

**PROGRAM AND EXPENDITURE PLAN
MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION**

Fiscal Years 2007-08 and 2008-09

PART I: PURPOSE, BACKGROUND AND DEFINITIONS

Purpose

The Mental Health Services Act requires that the California Department of Mental Health (DMH) shall establish guidelines for the content of the Prevention and Early Intervention (PEI) Plan that each county mental health program shall submit as part of the County's Three Year Program and Expenditure Plan. The purpose of this document is to set forth the proposed guidelines and proposed criteria for the release of Prevention and Early Intervention program funds to counties. These proposed guidelines and criteria will be forthcoming in regulations.

Time Period

These proposed guidelines cover the period FY 2007-08 and 2008-09, for the initial implementation of PEI. The subsequent Integrated Plan requirements are expected to be consistent with these proposed requirements, with a streamlined response required from counties that already have approved PEI plans.

Background

The Mental Health Services Act (MHSA) represents a comprehensive approach to the development of community-based mental health services and supports for the residents of California. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support the local mental health system. To provide for an orderly implementation of MHSA, DMH has planned for sequential phases of development for each of the five components. Ultimately, all five components will be integrated into the counties' Three-Year Program and Expenditures Plans with a continuum from prevention and early intervention to comprehensive, intensive interventions for those in need. The five components are:

- Community Services and Supports
- Workforce Education and Training
- Capital and Technology
- Prevention and Early Intervention
- Innovation

Statute

Statutory authority for PEI is from Welfare and Institutions Code, Division 5, Part 3.6, Section 5840. Please refer to Appendix 1 for statutory language.

Building the PEI Framework

Throughout its progression, developing the PEI framework has been a collaborative and dynamic process. The Mental Health Services Oversight and Accountability Commission (OAC) and its PEI Committee, composed of diverse members with experience in prevention and early intervention programs and services, held a series of ten public meetings to collect input and feedback as each subsequent draft of a policy paper was developed. Those involved in drafting and refining the policies included the OAC, the DMH, the California Mental Health Planning Council (CMHPC), the California Mental Health Directors Association (CMHDA), and statewide and community stakeholders. Out of this comprehensive process came joint policies—based on each organization’s principles and ongoing stakeholder input—that emphasize:

- Key PEI community mental health needs:
 - Disparities in access to mental health services
 - Psycho-social impact of trauma
 - At-risk children, youth, and young adult populations
 - Stigma and discrimination
 - Suicide risk;
- PEI priority populations:
 - Underserved cultural populations
 - Individuals experiencing onset of serious psychiatric illness
 - Children/youth in stressed families
 - Trauma-exposed
 - Children/youth at risk for school failure
 - Children/youth at risk of juvenile justice involvement; and
- State-administered projects:
 - Suicide Prevention
 - Stigma and Discrimination Reduction
 - Ethnically and Culturally Specific Programs and Interventions
 - Training, Technical Assistance and Capacity Building
 - Statewide Evaluation

The OAC approved the policy recommendations, which then became the framework for these PEI draft proposed guidelines. Final development came after the stakeholder input process, in broadly-inclusive stakeholder meetings held throughout California that included specific processes and representation from a number of ethnic and cultural groups and transition-age youth.

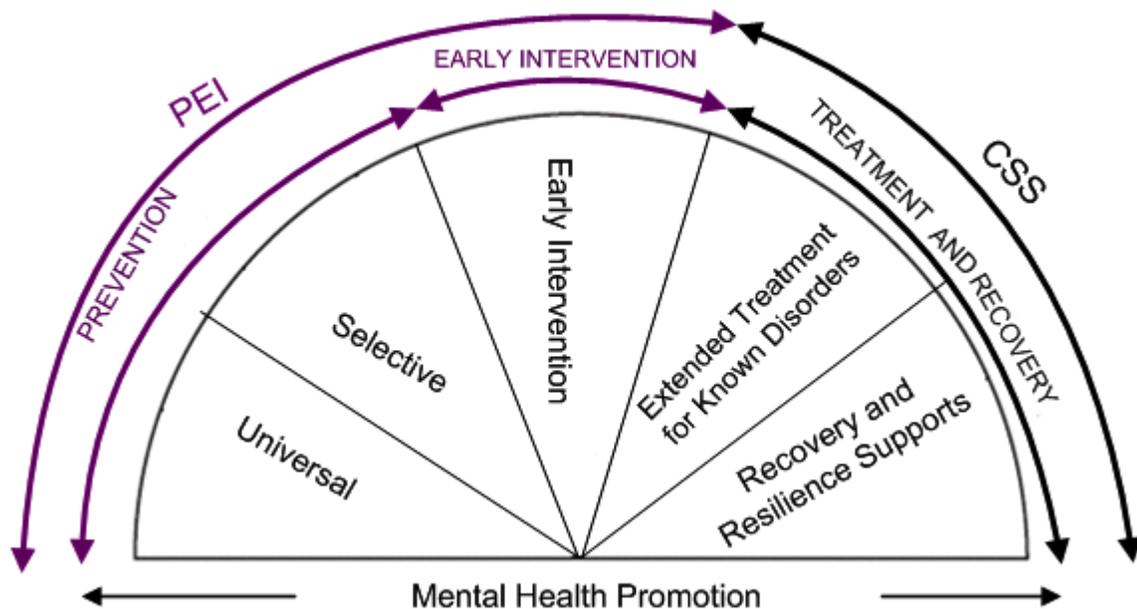
For background information on the PEI policies, please refer to the document, “MHSOAC Mental Health Services Act Prevention and Early Intervention: County and State Level Policy Direction,” adopted by OAC on January 26, 2007 (available at website: <http://www.dmh.ca.gov/MHSOAC/docs/PolicyRecMHSAPeI.pdf>).

