Enclosure 1

Mental Health Services Act

PROPOSED GUIDELINES

PREVENTION AND EARLY INTERVENTION COMPONENT
of the
THREE-YEAR PROGRAM AND EXPENDITURE PLAN

Fiscal Years 2007-08 and 2008-09

September 2007

Prevention and Early Intervention (PEI) Component of the Three-Year Program and Expenditure Plan Mental Health Services Act

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

Fiscal Years 2007-08 and 2008-09

PART I: PURPOSE, BACKGROUND AND DEFINITIONS

Purpose

The Mental Health Services Act (MHSA) authorizes the California Department of Mental Health (DMH) to establish guidelines for the content of the Prevention and Early Intervention (PEI) component of the Three-Year Program and Expenditure Plan that each county mental health program shall submit as part of the County's Three-Year Program and Expenditure Plan to receive PEI funding. 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 guidelines, with a streamlined response required from counties that already have approved PEI components.

Background

The MHSA represents a comprehensive approach to the development of community-based mental health services and supports for the residents of California. The MHSA 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 Facilities 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.

Prevention and Early Intervention: Key to Transformation

Prevention and Early Intervention approaches in and of themselves are transformational in the way they restructure the mental health system to a "help-first" approach. Prevention programs bring mental health awareness into the lives of all members of the community through public education initiatives and dialogue. To facilitate accessing supports at the earliest possible signs of mental health problems and concerns, PEI builds capacity for providing mental health early intervention services at sites where people go for other routine activities (e.g., health providers, education facilities, community organizations). Mental health becomes part of wellness for individuals and the community, reducing the potential for stigma and discrimination against individuals with mental illness.

The PEI programs described in these guidelines align with the transformational concepts inherent in the MHSA and the PEI policies adopted by the Mental Health Services Oversight and Accountability Commission (OAC). The concepts follow:

- Community Collaboration

  The goal of community collaboration is to bring members of the community together in an atmosphere of support to systematically address community wellness or solve existing and emerging problems by those related groups. The PEI community program planning process is intended to bring together various stakeholders, including groups of individuals and families, agencies, organizations and businesses to share information and resources to accomplish a shared vision for PEI.

  To facilitate ongoing community collaboration processes, from the planning through implementation and evaluation, the process is accessible and inclusive. The PEI Component of the Three-Year Program and Expenditure Plan also needs to be user-friendly to allow for meaningful stakeholder input and involvement.

- Cultural Competence

  Improving access to mental health programs and interventions for unserved and underserved communities and the amelioration of disparities in mental health across racial/ethnic and socioeconomic groups are priorities of the MHSA. Therefore, cultural competence must be emphasized in PEI programs.

  Cultural Competence means incorporating and working to achieve cultural competence goals into all aspects of policy-making, program design, administration and service delivery. Each system and program is assessed for the

strengths and weaknesses of its proficiency to achieve these goals. The infrastructure of a service, program or system is transformed, and new protocol and procedure are developed, as necessary to achieve these goals. (Please refer to Appendix 3, PEI Terms Glossary.)

- Individual/Family-driven Programs and Interventions, with Specific Attention to Individuals from Underserved Communities

  In an individual/family-driven system, adults and families of children and youth identify their needs and preferences that lead to the programs and services that will be most effective for them. Their needs and preferences drive the policy and financing decisions that affect them.

  Increasing opportunities for participants to have greater choices over types of programs and interventions, providers, and how service dollars are spent, empowers participants, facilitates recovery, and shifts the incentives towards a system that promotes learning, self-monitoring and accountability. Increasing choice protects individuals and encourages quality. (Source: The President's New Freedom Commission on Mental Health – *Achieving the Promise Transforming Mental Health Care in America*.)

- Wellness Focus, Which Includes the Concepts of Resilience and Recovery

  Programs and interventions are designed with an understanding that many mental health problems are preventable, early intervention is cost effective in terms of dollars and human suffering, and recovery is expected.

  Resilience refers to the personal qualities of optimism and hope, and the personal traits of good problem solving skills that lead individuals to live, work and learn with a sense of mastery and competence. Research has shown that resilience is fostered by positive experiences in childhood at home, in school and in the community. When children encounter negative experiences at home, at school and in the community, mental health programs and interventions that teach good problem solving skills, optimism and hope can build and enhance resilience in children. (Source: California Family Partnership Association, March 2005.)

