b>\$ 187,600</b>	<b>\$ 627,700</b>	<b>\$ 838,600</b>	<b>\$ 1,653,900</b>

**LOCAL EVALUATION OF A PEI PROJECT**

Form No. 7

**County: Nevada County**

**Date: 03/13/09**

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.
1. b. Explain how this PEI project and its programs were selected for local evaluation.
2. What are the expected person/family-level and program/system-level outcomes for each program?
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
<u>ETHNICITY/CULTURE</u>							
African American							
Asian Pacific Islander							
Latino							
Native American							
Caucasian							
Other (Indicate if possible)							

<b>AGE GROUPS</b>							
<b>Children &amp; Youth (0-17)</b>							
<b>Transition Age Youth (16-25)</b>							
<b>Adult (18-59)</b>							
<b>Older Adult (&gt;60)</b>							
<b>TOTAL</b>							
Total PEI project estimated <i>unduplicated</i> count of individuals to be served _____							

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 programs 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?

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

Date: March 13, 2009	County Name: Nevada
Amount Requested for FY 2008/09: \$13,200	Amount Requested for FY 2009/10: \$13,200

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

**We anticipate using the Training, Technical Assistance and Capacity Building funding to fund Crisis Intervention Teams (CIT) training for our first responders in Nevada County. We anticipate that our partners in this will be Sheriff's Department, Grass Valley, Nevada City, and Truckee Police Departments, fire departments, Nevada County National Alliance form Mentally Ill (NAMI), and Nevada County Forensic Task Force.**

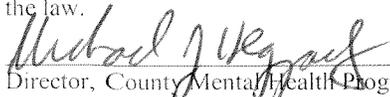
**Additionally we anticipate using the Training, Technical Assistance and Capacity Building fund to fund Second Step training in our community. We anticipate that our partners in this program will be the Superintendent of Schools in Nevada County and Placer County (some of our schools in Nevada County are under the jurisdiction of Placer County Superintendent of Schools), school administrators in the different school districts, principles, teachers, preschools, childcare providers, First 5 of Nevada County, and Nevada County's three Family Resource Centers.**

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)

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# NAMI Nevada County

*The County's Voice on Mental Illness*

**P.O. Box 1313, Grass Valley CA 95945**

**530-272-4566** [www.fncn.net/~ncami](http://www.fncn.net/~ncami)

April 13, 2009

Michael Heggarty, Director  
Nevada County Behavioral Health  
500 Crown Point Circle  
Grass Valley CA 95945

Re: Mental Health Services Act Prevention and Early Intervention Plan

Dear Mr. Heggarty,

On behalf of NAMI, I express our sincere appreciation for the comprehensiveness of the Prevention and Early Intervention planning process and resulting document. We respect its complexity and recognize the challenges of addressing effectively the wide scope of the issues involved. You and your staff are to be commended for the plan's breadth and cohesiveness.

NAMI greatly appreciates the inclusion of a number of our key concerns, including specifically addressing the high suicide rate in our county, a fact we in NAMI know too well. Voluntary mental health screenings in school are as essential as the other screenings available. Training primary care physicians to include screening for brain disorders known as mental illnesses is critical in early intervention and prevention of exacerbation of mental health problems. We are glad that Truckee's needs are integrated into the plan.

Ten years ago this coming August, NAMI presented a proposal to the County Board of Supervisors, documenting the tragic relationship between mental illness and the criminal justice system. The Board responded by authorizing the creation of the County's Forensic Task Force on Mental Illness. As you know, the Forensic Task Force, comprised of representatives from the justice system, law enforcement, your department, and community stakeholders including SPIRIT and NAMI, have met monthly since then. Although the Mental Health Court and other services have been instituted, there has long been a recommendation for a more comprehensive staff linkage for those with mental illnesses involved in the justice system with community services. Additionally, the Forensic Task Force has promoted first responder training on mental illness. This plan addresses both of these concerns,

However, we are concerned about several details in the plan. Specifically, personnel that support the Suicide Prevention and the Forensic Liaison programs are considered temporary workers. The facts show that these issues are not temporary problems. We recommend that these positions be permanent, that benefits be available, in order to attract and retain the best candidates and also to increase the likeliness of low staff turnover.

Although we respect the need for those with low incomes to be served, we in NAMI know that mental illness knows no income barriers. PEI is not only about those with low incomes. Therefore, we are concerned that services not be limited to those who are on MediCal or are MediCal eligible, especially young people who are at risk for disability from their illness without early intervention.

We are hopeful that the suicide prevention component will also include the Mental Health First Aid program which provides specific curriculum giving mental health the same parity status with other bodily first aid needs. This will do much to minimize the stigma which we in NAMI continue to face. We are also hopeful that by integrating these new services into the larger community, the Family Resource Centers and schools will become more competent in dealing with mental health issues.

We are still concerned that all of our community partners understand the trauma which mental illnesses cause individuals and their families. As you may know, SAMSHA has a wealth of information as well as supporting the National Center for Trauma Informed Care (<http://mentalhealth.samhsa.gov/nctic/>) which states: "Knowledge about the prevalence and impact of trauma has grown to the point that it is now universally understood that almost all of those seeking services in the public health system have trauma histories. Trauma-Informed Care (TIC) provides a new paradigm under which the basic premise for organizing services is transformed from 'what is wrong with you?' to 'what has happened to you?'" NAMI is working through the WET plan to support this competency with providers. We are hopeful that it extends to all segments of our community as it provides a powerful tool to help stop the stigma and discrimination which our families and friends continue to experience.

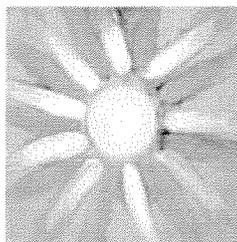
Finally, we are still deeply concerned about our community's response to Transitional Aged Youth and the need for better understanding of the spectrum of needs of this age group. The need for stronger coordinated supports for them is critical. Again, we in NAMI know directly what happens as we have members whose children are in this group, and we have yet to see a real understanding of the uniqueness of their needs. On p. 7 of the PEI plan The membership of the Executive Committee on Children's System of Care is listed. It does not include any family or youth representatives. Without these voices as part of a vigorous discussion of the issues the strong network of understanding essential to building effective services cannot be created.