Operational Definition of Prevention and Early Intervention

To clearly delineate the funding parameters for the PEI component of MHSOAC and to distinguish PEI from Community Services and Supports (CSS) and other components, the following elements comprise the operational definition of PEI.

While prevention and early intervention occur across the entire mental health intervention spectrum, the policy foundation constructed by the OAC and its PEI Committee, DMH, and CMHDA defines the PEI component of the MHSOAC as **programs and interventions at the early end of the spectrum.**

Mental Health Intervention Spectrum Diagram



Source: Adapted from Mrazek and Haggerty (1994) and Commonwealth of Australia (2000)

Prevention

The **Prevention** element of the MHSOAC PEI component includes programs and services defined by the Institute of Medicine (IOM) as **Universal** and **Selective**, both **occurring prior to a diagnosis** for a mental illness. (For MHSOAC purposes, IOM’s **Indicated** prevention category fits into the operational definition for Early Intervention, as explained in the next section).

Prevention interventions may be classified according to their target groups (IOM):

Universal: target the general public or a whole population group that has not been identified on the basis of individual risk. (Examples: education for school-aged children and youth on mental illnesses; gatekeeper training on warning signs for suicide and how to respond).

Selective: target individuals or a subgroup whose risk of developing mental illness is significantly higher than average. (Examples: behavioral health consultation to support groups for older adults who have lost a spouse; screening women for post partum depression).

Prevention in mental health involves reducing risk factors or stressors, building protective factors and skills, and increasing support. Prevention promotes positive cognitive, social and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances. Universal voluntary screening may also be a prevention intervention to facilitate early identification of potential mental health problems or concerns. MHSA calls for an approach to prevention that is integrated, accessible, culturally competent, strengths-based, effective, and that targets investments with the aim of avoiding costs (in human suffering and resources) for treatment services.

Generally, there are no time limits imposed on prevention programs and many are low cost. Cost sharing is a viable option for many prevention programs, especially those that serve multiple purposes (e.g., universal voluntary early childhood screening, youth development, constructive parenting education, social and support groups, health guidance).

Early Intervention

Early Intervention is directed toward individuals and families for whom a short-duration (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve mental health problems or concerns thereby avoiding the need for more extensive mental health treatment or services; or to prevent a mental health problem from getting worse. Examples include parent-child interaction training for children with behavioral problems, anger management guidance, and socialization programs with a behavioral health emphasis for home-bound older adults with signs of depression.

For individuals participating in PEI programs, the Early Intervention element:

- Addresses a condition early in its manifestation
- Is of relatively low intensity
- Is of relatively short duration
- Has the goal of supporting well-being in major life domains and avoiding the need for more extensive mental health services

- May include individual screening for confirmation of potential mental health needs

Please refer to the Mental Health Intervention Spectrum shown on Page 3.

Prevention and Early Intervention as a Whole

An objective of PEI is to increase capacity for mental health prevention and early intervention programs led or supervised by behavioral health professionals or other appropriately qualified individuals in organizations and systems where people in the community currently go for purposes other than mental health treatment services.