  Recovery refers to the process in which people who have a mental health problem are able to live, work, learn and participate fully in their communities. For some individuals, recovery means recovering certain aspects of their lives and the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery in service planning encourages and supports hope.

- Integrated Service Experience for Individuals and their Families

  Recent racially/ethnically and culturally specific interviews with key informants and focus groups on PEI priorities reaffirmed the complex needs of underserved

communities. While PEI funds will not be able to provide all of the needed services, PEI programs can place mental health services in locations where participants obtain other critical supports, can help link participants to other needed services and assist participants in navigating other systems. Of particular importance are programs in the areas of substance abuse prevention and treatment; community, personal and sexual violence prevention and intervention; and basic needs, such as food, housing and employment.

Working with other organizations and agencies to leverage resources for comprehensive mental health programs and coordinated services is a PEI principle as well.

- Outcomes-based Program Design

  There is a significant amount of flexibility in the local design of PEI projects, placing the emphasis on intended outcomes for individuals and families; programs and systems; and communities. PEI projects should include a combination of programs based on a logic model and a high likelihood of effectiveness (evidence-based practices, promising practices, locally proven practices, optimal point of intervention) to achieve PEI outcomes, use a methodology to demonstrate outcomes and advance program improvement and learning.

Building the PEI Framework

Throughout its progression, developing the PEI framework has been a collaborative and dynamic process. 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:

PEI Key Community Mental Health Needs
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.
Psycho-Social Impact of Trauma
PEI efforts will reduce the negative psycho-social impact of trauma on all ages.
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.
Stigma and Discrimination
PEI will reduce stigma and discrimination affecting individuals with mental health illness and mental health problems.
Suicide Risk
PEI will increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide.
PEI Priority Populations
Underserved Cultural Populations
PEI projects address those who are unlikely to seek help from any traditional mental health service whether 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.
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, including those who are unlikely to seek help from any traditional mental health service.
Children/Youth in Stressed Families
Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of caregiving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.
Trauma-Exposed
Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.
Children/Youth at Risk for School Failure
Due to unaddressed emotional and behavioral problems.
Children/Youth at Risk of or Experiencing Juvenile Justice Involvement
Those with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through Community Services and Supports (CSS).
State-Administered Projects
Suicide Prevention
Stigma and Discrimination Reduction
Ethnically and Culturally Specific Programs and Interventions
Training, Technical Assistance and Capacity Building
Statewide Evaluation

Student Mental Health Initiative (approved by OAC in June 2007)

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

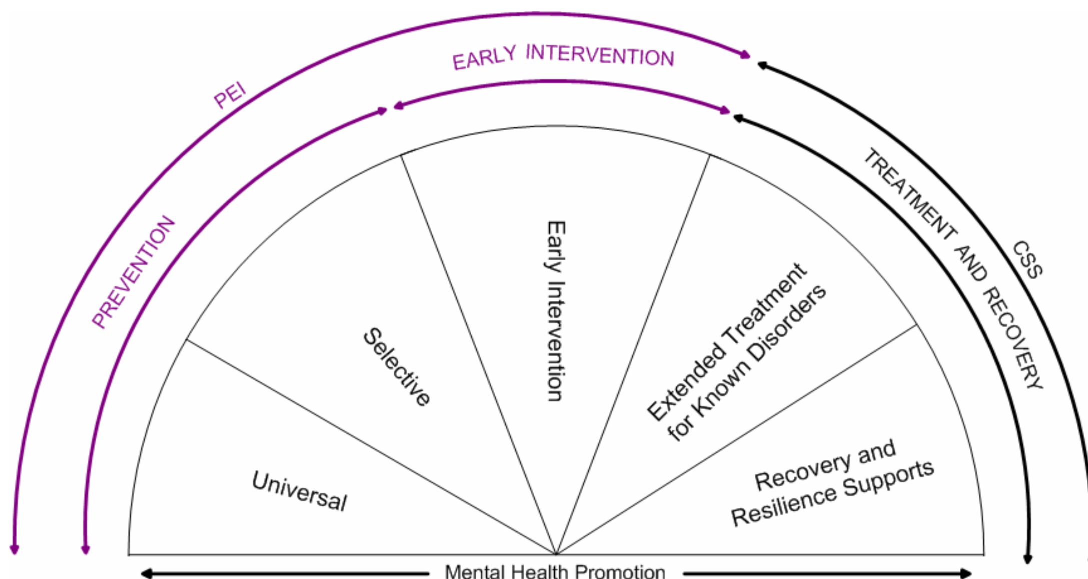
For background information on the PEI policies, please refer to the document, “MHSOAC Mental Health Services Act Prevention and Early Intervention: County and State Level Policy Direction,” adopted by OAC on January 26, 2007 (available at website: http://www.dmh.ca.gov/MHSOAC/docs/PolicyRecMHSAPEI.pdf).