One last correction we would like is also on p. 7. The official name of NAMI was changed. NAMI National Alliance on Mental Illness is the correct designation.

Thank you. We are committed to working together for the betterment of all in need in our community and will continue to support the realization of the promise of the Mental Health Services Act in Nevada County.

Sincerely,

Helen Williamson  
President



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DBSA Nevada County  
578 Sutton Way PMB 214  
Grass Valley, CA 95945

Mental Health Board  
County of Nevada  
500 Crown Point Circle, Suite 120  
Grass Valley, CA 95945

March 29, 2009

Honorable Mental Health Board members:

Thank you for your time.

The Depression and Bipolar Support Alliance of Nevada County (DBSA NC) submitted two proposals for educating professionals in the community so that timely interventions might be made.

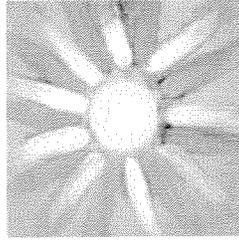
The Board of DBSA NC and other stakeholders would like the Mental Health Board to consider these DBSA peer-led groups:

- (1) Living Successfully with a Mood Disorder; and
- (2) Support groups including DBSA Recovery Dialogues;

each for various age groups, as a Best Practice model that is a relevant stakeholder priority not identified in the current PEI Plan.

Our final proposal was for a psychosocial and educational therapy group to be co-led by one peer and one licensed professional.

These plans were presented in writing to Rebecca Slade, the PEI staff person, at the meeting DBSA organized for the community on August 21, 2008. Then again, on October 3, 2008, three representatives from DBSA joined other PEI proposal-makers to recap our plans in front of the MHSA Steering Committee (see Attachment C, attached). DBSA was represented by Eric Rubinstein, M.D., our professional advisor; Linda Ketcham, our Vice President of Publicity and Public Relations; and Abigail Weissman, Immediate Past President of DBSA Nevada County.



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DBSA is requesting your consideration of these programs that have proven outcomes and national recognition. We are excited that through MHSA PEI funding we may have the opportunity to expand our outreach and offer more DBSA groups locally.

We feel this program is a preferred approach to education and early intervention through targeted education and the follow-up referral and supports in the communities. People identified with first onset especially need extra support and education not only from professionals but also from those who have personal experience with the same mood disorders.

Because this project is a component identified by the community stakeholder process we are asking what consideration you will be giving this identified need.

Sincerely yours,  
The DBSA Board of Directors

Chris Anderson, President

JoAnn Thompson, Vice President

Linda Ketcham, Vice President  
PR and Publicity

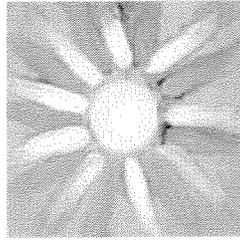
Gail Tagart, Secretary

Kathy Salivar, Treasurer

Abigail Weissman, Immediate Past President

ATTACHMENTS

- A1 Two educational plans
- A2 Transitional Aged Youth Plans
- A3 Older Adult Plans
- A4 Adult Plans
- B – letter of endorsement from national DBSA
- C – brief notes from October 3, 2008 meeting



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ATTACHMENT A-1  
Proposed Plans for Educating Professionals and Community Members

Educating Professionals Plan #1

DBSA NC's first **educational strategy** proposal calls for two DBSA members to present community members with information about mood disorders, the most common mental illnesses. The presenters would be DBSA NC members trained in presenting DBSA's Living Successfully with Mood Disorders. They would present condensed and modified portions of the material to fit appropriate educational presentations for community groups of professionals or other interested community members.

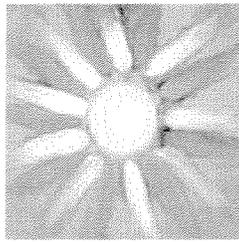
We want to allow time for Q&A.

The more quickly professionals recognize the possibility of mood disorder symptoms, the more quickly appropriate action(s) can be taken. That, in turn, **reduces suffering** and also economic costs to individuals, families, and the county.

*NOTE: These presentations might be collaborative in the sense that professionals from various fields could attend various meetings. In this way, a mix of professionals would learn together and from each other. We could provide a forum where those who normally would not mix might gather to discover some common solutions for assisting the people with mental illness whom the professionals serve.*

Some examples of professionals who deal with people who may show signs of being at risk for a mood disorder or who have experienced first onset would include:

1. Law and Order
  - Probation Officers
  - Police Officers
  - Judges
  - DAs and Public Defenders
  - County Mediators
  - etc.



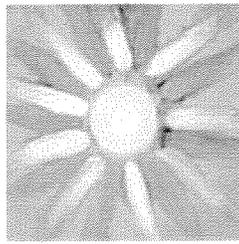
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ATTACHMENT A-1

Proposed Plans for Educating Professionals and Community Members

Educating Professionals and Community Members Plan #1, continued

2. Health Care Professionals
  - Licensed Psychotherapists
  - Addiction Counselors
  - Social Workers
  - Physical Therapists
  - Massage Therapists and massage schools
  - Chiropractors
  - Dentists
3. County Government employees who are part of Health and Human Services
4. School Personnel
5. Church clergy and pastoral counselors.
6. Home Health Workers
7. Visiting Nurses
8. Nursing Home staff
9. Senior Citizen Centers



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ATTACHMENT A-1

Proposed Plans for Educating Professionals and Community Members

Educating Professionals and Community Members Plan #2

Per Eric Rubinstein, M.D., Professional advisor to DBSA Nevada County, here's the outline of what he would like to present to professionals:

I. Teachers

Topic: How depression, hypomanic, and manic states might present in the classroom. When to refer and who to refer to.