PEI programs have the following characteristics:

- 1) Consistent with MHSA transformational principles, potential program participants and their families are involved in planning, implementing and evaluating PEI programs.
- 2) Programs are designed and implemented in collaboration with other systems and/or organizations.
- 3) Programs are generally delivered in a natural community setting (for example, tribal/Native American center, refugee resettlement agency, preschool and school, family resource center, juvenile justice probation department, comprehensive services for home-bound older adults, primary health care, community-wide wellness center).
- 4) Programs link individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or an other appropriate mental health services provider. Programs help individuals navigate systems (e.g., understand Medi-Cal or private health plan benefits and identify providers) to obtain needed services.
- 5) Programs also help link individuals and family members to other needed services, particularly in the areas of substance abuse treatment, community, family or sexual violence prevention and intervention, and basic needs.
- 6) Workplans include a combination of sufficient prevention programs and, for those individuals who need it, early intervention to achieve desired PEI outcomes. This may be accomplished by coordinating efforts with partners' existing programs.
- 7) Programs are consistent with non-supplant requirements, collaboration and leveraging principles, and all MHSA statutory and regulatory requirements.

PEI funding is to be used to achieve specific PEI outcomes for individuals, programs/systems and communities. PEI funding is to be used to prevent mental health problems or to intervene early with relatively short duration and low intensity approaches to achieve intended outcomes, *not* for filling gaps in treatment and recovery services for individuals who have been diagnosed with a serious mental illness or serious emotional disturbance and their families.

Exception for Early Onset of a Serious Psychiatric Illness with Psychotic Features

There is an exception for use of PEI funds for the type of program and interventions described in the PEI Resource Materials for Early Onset of a Serious Psychiatric Illness, or similar programs with comparable effectiveness. The standards of low intensity and short duration do not apply to services for individuals experiencing early onset of a serious psychiatric illness with psychotic features that receive this type of transformational intervention.

Further Distinction of PEI from CSS

Some of the Community Services and Supports (CSS) Workplans (particularly in the Outreach and Engagement element) contain a variety of partnerships with non-mental health entities to improve the identification of mental health issues, enhance referral relationships, co-locate services, and build the capacity of these entities to deliver mental health services. Many plans, for example, include partnerships with ethnic/cultural community based entities and/or with health care sites. These CSS Outreach and Engagement efforts have many elements in common with the recommended PEI strategies. What distinguishes these CSS activities from PEI strategies?

Distinction in Intent and Practice: The intent of the CSS outreach and engagement strategies was to reduce the barriers to services for individuals who would otherwise qualify for CSS mental health services; i.e., persons with serious mental illness or children/youth with serious emotional disturbances. To distinguish, the intent of the PEI strategies is to engage persons prior to the development of serious mental illness or serious emotional disturbances, or, in the case of early intervention, to alleviate the need for additional mental health treatment and/or to transition to extended mental health treatment.

In practice, the content of the CSS Outreach and Engagement partnership program is not always restricted to increasing access only for those with serious mental illness or emotional disturbances. It is possible, therefore, that some of the CSS work plans now being implemented may meet the criteria for PEI funding.

Counties wishing to transfer a CSS-funded activity to PEI funding should:

- Ensure that the workplan meets PEI requirements
- Complete and submit a Plan Amendment for its CSS Plan (refer to instructions at www.dmh.ca.gov/DMHDocs/docs/notices06/06-15.pdf, DMH Information Notice No.: 06-15)
- Provide full details about the activity in the PEI Plan, according to the PEI proposed guidelines

PART II: COMMUNITY PROGRAM PLANNING PROCESS

Counties must conduct a planning process consistent with California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3300 and that specifically addresses PEI priorities and considerations. The county's PEI Program and Expenditure Plan must document how the regulatory requirements were met.

Some county mental health programs may find that they need additional funds to complete the program planning and PEI Plan preparation processes. DMH will describe how county mental health programs will be able to request approval for a larger amount of their PEI Planning Estimate to be directed toward Community Program Planning activities.

Through the planning process, counties must select Key Community Mental Health Needs and Priority Populations from those identified and approved by the OAC (available at website <http://www.dmh.ca.gov/MHSOAC/docs/PolicyRecMHSAPEI.pdf>).

Similar to Community Services and Supports (CSS), the PEI County Plan will be based on a logic model. The planning process informs each part of the logic model. The PEI logic model includes the following sequence:

- Identification and selection of Key Community Mental Health Needs and related PEI Priority Populations for PEI Programs and Interventions
- Selection of PEI Strategies (including programs, approaches, activities and policies) to achieve Desired Outcomes
- Assessment of Community Capacity and Strengths
- Development of Workplans with Timeframes, Staffing and Budgets
- Implementation of Accountability, Evaluation and Program Improvement Activities

Required Comment Period and Public Hearing

Consistent with MHSAs statutory and regulatory requirements (Welfare and Institutions Code Sections 5848 (a) and (b) and California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3315), each county's draft Prevention and Early Intervention plan shall be developed with local stakeholders and circulated for review and comment for at least 30 days to representatives of stakeholder groups and any interested party who has requested a copy of the plan. The draft plan should be widely circulated to all participants, communities and agencies who were involved in the planning process. A public hearing then must be held by the local mental health board/commission. Concerns raised at the public hearing should be included in the final plan, including the county mental health program's response.