Operational Definition of Prevention and Early Intervention

To clearly delineate the funding parameters for the PEI component of MHSA and to distinguish PEI from 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 MHSA 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 MHSA 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 MHSA 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 intervene)
>
> Selective: target individuals or a subgroup whose risk of developing mental illness is significantly higher than average. (Examples: mental health consultation to support groups for older adults who have lost a spouse; screening women for post partum depression and targeting children of parents with depression for intervention; mental health consultation to facilitators of group sessions for youth engaged in substance use/abuse and children of substance-abusing parents; and mental health consultation to child care centers and family child care homes)

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. 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. Cost sharing is a viable option for many prevention programs, especially those that serve multiple purposes (e.g., universal access to voluntary early childhood or maternal depression screening; youth development; constructive parenting education; social and support groups; health guidance).

There may be a role for PEI funds to be used in mental health oriented activities within broad community-wide health promotion approaches targeting one or more PEI priority populations when these are collaboratively planned, funded and implemented with other organizations and achieve PEI mental health outcomes at the individual/family, program/system or community levels.

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 a mental health problem or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services; or to prevent a mental health problem from getting worse. (Examples: mental health consultation/with interventions in child care environments; parent-child interaction training for children with behavioral problems; anger management guidance; and socialization programs with a mental 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 (usually less than one year)
- 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 6.

Prevention and Early Intervention as a Whole

An objective of PEI is to increase capacity for mental health prevention and early intervention programs led by appropriately trained and supervised 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 often designed and implemented in collaboration with other systems and/or organizations.
3) Programs are generally delivered in a natural community setting (e.g., tribal/Native American center, refugee resettlement agency, infant/toddler programs, preschool and school, family resource center, juvenile justice probation department, comprehensive services for home-bound older adults, primary health care, community clinic or health center, 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 another 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 recognize the underlying role of poverty and other environmental and social factors that impact individuals' wellness, therefore programs also help link individuals and family members to other needed services provided by grassroots organizations and local agencies, particularly in the areas of substance abuse treatment; community, family or sexual violence prevention and intervention; and basic needs, such as food, housing and employment.
6) 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 Individuals Experiencing At Risk Mental State (ARMS) or First 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 individuals experiencing ARMS or First onset of a serious psychiatric illness with psychotic features, (or similar programs with comparable effectiveness). The standards of low intensity and short duration do not apply to services for individuals experiencing ARMS or first 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 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 county CSS plans, for example, include partnerships with racial/ethnic and 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 programs. What distinguishes these CSS activities from PEI programs?

Distinction in Intent and Practice: The intent of the CSS outreach and engagement programs 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 programs 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 workplans 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 PEI project meets PEI requirements
- Ensure that the PEI project engages persons prior to the development of serious mental illness or serious emotional disturbances
- Complete and submit a Plan Amendment for the CSS component of the county's Three-Year Program and Expenditure Plan to remove the activity from the CSS component (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 component, according to the PEI proposed guidelines
- Justify the transfer of funding source by describing in detail how the PEI program is different from the existing CSS program, and furthers PEI goals rather than CSS goals

Plan amendments for such a transfer will be considered only if the county intends to make the transfer to PEI funding effective at the start of the fiscal year following approval of the PEI component. Retroactive transfer of a CSS activity to PEI funding will not be approved. Once the transfer is approved, the activity may not be transferred back to CSS funding. Transfer of approved CSS *funding* to PEI will not be approved.

PART II: COMMUNITY PROGRAM PLANNING PROCESS

Note: The information in this section also appeared in Information Notice 07-17 dated August 10, 2007, titled "County Funding Request for Mental Health Services Act (MHSA) Prevention and Early Intervention -- Community Program Planning Funds." It is provided in the Guidelines as reference information for completing Form 2 PEI Community Program Planning Process, required as part of the PEI Component of the Three-Year Program and Expenditure Plan.