Dr. Rubinstein envisions three (3) presentations, based on age of teachers' students: Grade and early middle school; Upper middle school and high school; and College (Sierra College)

*Person with mood disorder might accompany doctor to teacher presentations to participate in Q & A as appropriate.*

II. Physicians

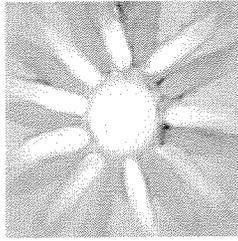
Dr. Rubinstein envisions four presentations at the hospital, as follows:

Topic 1. Bipolar vs. Unipolar depression--how they present across age groups, how to differentiate between them, treatment approaches, and when to refer.

Topic 2. Dementia vs. depressive pseudo dementia--how they present, screening for reversible causes of dementia, treatment modalities, preventive strategies, etc.

Topic 3. Relationships between coronary artery disease and depression. How to safely treat depression in CAD patients.

Topic 4. Post stroke depression. Is it worth treating stroke victims for depression prophylactically? Experimental early treatments after stroke onset. Preventive strategies, etc.



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## ATTACHMENT A-2

Proposed Plans for **Transitional Aged Youth (TAY)** Experiencing or At Risk of Experiencing Onset of Serious Psychiatric Illness

I. Living Successfully with a Mood Disorder 4-week series to be co-led by DBSA peer facilitators specifically trained to present and facilitate LS. Each session to last approximately three hours.  
May be a good introduction to DBSA support groups, though it is definitely not a prerequisite.

II. Weekly Support Groups co-led by trained DBSA peer facilitators, trained in either Recovery Dialogues (RD) format and/or standard peer support format.

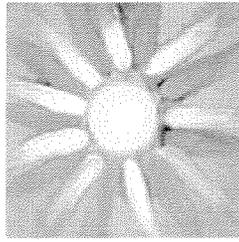
A. Recovery Dialogues format co-facilitated by peers trained in the RD method. Recently DBSA has also offered training in this markedly different method. It was well received when a facilitator tried it out with the DBSA NC group for the first time. It requires more preparation than the standard format.

B. DBSA peer support group co-facilitated by peers trained in the standard peer support group format that DBSA NC has used during our first two years. It is based on guidelines supplied by the national Depression and Bipolar Support Alliance.

III. Psycho-Educational therapy group to meet one or two times monthly.

"Becoming and Staying Mentally Healthy," an ongoing therapy group that includes both an educational components well as group therapy at each meeting.

Group to be co-led by one DBSA NC trained facilitator and one licensed mental health professional, both trained in group dynamics.



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#### ATTACHMENT A-2

Proposed Plans for **Transitional Aged Youth (TAY)** Experiencing or At Risk of Experiencing Onset of Serious Psychiatric Illness  
III. Psycho-Educational therapy group (continued)

The professional's credentials should include:

- Experience with group therapy;
- Expertise in mood disorders;
- At least a master's degree, preferably a higher level degree;
- Respect for peer facilitators and interest in co-leading with a paid peer.

Ideally Eric Rubinstein, M.D., the professional advisor to DBSA NC, will fill this position, at least initially.

Desired outcomes:

1. Participants develop greater recovery and resilience as a result of ongoing, in-depth interaction with other members of group; and
2. Participants learn and apply new wellness strategies that enable them to lead healthy and productive lives, according to their own definitions of a content and rewarding life.

Format:

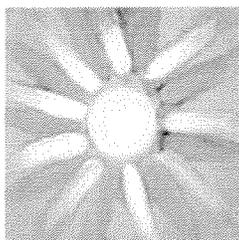
Meet one or two times monthly.

At the beginning of the meeting, one or both of the leaders would provide some information to help members develop and maintain wellness. That might be incorporated into the group therapy, when appropriate.

This proposal addresses the following state-designated needs felt by transitional aged youth:

N1 - Disparities in Access to Mental Health Services.

Group meetings led by peers for people who experience the same issues are typically more inviting and less threatening to some who are unlikely to seek help from any traditional mainstream mental health services.



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ATTACHMENT A-2

Proposed Plans for **Transitional Aged Youth (TAY)** Experiencing or At Risk of Experiencing Onset of Serious Psychiatric Illness  
III. Psycho-Educational therapy group (continued)

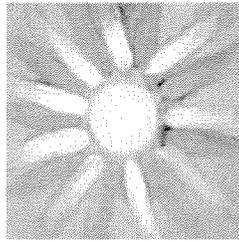
N2 - Psycho-Social Impact of Trauma (for adults)

Adults who are experiencing the negative psycho-social impact of trauma, and who also seem to be at risk of a mood disorder or who are newly diagnosed with a mood disorder, could benefit by attending these groups. Even without some additional traumatizing event or circumstance, such as divorce, death of a close family member, a debilitating and severe physical illness, becoming homeless, etc., we believe those experiencing "first break" are traumatized. Therefore, all participants would most likely be able to relate to each other.

We believe all of the above meet needs for adult Individuals Experiencing Onset of Serious mood disorders or those who are At Risk of developing same. Other priority populations with symptoms of mood disorders, such as Underserved Cultural Populations [P1] and those who are trauma-exposed [P4] per the Department of Mental Health's definitions stated on on page 11, could also benefit from these groups.

Depending upon the youth served, these plans might address any or all of the following needs: 1, 2, 3, 4, 5. (See page 11).

Depending upon the youth served, these plans might address any or all of the following priority populations: 1, 2, 3, 4, 5, 6. (See page 11).



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### ATTACHMENT A-3

Proposed Plans for **Older Adults** Experiencing or At Risk of Experiencing Onset of Serious Psychiatric Illness (priority population 2)

I. Living Successfully with a Mood Disorder 4-week series to be co-led by DBSA peer facilitators specifically trained to present and facilitate LS. Each session to last approximately three hours.