Building on the CSS Planning Process

Following are some ideas that counties may consider as they develop their planning process. Many counties conducted extensive community planning processes for the CSS component and can build on that effort for the PEI planning process in a number of ways including:

- Use existing relationships and partnerships for outreach and seek out partnerships in underserved communities
- Use developed education, information templates and communication methods
- Obtain updated versions of demographic and service data files collected for the CSS process
- Reassess information collected during the CSS process to determine applicability to the PEI planning process
- Use venues identified as effective gathering places for meetings to optimize participation of underserved populations.
- Use procedural and facilitation methods found to be successful in public hearings
- As appropriate, conduct meetings in the languages used in specific communities

Inclusive Planning Process for PEI

The community program planning process should include meaningful involvement and engagement of diverse communities and potential individual participants, their families and other community stakeholders. Consistent with California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3200.270, the county must also include the key strategic sectors, systems, organizations and people that contribute to particular mental health outcomes in successful prevention and early intervention programs. Partnerships should extend across sectors of the community, including, but not limited to, the list in Table 1. The PEI process may target outreach to expand participation by additional PEI constituency groups and collect data from additional service sectors.

Table 1: Required and Recommended Sectors and Partner Organizations for Prevention and Early Intervention Planning

Required Sectors	Recommended Partner Organizations
Underserved Communities	Community based organizations representing Native American, African American, Hispanic/Latino, Asian/Pacific Islander, Refugee, Lesbian/Gay/Bisexual/Transgender, and other underserved/unserved communities
Education	County offices of education, school districts, Special Education Local Plan Areas, school-based health centers, universities, community colleges, adult education, First 5 Commissions
Health	Health clinics, public health, primary health care settings, specialist mental health services, specialist older adult care health services, Native American Health Centers, community health, alcohol and drug treatment centers, regional centers, emergency services, maternal child and adolescent health services
Social Services	Child and family welfare services, CalWORKs, child protective services, home and community care, disability services, adult protective services
Law Enforcement	County criminal justice, courts, juvenile and adult probation offices, judges and public defenders, sheriff/police
Recommended Additional Sectors	Recommended Partner Organizations
Community Family Resource Centers	Multipurpose family resource centers, faith centers, arts, sports, youth clubs/centers, parks and recreation, homeless shelters, senior centers, refugee assistance centers
Employment	Public and private sector workplaces, employee unions, occupational rehabilitation settings, employment centers, Work Force Investment Boards
Media	Radio, television, internet sites, print and newspaper offices

Direct efforts to include individuals from underserved communities in the planning process may be needed. Outreach efforts could include consultations with key informants, members and leaders of underserved communities with knowledge of mental health needs. Input from key informants could be sought through focus groups and other appropriate methods regarding community perceptions of needs, priority populations, community assets relevant to PEI efforts, potential strategies, and evaluation methods. These efforts might have as their goal the ongoing inclusion of community perspectives in PEI plan implementation over the long term. Informants representing underserved communities should be involved in the drafting of county plans. Successful outreach and engagement processes in the planning stage can be reflected in elements of the county plans, demonstrating collaboration with community based organizations to address needs of underserved communities.

PART III: PEI WORKPLANS

Each PEI workplan is generally a combination of related prevention programs and early intervention activities that are designed to address one or more PEI Key Community Needs and PEI Priority Populations, consistent with PEI Principles, to meet specific PEI outcomes. The scope of each workplan should not be overly broad or too narrow to achieve the outcomes.

Connection of PEI Workplans with PEI Priority Populations

The nature of the PEI Priority Populations, of the recommended strategies (programs, activities, and approaches), and of the partner organizations create numerous opportunities for overlaps.

- The same individual or family can fit into more than one Priority Population. For example, a child might have been exposed to major trauma, might live in a stressed family, might be at risk of contact with the juvenile justice system, and at risk of school failure. In fact, the presence of more than one of these risk factors increases the likelihood of negative outcomes.
- Community organizations or agencies implementing PEI strategies in partnership with County Mental Health will potentially serve individuals that represent several or all of the PEI Priority Populations.