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 component must document how the regulatory requirements were met.

Counties have an opportunity to use a portion of the 2007-2008 PEI Planning Estimate for Community Program Planning. Refer to DMH INFORMATION NOTICE NO.: 07-17 (available at http://www.dmh.ca.gov/DMHDocs/default.asp?view=notices).

Some county mental health programs may find that they need additional funds to complete the program planning and PEI component preparation processes. Upon request and after January 2008, DMH will describe how county mental health programs may 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 (refer to Page 4).

Similar to CSS, the PEI county component 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
- Assessment of Community Capacity and Strengths (Counties are encouraged to incorporate current or recent asset mapping results)
- Selection of PEI Programs to achieve Desired Outcomes
- Development of PEI Projects with Timeframes, Staffing and Budgets
- Implementation of Accountability, Evaluation and Program Improvement Activities

Required Comment Period and Public Hearing

Consistent with MHSA 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 component 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 component. The draft component 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. Substantive comments raised at the public hearing should be included in the final component, including the county mental health program's response.

Building on the CSS Planning Process

Many counties conducted extensive community planning processes for their CSS plans and can build on that effort for the PEI component planning process in a number of ways. The comprehensive planning processes undertaken by counties in developing their CSS components of their Three-Year Program and Expenditure Plans should provide the foundation for future planning processes. Counties are encouraged to develop on-going planning and monitoring stakeholder committees, and to use and augment these groups as needed for the particular planning and oversight expertise for the PEI component. Planning processes should continually augment and strengthen what is already in place. In this way, counties will be able to develop an informed constituency, while continually reaching out to broaden diversity and expertise.

The planning process for the PEI component should revisit the priorities and discussions documented in previous MHSA planning processes, and should focus upon getting additional input from any stakeholders who have experience, interest or expertise in this subject, including both those stakeholders who are new to the community program planning process, and those who participated in planning for the CSS component of the Three-Year Program and Expenditure Plan. PEI issues have a broad constituency and will draw upon expertise outside of the more formal MHSA planning processes. In any case, the county shall ensure that on-going stakeholder committees and/or key stakeholders are involved regarding recommendations for this component.

Inclusive Planning Process for PEI

The community program planning process was established to 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. Table 1 indicates sectors that counties are required to include in the planning process (by regulation) plus a few additional sectors that are examples of other organizations that may be key PEI implementation partners. 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 for Planning	Recommended Partner Organizations for Planning
Underserved Communities	Individuals, families and community-based organizations (administrators and front line staff) representing Native American, African American, Hispanic/Latino, Asian/Pacific Islander, Refugee, Immigrant, Lesbian/Gay/Bisexual/Transgender/Questioning and other underserved/unserved communities
Education	County offices of education, school districts, parent/teacher associations, Special Education Local Plan Areas, school-based health centers, colleges/universities, community colleges, adult education, First 5 Commissions, early care and education organizations and settings
Individuals with Serious Mental Illness and/or their Families	Client and family member organizations
Providers of Mental Health Services	Mental health provider organizations
Health	Community clinics and health centers, school-based health centers, primary health care clinics, public health, specialist mental health services, specialist older adult care health services, Native American Health Centers, alcohol and drug treatment centers, developmental disabilities 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 for Planning	**Recommended Partner Organizations for Planning**
Community Family Resource Centers	Multipurpose family resource centers, spiritual/faith centers, arts, sports, youth clubs/centers, parks and recreation, homeless shelters, senior centers, refugee and immigrant 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, newspaper, ethnic media

Efforts should be made to include individuals from underserved racial/ethnic and cultural communities in the planning process. 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 projects and evaluation methods. These efforts might have as their goal the ongoing inclusion of community perspectives in PEI component implementation over the long term. Informants representing underserved communities should be involved in the drafting of county components. Successful outreach and engagement processes in the planning stage can be reflected in elements of the county components, demonstrating collaboration with community based organizations to address needs of underserved communities.

PART III: PEI PROJECTS

Each PEI project is prevention and/or early intervention programs that are designed to address one or more PEI Key Community Needs and one or more PEI Priority Populations, consistent with PEI Principles, to meet specific PEI individual/family and/or program/system outcomes. The scope of each project should not be overly broad or too narrow to achieve the outcomes for the target population.