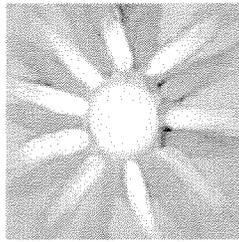
May be a good introduction to DBSA support groups, though it is definitely not a prerequisite.

II. Weekly Support Groups co-led by trained DBSA peer facilitators, trained in either Recovery Dialogues (RD) format and/or standard peer support format.

- A. Recovery Dialogues format co-facilitated by peers trained in the RD method. Recently DBSA has also offered training in this markedly different method. It was well received when a facilitator tried it out with the DBSA NC group for the first time. It requires more preparation than the standard format.
- B. DBSA peer support group co-facilitated by peers trained in the standard peer support group format that DBSA NC has used during our first two years. It is based on guidelines supplied by the national Depression and Bipolar Support Alliance.

Depending upon the senior served, these plans might address any or all of the following needs: 1, 2, 4, and 5. (See page 11).

Depending upon the senior served, these plans might address any or all of the following priority populations: 1, 2, and 4. (See page 11).



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#### ATTACHMENT A-4

Proposed Plans for **Adults** Experiencing or At Risk of Experiencing Onset of Serious Psychiatric Illness (priority population 2)

I. Living Successfully with a Mood Disorder (LS) 4-week series to be co-led by DBSA peer facilitators specifically trained to present and facilitate LS. Each session to last approximately three hours.

May be a good introduction to DBSA support groups, though it is definitely not a prerequisite.

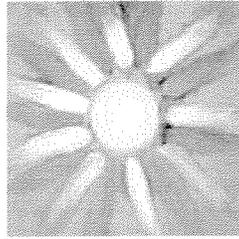
II. Weekly Support Groups co-led by trained DBSA peer facilitators, trained in either DBSA's standard peer support format and/or the newer Recovery Dialogues (RD) format.

A. DBSA peer support group co-facilitated by peers trained in the standard peer support group format that DBSA NC has used during our first two years. It is based on guidelines endorsed by the national Depression and Bipolar Support Alliance.

B. Recovery Dialogues format co-facilitated by peers trained in the RD method.

RD's specific design encourages rebuilding a positive self-image and strengthening the belief in one's own abilities and potential for growth and recovery.

Recently DBSA has also offered training in this markedly different and more structured methodology. It was well received when one of our facilitators tried it out with the DBSA NC group for the first time. It encouraged more interaction while still honoring our guideline of staying with "I" statements and not telling another member what would be best for his/her recovery. It does require that the facilitators spend more preparation than the standard format.



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Per Department of Mental Health,  
California's Key Mental Health Needs:

[N1] Disparities in Access to Mental Health Services – PEI efforts will reduce disparities in access to early mental health interventions due to stigma, lack of knowledge about mental health services, or lack of suitability (i.e., cultural competency) of traditional mainstream services.

[N2] Psycho-Social Impact of Trauma – PEI efforts will reduce the negative psycho-social impact of trauma- on all ages.

[N3] At-Risk Children, Youth and Young Adult Populations – PEI efforts will increase prevention efforts and response to early signs of emotional and behavioral health problems among specific at-risk populations.

[N4] Stigma and Discrimination – PEI will reduce stigma and discrimination impacting individuals with mental illness and mental health problems.

[N5] Suicide Risk – PEI will increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide.

California's Priority Populations:

[P1] Underserved Cultural Populations-Those who are unlikely to seek help from any traditional mental health service either because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, etc.) and would benefit from Prevention and Early Intervention programs and interventions.

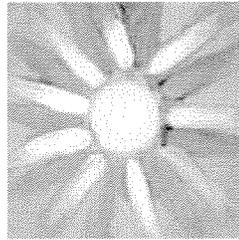
[P2] Individuals Experiencing Onset of Serious Psychiatric Illness- Those identified by providers, including but not limited to primary health care, as presenting signs of mental illness "first break" and are unlikely to seek help from any traditional mental health service.

[P3] Children/Youth in Stressed Families - i.e., families where parental conditions place children at high risk of behavioral and emotional problems, such as parents identified with mental illness, serious health conditions, substance abuse, domestic violence, incarceration, child neglect or abuse.

[P4] Trauma-Exposed - Those who are exposed to traumatic events or prolonged traumatic conditions, including grief, loss and isolation and are unlikely to seek help from any traditional mental health service.

[P5] Children/Youth at Risk for School Failure - due to unaddressed emotional and behavioral problems.

[P6] Children and Youth at Risk of Juvenile Justice Involvement - Those at-risk of, or who have had first point of contact with any part of the juvenile justice system with signs of behavioral and emotional problems.



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**ATTACHMENT B**

Letter of Endorsement from National Depression and Bipolar Support Alliance for our local chapter

Depression and Bipolar  
Support Alliance

August 19, 2008

To Whom It May Concern:

I am writing in support of the Depression and Bipolar Support Alliance Nevada County chapter's proposal to provide prevention and early intervention services to residents in their county.

DBSA Nevada County has been in contact with the national office of DBSA in regards to this program and has worked with us as they have developed their proposal outlines. They have requested that we provide master trainings on our Recovery Dialogues and Living Successfully curriculums for the chapter.

Both of these curriculums are customizable programs to help those living with mental health problems realize the importance of diagnosis and treatment, the realities of recovery, and what they can do to improve their lives and the lives of fellow consumers.

In addition to providing training for the DBSA Nevada County chapter, we will also provide information helpful to the creation of their local task force as well as many of the needed materials.

The Depression and Bipolar Support Alliance (DBSA) is the leading patient-directed national organization focusing on the most prevalent mental illnesses – depression and bipolar disorder. The organization fosters an environment of understanding about the impact and management of these life-threatening illnesses by providing up-to-date, scientifically-based tools and information, all written in language the general public can understand. DBSA's mission is to improve the lives of people living with mood disorders.