To accommodate this complexity while maintaining a consistent structure counties can choose from the following alternatives for dealing with these overlaps.

Choice 1: The county may place activities, programs, and approaches directed at multiple priority populations into one priority population workplan based on the most salient of the risk factors. When the county makes such a decision it should specify in the workplan description the various priority populations which might be included in the intervention and describe the reasons for its selection.

Choice 2: The county may combine two or more priority populations into one workplan if all the activities, programs, and approaches are relevant to those priority populations. The county should specify in the workplan description how it will verify that the individuals or families meet the various priority population categories.

In either case, as specified in the evaluation section, the county will be expected to track by workplan the nature of the problem or risk factors (corresponding to PEI Priority Populations, suicide prevention or reduction of stigma and discrimination) that its activities, programs, and approaches are designed to alleviate.

Reducing Disparities

An overarching goal of the MHSA is to reduce disparities experienced by specific ethnic and cultural groups. This goal is central to PEI planning and the implementation of workplans and strategies. Specifically, PEI workplans can contribute to this goal through three major objectives:

- Providing culturally competent and appropriate strategies (programs and interventions);
- Facilitating access to PEI programs, interventions and services; and
- Improving individual outcomes of participants in PEI programs.

Improving access to mental health services for underserved communities and reducing disparities in mental health across socioeconomic and racial/ethnic groups are key priorities of the MHSA. To address this, DMH worked with the University of California, Davis, Center for Reducing Health Disparities (CRHD) to develop a process for community outreach and engagement in underserved and isolated communities to encourage ongoing, meaningful input and participation in the planning and implementation of Prevention and Early Intervention programs. DMH is currently developing a plan to disseminate the outreach and engagement methodology and findings.

Priority Age

Counties should develop workplans and select strategies based on the requirement that PEI County Plans must reflect strategies that address all age groups and a minimum of **51 percent of their overall PEI Plan budget must be dedicated to individuals who are between the ages of 0 to 25**. Small counties are excluded from this requirement. The California Code of Regulations, Section 3200.260 defines “small county” as a county in California with a total population of less than 200,000, according to the most recent projection by the California State Department of Finance.

County Selection of Strategies

A PEI Resource Materials, available at www.dmh.ca.gov/mhsa/PreventionEarlyIntervention.asp was developed to provide examples of strategies counties may consider implementing.

Counties may wish to select alternative strategies that better fit their community context, and may do so with a sufficient rationale. Please refer to the instructions accompanying Form 3, PEI Workplan, for the information to provide in the rationale.

The PEI Resource Materials are organized in the following sections:

PEI Priority Populations:

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 Juvenile Justice Involvement

Key PEI Community Needs:

6. Suicide Prevention
7. Reduction of Stigma and Discrimination

Each section provides programs, policies, activities and potential additional funding sources to leverage (with the exception of Reducing Stigma and Discrimination). The programs are evidence-based practices, promising practices or emerging best practices (please refer to the PEI Terms Glossary, Appendix 3, for a definition of each of these terms). The PEI Resource Materials are designed to be a dynamic resource, evolving to incorporate new information about effective PEI strategies.

Making a Difference

In this initial PEI Plan, counties are not required to implement PEI workplans or strategies countywide or address all PEI priority populations. Furthermore, counties are not required to include all example programs, policies and activities from the PEI Resource Materials in the county's workplan design. However, counties should combine sufficient programs, policies, activities and additional leveraged funding sources or resources in the county's workplan(s) to achieve desired PEI outcomes at the individual/family, program/system, and, if applicable, community levels. Refer to PART V, Accountability and Evaluation.

State-Administered Projects to Support County PEI Strategies

Five state-administered projects will complement and support county PEI strategies and programs. These projects are currently under development and the proposed expenditures will be approved by OAC before implementation.

1. Suicide Prevention: A fund of \$14 million annually for four years is established for activities such as training of trainers for program staff and partners, consultation to counties and PEI partners on successful approaches, and public education efforts. Furthermore, \$500,000 annually for two years is provided for development and dissemination of a statewide suicide prevention plan. DMH has convened a

California Suicide Prevention Plan Advisory Committee to provide recommendations for the statewide strategic plan.

2. Stigma and Discrimination Reduction: A fund of \$20 million annually for four years is established for priority activities identified through OAC's Policy Work Group, public hearings, and stakeholder processes. Please refer to the OAC policy paper, "Eliminating Stigma and Discrimination Against Persons with Mental Health Disabilities" for recommendations from the Policy Work Group:
www.dmh.ca.gov/MHSOAC/docs/StigmaAndDiscriminationReport07Jun12.pdf
3. Ethnically and Culturally Specific Programs and Interventions: A fund of \$15 million annually for four years is established to support special projects for reducing ethnic and cultural disparities based on the results of targeted stakeholder processes. These projects are in addition to, rather than instead of, counties' work to reduce disparities as identified in all county PEI plans. The target groups for these activities will initially focus on those racial, ethnic and cultural groups that demonstrate historic disparities in access to mental health services: African American, Latino, Asian/Pacific Islander, Native American, and the lesbian/gay/bisexual/transgender/and questioning (LGBTQ) communities.
4. Training, Technical Assistance and Capacity Building: A fund of \$12 million annually for four years is established to support specific PEI strategies. The emphasis is to increase capacity among PEI partners (outside the mental health system) to implement successful programs and interventions. Methods may include expanding training capacity in specific systems, learning communities, materials development and dissemination, web resources, and other program improvement approaches.
5. Statewide Evaluation: A fund of up to five to eight percent of the total county PEI planning estimates is established for statewide PEI evaluation. To the extent possible, the statewide evaluation may be paid for by the MHSA Administrative Budget.

A portion of the funding for state-administered projects has been proposed for a state-administered Student Mental Health Initiative (\$60 million total over four years). This funding will support college campuses and K-12 public schools and agencies to improve recognition and responses to students experiencing mental distress, reduce stigma and discrimination against persons with mental illness, and support resiliency and a healthy learning community. A description of the initiative is available at:
www.dmh.ca.gov/MHSOAC/docs/OversightAcctCommittee/MHSASStudentMentalHealthInitiative5_24.pdf

PART IV: FUNDING

PEI funding is for programs and interventions that meet the PEI operational definition and the necessary costs to implement and evaluate those programs and interventions.

Understanding there may be some overlap initially with PEI and CSS. Each county needs to distinguish PEI-funded activities from CSS-funded activities and, as required by statute, track PEI expenditures separately.

Non-Supplant

The MHSA's non-supplant requirements related to county expenditures consist of the following, all of which must be met in order for an expenditure to be eligible for reimbursement under the MHSA:

1. Funds must be used for programs authorized in Section 5892 of the W&I Code.
2. Funds cannot be used to replace other state or county funds required to be used to provide mental health services in fiscal year 2004-05 (the time of enactment of the MHSA).
3. Funds must be used on programs that were not in existence in the county at the time of enactment of the MHSA (new programs) or to expand the capacity of existing services that were being provided at the time of enactment of the MHSA (11/02/04).

Allowable Expenditures: Prevention and Early Intervention funding is intended for prevention programs and early intervention services that meet the PEI operational definition. Expenditures may include:

- Personnel (such as behavioral health professionals, culturally/linguistically competent family liaisons, program managers)
- Operating costs (such as curricula and other educational materials, supplies, travel, equipment and facilities rental)
- Subcontracts (such as professional services for training or program evaluation)

Non-allowable Expenditures: Prevention and Early Intervention funding is not intended for expenditures in areas such as:

- Filling gaps in treatment and recovery services for individuals who have been diagnosed with a serious mental illness or serious emotional disturbance.
- Subsidizing academic degree programs to expand the workforce.
- Capital projects or housing.
- Technology projects.
- Broad social marketing campaigns (State-administered projects will support this activity).
- Development of costly new training curricula (State-administered projects will support this activity).

Leveraging: Leveraging is a principle for all PEI programs. Counties should describe cash match and in-kind contributions in the budget forms and in the budget. For PEI purposes, the term leveraging is used broadly and may be demonstrated by partners in numerous ways such as:

- Cash match
- Federal reimbursements in the health system
- "Readiness" to implement PEI strategies by training staff and covering release time, creating supportive policies, etc.
- Use of facilities and other resources
- Coordinating existing prevention programs with new PEI-funded early intervention strategies

Please see the Budget Worksheet forms in the Appendix to provide proposed expenditures for the PEI Plan budget.