We've been there. We can help.  
730 N. Franklin Street, Suite 501 Chicago, IL 60610-7224  
(312) 642-0049 Toll free (800) 826-3632 Fax (312) 642-7243 www.DBSAlliance.org

**ATTACHMENT B**

**Letter of Endorsement from National Depression and Bipolar Support Alliance for our local chapter (continued)**

Depression and Bipolar  
Support Alliance

Assisted by a Scientific Advisory Board comprised of leading researchers and clinicians in the field of mood disorders, DBSA has a grassroots network of approximately 1,000 peer-run support groups across the U.S. and Canada. Nearly five million people requested information and assistance from DBSA last year.

DBSA chapters vary greatly in their level of performance, resources, size and activity. Each chapter has the potential for incredible achievement, and each chapter should do all that they can to support the mission of DBSA, to improve the lives of people living with mood disorders. The highest achieving chapters are always expanding their services in support of the mission of DBSA, and continue to grow and prosper in new and creative ways. DBSA chapters engage in four major functions to achieve this mission: Advocacy efforts, Community Outreach activities, Education and Support groups/self-help options.

DBSA Nevada County has been an exemplary chapter and has shown a tireless effort to improve the lives of people living with mood disorders in the state of California. We look forward to the opportunity to work with them further on the development of this program.

We are pleased to support DBSA Nevada County in their proposal to offer prevention and early intervention services in their county.

Sincerely,

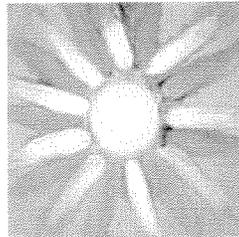


Peter Ashenden  
Interim President  
Depression and Bipolar Support Alliance



Ingrid Deetz  
Director, Chapter Relations  
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ATTACHMENT C – brief notes from October 3, 2008 meeting

Oct 3, 2008 Notes for MHPA PEI meeting at Rood Center

Hello, my name is Abigail Weissman, and I'm a member of the local chapter of Depression Bipolar Support Alliance, known as DBSA Nevada County. With me is Dr. Eric Rubinstein who has served as our professional advisor since our chapter was in the planning stages and Linda Ketcham, DBSA VP of Publicity and Public Relations.

Before we share our ideas with you, I'd like to give you a little background information about our national organization. . .

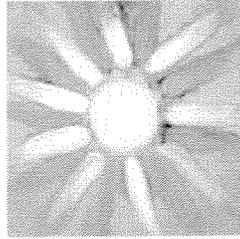
The Depression and Bipolar Support Alliance (DBSA), founded in 1985, is the leading peer-directed national organization focusing on the most prevalent mental illnesses. Based in Chicago, DBSA is the nation's largest consumer-directed mental health organization, offering help, hope, and support to nearly five million people every year.

The national organization fosters an environment of understanding about the impact and management of these life-threatening illnesses by providing up-to-date, scientifically based tools and information written in language the general public can understand.

DBSA has a grassroots network of nearly 1,000 patient-run support groups across the country. Our peer-led chapters and support groups serve about 70,000 people every year. Support groups play an important role in recovery with 86 percent of support group members reporting that their group helped with treatment adherence.

This is a key finding because  
treatment adherence means fewer hospital stays,  
which in turn means lower insurance costs,  
greater employee productivity and  
significantly increased quality of life.

Our local chapter of DBSA was founded 2 years ago; we meet two times/month.



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ATTACHMENT C – brief notes from October 3, 2008 meeting (continued)

Oct 3, 2008 Notes for MHSA PEI meeting at Rood Center

In August, we offered in writing [see Attachments A1-4] five ways we think we can directly or indirectly help people and who are very anxious and confused about their emotional and mental states.

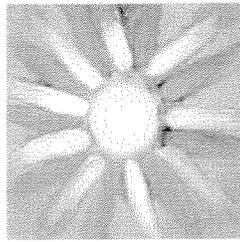
Most of the proposals are based on DBSA materials; thus they are applicable to those concerned with mood disorders. The support groups, designed for Individuals Experiencing Onset of Serious Psychiatric Illness (Priority Population 2) and people who are deemed at risk of mental illness (ARMS).

Our first proposal, an education and collaboration strategy, is targeted for a mix of professionals in our community who deal with people who may exhibit signs of mood disorders or people who have recently been diagnosed with either depression or bipolar disorder.

The second educational proposal consists of presentations from psychiatrist Eric Rubinstein, DBSA NC's professional advisor, for teachers and doctors.

The next group of plans specifically targets **Transition Aged Youth**, the 18 – 25 year olds. We recommend using both Living Successfully and Recovery Dialogues as well as DBSA's more typical format for this age group. We believe these groups will be most effective if co-led by one trained peer facilitators in the same age group and one more experienced, older DBSA facilitator. The youth facilitators and the older advisor would all be backed up by a DBSA professional advisor. (We envision that all facilitators and professional advisors would be paid with MHSA monies. It takes more time to prepare for and to facilitate LS and RD than for our regular support meetings, although they also require some preparation. To date everything we have done has been on a strictly volunteer basis).

Also for the ARMS and First Onset priority population youths, we would like to pilot a psychosocial educational group model. We named it "Becoming and Staying Mentally Healthy." It calls for two people to co-lead an ongoing therapy group. One would be a



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ATTACHMENT C – brief notes from October 3, 2008 meeting (continued)

Oct 3, 2008 Notes for MHSA PEI meeting at Rood Center

peer; the other a licensed professional. A portion of the group time would be educational and much of it would be a more typical process group. Both leaders would have experience with groups.

The third group of plans are intended for older adults. The first is a support group for older adults using DBSA's Recovery Dialogues, a format specifically designed to encourage rebuilding a positive self-image and belief in one's own abilities to recover, based on each person's prior positive experiences.

The other plan for older adults is a four-session course is titled LIVING SUCCESSFULLY with a Mood Disorder. We would meet once a week for four weeks. Living successfully includes two videos in the first session – one narrated by Tony Dow on bipolar disorders and the other narrated by Mike Wallace on The State of Depression in America. Both include interviews with patients and providers.