PART V: ACCOUNTABILITY AND EVALUATION

The PEI component of MHSA will fund many programs and interventions new to the mental health system. The accountability and evaluation framework for PEI is intended to achieve multiple objectives:

- Demonstrate accountability to the public; i.e., show that the funds have been:
 - Used for the purposes specified in the Act
 - Used efficiently and effectively including obtaining desired outcomes
- Document progress towards meeting overall aims of PEI; i.e., measure the extent to which PEI successfully:
 - Moves the entire mental health system more towards PEI
 - Addresses the needs of ethnic/cultural communities
 - Enhances a recovery/resilience orientation and individual/family involvement
 - Utilizes more non-traditional community partners
 - Reduces stigma and discrimination
 - Increases awareness of suicide and how to prevent it
 - Reduces ethnic disparities
- Inform both policy and practice about the PEI component of MHSA; i.e., serve an ongoing quality improvement function.
- Create a co-operative learning environment among stakeholders; i.e., the system should engage stakeholders and provide opportunities for mutual sharing and learning and allow for failures with quick remediation.
- Advance the state of the art in mental health PEI; i.e., results from the system should be of high significance and credibility and add to the field's knowledge of evidence based and promising practices.
- Be objective; i.e., be perceived as valid, fair, and not unduly influenced by any of the major stakeholders.
- Be timely and feasible; i.e., produce results quickly so that success can be publicized and improvements made.
- Be sustainable; i.e., continue beyond the first few years of MHSA.

Note: Please see the Resource Materials for a “PEI Logic Model” and the “Potential Overall Outcomes of PEI Strategies”.

Section A: Evaluation Questions

Evaluation of local PEI activities will be designed to address the following evaluation questions¹.

- Individual Person/Family Level
 - Do persons/families who receive PEI services show improved mental health status/resilience and/or reduced risk for emotional and behavioral disturbances, problems, or disorders? (Refer to Appendix 1, MHSA PEI Statutory Authority, W&I Code, Division 5, Part 3.6, Section 5840)
 - Do persons/families who receive appropriate PEI services show fewer negative consequences from emotional and behavioral disturbances, problems, or disorders?

- System Level
 - How is the PEI money being spent?
 - Who is receiving services?
 - What problems/needs are being addressed?
 - What services are being provided?
 - Is money being spent according to all the rules and requirements?
 - What strategies show promise and/or evidence of being effective and efficacious?
 - What impacts are there from PEI on the mental health system and other organizations/agencies/systems?
 - What happens to referrals to mental health in terms of numbers, ethnicity, appropriateness?
 - Are more persons identified and/or served in partner organizations?
 - Are there barriers to effective PEI strategies that can be removed by local or state policy change?
 - Are PEI strategies directed towards engaging and serving ethnic/cultural communities designed and implemented appropriately?

It is anticipated that community/impact level evaluation will be conducted at the state, not the local level. For example, the tracking of changes in the incidence of mental illness or suicide rates will be done statewide, largely using secondary data sources.

¹ This framework uses the distinction between person, system, and community levels that have formed the basis for conceptualizing evaluation of MHSA activity. Link to framework description: <http://www.dmh.ca.gov/mhsa/docs/meeting/05may04/Preliminary%20Performance%20Measurement%20Concepts%20DMH%20Draft%204%2028%2005%20.pdf>).

Section B: Evaluation Components

The required evaluation components follow:

- Tracking of expenditures at the workplan level
- Semi-annual narrative reporting
- Participation in on-site program reviews
- Participation in surveying of required community program planning sectors (refer to Table 1, Page 9), PEI implementation, funding, and collaborative partners
- Conducting a local outcome evaluation of the strategies within one work plan

These components do not include whatever fiscal compliance mechanisms and program progress monitoring that will be included in the state contracts with counties that will ensure that funds are used for allowable purposes, in accordance with approved plans and state requirements.

It is anticipated that the counties will participate at a later date in the evaluation of any local aspects of the statewide initiatives on stigma and discrimination reduction and suicide prevention. The state may also conduct, in subsequent years, special studies of selected strategies and solicit county participation in these. Any future evaluation activities involving counties will be developed in consultation with the counties.

Section C: Tracking of Expenditures

The purpose of this section is to track how the PEI funds have been used. The information that will be required for each workplan in the PEI plan includes the following:

- Description of the target population for the workplans
- The number who received the prevention and early intervention strategies within the workplan
- Characteristics of those who received the early intervention, where appropriate and feasible
 - Age
 - Ethnicity
 - Culture
 - Gender
- Type of problem(s)/need(s) for which intervention was directed
- Number of services by type of service(s); e.g., screening, consultation, group counseling
- Type and nature of implementation, funding, or collaborative partner; e.g., ethnic organization, school, probation department, primary care clinic with whom the strategy is being coordinated and/or whose site is being used

- Dollars and funding source
 - PEI funds
 - Other MHSA
 - Other mental health
 - Other (an indication of amount and source of leverage)

Section D: Narrative Reporting

Counties will be required to report semi-annually (in a format that corresponds to that of the work plans), in short narrative fashion, on at least the following

- Progress in implementation of workplans in relationship to timeframes in approved plan
- Successes
- Challenges in implementation and how they have been addressed
- Changes in environmental factors that have impacted PEI efforts

Section E: Participation in On-Site Program Reviews

Counties will be asked to host a DMH-led review team once every year or two that will examine its PEI workplans. The team will be on site from one-half to two days depending on the size and scope of PEI activities. It is anticipated that this program review activity will be at some point combined with similar review activities for other MHSA components, but at this point counties should assume that they will be required to at least comply with this review of PEI activity.