Finally, for adults, we propose the same two plans, Recovery Dialogues and LIVING SUCCESSFULLY with a Mood Disorder.

## Nevada County Mental Health Board Minutes

<b>Date:</b>	<b>March 6, 2009</b>
<b>Time:</b>	<b>10:00 a.m.</b>
<b>Place</b>	<b>Behavioral Health Conference Room – Crown Point Circle</b>

**STANDING ORDERS**

1. **Call to Order** – The meeting was called to order, self-introductions were made and a sign in sheet was passed around.
2. **Minutes from February 6, 2009.**  
Minutes from last month are not finished. We will approve them at next month's meeting.
3. **Announcements.**  
Barbara Lindsay-Burns announced SPIRIT Peer Empowerment Center is getting a \$14,000 grant to expand to Truckee. They will start in June one day per week with a support group and peer counseling.

Scottie Hart announced she will be facilitating the NAMI Connections Recovery Support Group. There are two NAMI Connections Recovery Support Groups one meets on Tuesday night at SNMH and one meets on Wednesday night in Truckee.

Abigail Weissman announced the Depression and Bipolar Support Alliance provides support for family members and anyone with depression or bipolar disorder. The Depression and Bipolar Support Alliance meets twice a month on the 1<sup>st</sup> and 3<sup>rd</sup> Thursday of each month 6:00 – 7:30 p.m. at the Unitarian Church, 246 South Church Street.

Michele Violetta announced the Continuum of Care meeting is at 12 noon today at the Salvation Army.

4. **Probation – Doug Carver, Chief Probation Officer.**  
Doug Carver was invited to today's meeting over concern that there is only one Probation Officer in Truckee. There have been difficulties filling Probation Officer vacancies. The Truckee Office has two Probation Officers and a Legal Office Assistant position. There was a period of time when the only Probation staff in Truckee was one Probation Officer. They now have a Legal Office Assistant in Truckee. The Deputy Probation Officer position has had several recruitments, but none of the candidates were qualified. In December the position was filled, but the person resigned in January. In the past year Probation Officers from Nevada City have been filling the position. One of the Probation Officers from Nevada City will be permanently assigned to the Truckee Office. There are no mandated caseload standards for Probation Officers. There have also been a diminishing number of MFT's in Truckee that accepts sliding fee scale. Probation is working to get a Juvenile Mental Health Court in Truckee. They have established a Juvenile Drug Court.

With the State budget shortfalls there is some concern about cuts to Juvenile Justice Crime Prevention Act funding, Juvenile Camps and Probation funding. The State budget passed without those cuts, but it is contingent on the special election in May and Vehicle License Fee (VLF) passing. A portion of the VLF goes to Public Safety Programs.

EMQ has two staff members in the Truckee area; they are currently serving 5-6 youth in the Truckee area. The current Victor contract does not include the Truckee area. Victor will have a satellite office in Truckee at some point in the future. Currently there are no Victor staff that live in the Truckee area. EMQ is serving the Truckee area since their time is more productive and can be spent providing services to youth instead of driving. Sierra Family Services will soon begin to provide services in Truckee.

**5. Workforce Education and Training (WET) Plan Public Hearing – Denise Harben and Michele Violett. Handout.**

Barbara Lindsay-Burns wanted clarification that family and consumers are included in the plan. There are several places in the plan where consumers and family members are included. Denise Harben was asked to make the plan very flexible, so specific organizations or teachers are not in the plan. Under Training and Technical Assistance on page 17, Objectives 1 & 2, consumers and family members are included. Also under the Financial Incentive Program creation of a speaker's bureau on page 21 includes client and family member involvement. In addition teleseminars and library materials will be available to consumer and family members.

Denise Harben gave a brief overview. The plans intent is to develop a culturally competent workforce. The Workforce Education and Training subcommittee started meeting in July 2007 with monthly meetings. In October 2008 a survey was sent out for input on training topics. The top two were trauma assessment and Co-Occurring Disorders. WET funds total \$457,000. The WET coordinator position is \$33,800. The plan has five categories. Four of the categories are funded for four years. The Mental Health Career Pathway Program is funded for two years.

**Public Comment:** The Depression and Bipolar Support Alliance (DBSA) would have liked to have received the survey. DBSA would like specialized evidence based training for licensed providers who provide services to adults with mood disorders. Michele Violett replied that on page 16 under Training and Technical Assistance Action #2 includes evidence based training on various topics. Concern that the training addresses specific psychotherapy techniques to use with an adult population with mood disorders. DBSA would like to give input on training topics and participate in trainings. DBSA has been invited to be a part of the MHSA Steering Committee and/or MHSA Subcommittees. Representatives of DBSA are included in the MHSA email contact list.

**REPORTS**

**1. Behavioral Health Director's Report, Grant & MHSA update – Handouts.**

Darryl Quinn & Michele Violet. Handout.

Darryl Quinn handed out a report on the adult client population diagnoses. Roughly one third of our population has major depression or anxiety disorder, one third has bipolar disorder, and one third has schizophrenia or schizoaffective disorder.

Question was asked about Behavioral Health clients not receiving full service partnership services from Turning Point. Behavioral Health has converted the Day Treatment Program into a mini-ACT Team called New Directions.

The COD grant is a 2 ½ year grant for Mental Health Court clients with co-occurring disorders. This allowed us to expand Mental Health Court. This grant ends in April 2010. The courts will apply for a 2 year expansion grant that would provide additional services at CORR.

Terry Winters will bring the Housing MOU to the Nevada County Housing Development Corporation Board. Then it will go to County Counsel for review. After that we can begin to look at potential projects.

Capital Facilities Project #1 Turning Point remodel will be completed next week. Turning Point will be having an Open House, date to be announced. Capital Facilities Project #2 has been approved by the State. The RFP process has been completed and a contractor has been chosen. Denise Harben has been involved with the Information Technology subcommittee that will choose a new software program for billing and electronic health records. Iden Rogers will be joining the committee. Michele Violet invites others to join. This is a short term committee as we expect to submit the plan in June.

We expect to have the Prevention and Early Intervention (PEI) plan released for 30-day public comment on March 16<sup>th</sup>. There will be a Public Hearing on April 3<sup>rd</sup> for the PEI Plan. Michele Violet and Becky Slade will have a phone conference with the Oversight and Accountability Committee on Monday for instructions on submitting the plan. We will be asking for the entire 1.6 million, this will cover more than one year.

The guidelines for Innovation have been released. Becky Slade has offered to take the lead on this project.

Nevada County Superintendent of Schools has applied for a Safe and Healthy Schools 4-year Grant. The grant includes funding for three therapists to be located in the schools. The Truckee area school district did not want to participate in this grant, they intend to apply for their own grant next year.

**2. Truckee – Mary Folck.**

Mary Folck announced that there may be three people interested in applying for the Mental Health Board. There is concern about school counselor's employment in Truckee due to the school budget shortfalls.

**3. Peer Counselors – Barbara Lindsay-Burns.**

SPIRIT Peer Empowerment Center will be signing a contract with Big Brothers/Sisters to fund training. The grant serves high risk youth including those with mental illness who may need a mentor. The grant also allows SPIRIT Peer Empowerment Center to train members who want to be mentors.

SPIRIT Peer Empowerment Center will have its first Board Retreat to put together a strategic plan. They are seeking additional board members. Gail Gordon is the Board Chairperson.

SPIRIT Peer Empowerment Center will be attending the Continuum of Care meeting today and will collaborate with Hospitality House to develop Respite Care.

**Public Comment**

Rich Stone asked everyone to invite consumers and family members who have an interest in participating in the Mental Health Services Act Steering Committee and/or subcommittees meetings. This is a huge opportunity to shape how services are delivered in the community. There has been a drop in participation for various reasons. If we are not represented we won't be heard. Please encourage new consumers, family members and other community organizations to attend.

**ATTENDANCE:**

- Members Present:** Joan Rogers-Toensing, Supervisor Scofield, Iden Rogers, Richard Stone, Mary Folck.
- Excused Absent:** Pat Sweetser.
- BH Staff:** Annette LeFrancois, Michele Violet, Denise Harben, Darryl Quinn
- Visitors:** Barbara Lindsay-Burns, Abigail Weissman, Scottie Hart, Fredi- Ruth Levitt, Doug Carver.

Minutes by Annette LeFrancois, Recording Secretary

## Nevada County Mental Health Board Minutes

<b>Date:</b>	<b>April 13, 2009</b>
<b>Time:</b>	<b>10:00 a.m.</b>
<b>Place</b>	<b>Behavioral Health Conference Room – Crown Point Circle</b>

**STANDING ORDERS**

6. **Call to Order** – The meeting was called to order, self-introductions were made and a sign in sheet was passed around.
7. **Minutes from April 3, 2009.**  
Motion was made by Rich Stone to approve the minutes as written. Seconded by Mary Folck. Supervisor Scofield abstained. All other members present were in favor.
8. **Announcements.**  
There were no announcements.
9. **Prevention and Early Intervention (PEI) Plan Public Hearing – Michele Violett. Handout.**  
Copies of the Prevention and Early Intervention Plan were handed out to those who have not already received one. Michael Heggarty announced that the Prevention and Early Intervention Plan is not for direct treatment services unless it is brief or for treatment at the beginning or onset of an illness. The PEI plan target population is for people who have not yet been diagnosed. Funding for PEI is approximately \$750,000 per year with a decrease in funds for the next three years.

**Public Comment:**

- 1) Joan Rogers-Toensing, Mental Health Board Chair commends Becky Slade, Rich Stone and the PEI Subcommittee for writing a terrific plan.
- 2) Rich Stone, Mental Health Board member comments that the committee heard from many people all over the county with various points of view relating to mental illness. There were not any bad proposals. It was a long process getting public input and comment. There isn't and never will be enough money to address all of the proposals.
- 3) Mary Folck, Mental Health Board member commented that the word blessed was used in the plan. Suggestion that the word be removed and replaced with something else like enriched. Mary would like more information included on the homeless outreach person referred to as a case manager. Mary wanted the definition of case manager in an outreach context. Becky Slade replied that the case manager would establish trust and go to where the homeless are (i.e. Hospitality House, Truckee and other locations). The case manager will attempt to connect the homeless to services including applying for Medi-Cal, SSI, CalWorks, and finding housing. Mary felt the term case manager is a turnoff in consumer populations.