Counties will be required to assist the review team in organizing and scheduling a set of interviews with at least the following:

- County mental health staff—management and staff involved in the planning for and implementation of PEI workplans
- Staff from partner agencies/organizations where or with whom interventions are occurring
- Individual persons and family members, particularly those from underserved ethnic/cultural groups
- Other significant stakeholders and participants in the PEI planning, implementation, and monitoring processes

The following are the kinds of information that will be gathered during the on-site program review.

- How have the workplans and strategies been implemented, compared to what was in the plan?
- What have the major challenges been and how have they been addressed?
- What promising practices are being implemented?
- What are the levels and quality of collaboration with partner organizations?
- What do stakeholders think about the planning and implementation process?

- How responsive have the PEI workplans and strategies been to ethnic/cultural issues and concerns?
- What state and/or local policies and/or procedures create barriers to PEI?
- What impacts have there been on the rest of the mental health system and other organizations?

Section F: Participation in Surveying of Partner Organizations

Counties will be expected to participate in whatever survey of partner organizations is implemented as part of the state evaluation. Specifically, counties will be asked to facilitate the state evaluator's access to partner organizations. Engaging non-traditional underserved and traditional organizations (refer to the "required sectors" in Table 1 on Page 9) in the provision of PEI services is a critical element of this initiative and will thus be one of the foci of the evaluation. Partner organizations ("required sectors," PEI implementation, funding and collaborative partners) will be asked about:

- Their knowledge of and attitudes toward mental health programs and services within their community including any specific ethnic/cultural issues
- Their capacity to address mental health needs in their population
- The extent, quality, and nature of their relationship with the mental health system

Section G: Conduct a Local Outcome Evaluation of One Workplan

The county will be required to conduct an outcome evaluation of one workplan of its choosing. Please refer to Form 7, "Local Evaluation of A Workplan."

The county will specify in its plan the following information:

1. Workplan to be evaluated and how the workplan and strategies were selected.
2. Person-level and system-level expected outcomes for the strategies.
3. Numbers and types of persons to receive the strategies.
4. How achievement of the outcomes will be measured.
5. How the data will be collected and analyzed.
6. How the strategy and the evaluation will be culturally competent.
7. What procedure will be used to ensure fidelity in implementing the model and any adaptations.
8. How the report on the evaluation will be disseminated to interested local constituencies.

Selected example strategies in the PEI Resource Materials identify research-based outcomes previously documented for the strategy. It is expected that a county using those strategies will use the noted outcomes for local evaluation. If a county selects strategies for which documented outcomes are not identified in the PEI Resource Materials, the county will use specific statewide outcomes to be determined jointly by DMH, OAC, CMHPC and CMHDA.

PART VI: SUBMISSION GUIDELINES

To receive MHSA funding to implement Prevention and Early Intervention programs, county mental health departments must submit a complete Program and Expenditure Plan for Prevention and Early Intervention. Due to the comprehensive review and approval process for these Program and Expenditure Plans by both the OAC and DMH, the review process is expected to take up to three months. OAC will have final approval of plan expenditures. Refer to the Appendix for the PEI Budget and Planning Worksheets.

Please submit an original county PEI plan along with 11 copies, plus an electronic format on CD, of the completed Planning and Program and Expenditure Plan to:

<p>Prevention and Early Intervention Branch California Department of Mental Health 1600 9th Street, Room 350 Sacramento, CA 95814 e-mail: caitlin.viscardi@dmh.ca.gov</p>
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Instructions for Completing Plan

Complete Form No. 1: “Face Sheet”

A. Community Program Planning

Complete a Form No. 2 “Community Program Planning Process”

B. Workplans

Complete Form No. 3: “PEI Workplan Summary”, for each workplan, including accompanying narrative (as needed).

C. Budget and Financial Information

1. Complete Form No. 4: “Revenue and Expenditure Budget Worksheet” and narrative for each workplan.
2. Complete Form No. 5: “Administrative Budget Worksheet” and narrative.
3. Complete Form No. 6: “Prevention and Early Intervention Budget Summary”

D. Accountability and Evaluation

Complete Form No. 7: “Local Evaluation of a Workplan”