- 4) Abigail Weissman a member of The Depression and Bipolar Support Alliance of Nevada County. Abigail stated that Linda Ketcham had a strong interest in the MHSA process and she communicated that she wanted to be on the PEI Committee but for some unknown reason it never happened. Abigail Weissman was concerned about the process and that it seemed like some input was turned down. Abigail had asked if she could be hired as a consumer to help write the plan. Becky Slade let her know that Behavioral Health would not spend money on outside help.
- 5) Linda Brannon from the Nevada City School District. Linda brought two handouts: A summary of the PAL Program and an article about mentoring and its importance for youth. Linda said the PAL Program is currently within the Nevada City School District but is being used as a benchmark program to expand it to other schools in the community. The PAL Program works with Sierra Mentoring Partnership who provides coordination of the mentoring programs. Linda is grateful that the plan includes mentoring. Linda is grateful for the work done on this plan and has been involved in the process.
- 6) Lael Walz from EMQ Families First and Sierra Family Medical Clinic realizes from the CSS process that we won't make everyone happy but is hopeful at implementation that we can encourage and involve others. Lael feels that education of professionals in the community is important and it could happen through the doctors at Sierra Family Medical Clinic.
- 7) Helen Williamson represents NAMI and wants to mention the concern NAMI has with hiring temporary workers for several PEI positions and what happens to the effectiveness of the program when knowledgeable and effective people leave and have to be replaced. On page seven of the PEI Plan it mentions the Children's System of Care Executive Committee, but it did not include any family representatives or consumer representatives. NAMI would like the Children's System of Care Executive Committee to include family and consumer representatives. The PEI Plan lists the old name for NAMI. NAMI should be listed as the National Alliance on Mental Illness.
- 8) Iden Rogers, Mental Health Board member is also concerned about hiring three temporary workers for such key positions in Prevention and Early Intervention as he stated at the previous PEI Public Hearing.
- 9) Chris Anderson, President of the Nevada County Depression and Bipolar Support Alliance (DBSA). Chris read into the record the letter that was submitted to the Mental Health Board on March 29, 2009. DBSA submitted two proposals for educating professionals in the community. DBSA would like the Mental Health Board to consider two DBSA peer-led groups: 1) Living Successfully with a Mood Disorder and 2) Support groups including DBSA Recovery Dialogues. The final proposal was for a psychosocial and educational therapy group to be co-led by one peer and one licensed professional. Refer to the attached letter.
- 10) Roger Steel, Superintendent of the Nevada City School District supports Linda Brannon's comments about the PAL Program. Unfortunately this year with major budget cuts from the State, the Nevada City School District is unable to financially support the PAL Program. PAL is a very crucial program that serves kids at risk that may not have an effective role model at home. Many of the Middle School aged kids who have gone through the program become mentors when they reach High School. Roger appreciates the PEI Plan for including financial support for the PAL Program.

- 11) Mary Folck is happy for the PAL Program and asked about the mechanism for engagement for children with mental illness. What is the process in the mentoring relationship for supporting the child with mental illness? Linda Brannon replied that the program's intent is for prevention and early intervention and they hope that mentors can receive additional training through MHSA. If a child exhibits behaviors that are of concern to the big PAL like depression or expresses their dislike of school; the mentor brings their concern to the Program Coordinator. The Program Coordinator works with administration to refer the child to counseling. CPS would be contacted if there are issues of child abuse or neglect. Michele Violetta stated that the Suicide Prevention Coordinator will provide training to mentors and other groups in the community.
- 12) Lael Walz announced that everyone is invited to participate in the Suicide Prevention Taskforce which meets this Friday at the Eric Rood Administrative Building in the Providence Mine Room at 10:00 a.m.
- 13) Rich Stone stated that DBSA's proposals were given consideration during the process. There were concerns that the support groups might not meet the State criteria for PEI. It may be more appropriate under CSS funding. Rich recommends that at the next MHSA Steering Committee Meeting that DBSA make a proposal for funding for the next fiscal year under CSS. Abigail was unaware that their proposal would not meet criteria for PEI. Michele Violetta stated that the WET Plan would be appropriate for DBSA's proposal to provide training to clinicians. Abigail feels that DBSA's Proposals are pertinent for PEI when the focus was changed to groups with first onset. It should be noted that Abigail submitted a proposal in the original CSS Plan that did not receive funding, though not in connection with DBSA. Nevada County DBSA was not in existence at the time the original plan was submitted.
- 14) Mary Folck asked if DBSA's proposal would fit under Innovative Funding. Michele Violetta stated that Innovation is short term to try something out for 1 – 3 years. Once it is done there is no more funding. The community would need to decide if it should be funded with other MHSA PEI or CSS funds. The State suggests counties choose projects that improve processes you are already doing or projects that cost more upfront and then would require little funding to continue. Innovative funds are \$199,600 for this fiscal year with less than that amount in future years.
- 15) Helen Williamson from NAMI voiced concern about services for Transitional Aged Youth (TAY) and the need for stronger coordinated supports for TAYs. We commend you for including TAYs and recommend that it be strengthened and included in MHSA plans wherever possible.
- 16) Michele Violetta announced that everyone is invited to attend the MHSA Steering Committee meetings. Meeting dates are announced through an email list. Contact Annette LeFrancois at 265-1758 or [annette.lefrancois@co.nevada.ca.us](mailto:annette.lefrancois@co.nevada.ca.us) to be added to the email list.
- 17) Abigail Weissman referred to a PowerPoint presentation on suicide where it was unclear who (age group, diagnosis) is doing most of the suicides. Abigail asked if we knew ages or diagnosis. Michael Heggarty does receive information on age, gender, and cause of death. Other information is available, but we need someone to collate it, enter it into a data base and analyze it. Michael Heggarty would like the Suicide Prevention Coordinator to have the skills to do this. It is often hard to draw conclusions since we are a small county and the next year can be very different. Patterns over the years are not consistent.

- 18) Becky Slade wants everyone to be involved in planning implementation of the programs once we have approval from the State. How they look in the plan and how they end up can be very different. We can make minor changes in the plan without approval from the State.
- 19) Abigail Weissman asked if DBSA's entire letter will be included with the plan submission. Michele Violetta will attach it to our plan along with any other written public comment received in the 30-day public comment period.
- 20) Becky Slade apologized for any poor communication or issues that were dropped. That was not her intent. The process has been a learning curve for Becky. Becky also apologized to DBSA if they haven't felt included in the process. Becky Slade wants DBSA to stay in contact and continue to be part of the process.
- 21) Mary Folck thanks Abigail for continuing with the peer and provider coordinated group. It is a great idea.

**ATTENDANCE:**

**Members Present:**

Joan Rogers-Toensing, Supervisor Scofield,  
Iden Rogers, Richard Stone, Mary Folck.

**Excused Absent:**

Pat Sweetser.

**BH Staff:**

Annette LeFrancois, Michele Violetta, Michael Heggarty,  
Becky Slade.

**Visitors:**

Abigail Weissman, Lael Walz, Linda Brannon, Helen Williamson,  
Joann Thompson, Susanna Dimmitt, Jack Meeks, Roger Steel,  
Chris Anderson.

Minutes by Annette LeFrancois, Recording Secretary