Connection of PEI Projects with PEI Priority Populations

The nature of the PEI Priority Populations, of the recommended programs (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 or experiencing 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 programs 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 PEI project based on the most salient of the risk factors. When the county makes such a decision it should specify in the PEI project description the various priority populations that 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 PEI project if all the programs are relevant to those priority populations. The county should specify in the PEI project 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 and consistent with MHSA's policy on outcomes-based program design, the county will be expected to track by PEI project the nature of the problem or risk factors (corresponding to PEI Priority Populations, suicide prevention or reduction of stigma and discrimination) that its programs, are designed to alleviate.

Reducing Disparities

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

- Providing culturally competent and appropriate programs;
- Facilitating access to PEI programs; 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 racial/ethnic and socioeconomic 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 the Prevention and Early Intervention Component. DMH is currently developing a plan to disseminate the outreach and engagement methodology and findings.

Priority Age

Counties should develop PEI projects and select programs based on the requirements that PEI county components must reflect programs that address all age groups and a minimum of **51 percent of their overall PEI component budget must be dedicated to individuals who are between the ages of 0 to 25**. Small counties are excluded from the requirements to address all age groups and dedicate a minimum of 51 percent of their overall PEI component budget to individuals who are between the ages of 0 and 25. 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 Department of Finance.

This policy acknowledges the efficacy of prevention programs geared to the earliest years of life and early intervention for maternal depression or child behaviors that indicate developing social and emotional issues. It also acknowledges that onset of a serious psychiatric illness most often occurs by age 25.

County Selection of Programs

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

Counties might select from these example programs or may select alternative programs that meet the same standards that are better for their community needs,

assets and goals. Please refer to the instructions accompanying Form 3, PEI Project Summary, for the information to provide in the rationale for using alternative programs.

The PEI Resource Materials are organized in the following sections:

PEI Priority Populations (all are inclusive of Underserved Cultural 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 or Experiencing Juvenile Justice Involvement

Key PEI Community Needs:

6. Suicide Prevention
7. Reduction of Stigma and Discrimination

Each section (with the exception of Reduction of Stigma and Discrimination) provides programs, policies, activities and potential additional funding sources to leverage. The programs are evidence-based practices, promising practices or emerging best practices (please refer to the PEI 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 programs.

Making a Difference

In this initial PEI component period, counties are not required to implement PEI projects or programs countywide or address all PEI priority populations. Furthermore, counties are not required to include all example programs from the PEI Resource Materials in the county's PEI project design. However, some of the listed individual programs, such as a community engagement approach, are not sufficient in and of themselves to comprise a PEI Project. Counties should combine sufficient programs, policies, activities and additional leveraged funding sources or resources in the county's PEI project(s) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels. Refer to PART V, Accountability and Evaluation.

State-Administered Projects to Support County PEI Programs

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

1. Suicide Prevention: A fund of $14 million annually for four years is established for activities such as training of trainers for PEI staff and providers, consultation to counties and PEI providers 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. For recommendations from the Work Group, please refer to the OAC policy paper, "Eliminating Stigma and Discrimination Against Persons with Mental Health Disabilities" (available at: 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 components. The target groups for these activities will initially focus on 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. Within these target groups, gender appropriate approaches will be included.

4. Training, Technical Assistance and Capacity Building: A fund of $12 million annually for four years is established to support specific PEI programs. The emphasis is to increase capacity among PEI providers (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.

6. Student Mental Health Initiative: 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 or suicide risk, reduce stigma and discrimination against persons with mental illness, and support resiliency and a healthy learning community. A description of the proposal is available at: www.dmh.ca.gov/MHSOAC/docs/OversightAcctCommittee/MHSAStudentMentalHealthIntiative5_24.pdf.

PART IV: FUNDING

The counties' PEI Planning Estimates appear in Appendix 4. 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

According to California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3410, 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 mental 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

- Workforce Education and Training activities (as described in the Workforce Education and Training Component - Proposed Three-Year Program and Expenditure Plan Guidelines) in the following categories:
  - Mental Health Career Pathway Programs
  - Residency, Internship Programs
  - Financial Incentive Programs
- Capital projects or housing
- Technology projects
- Broad social marketing campaigns (State-administered projects will support this activity)
- Development of 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 narrative. 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 programs 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 programs

Please see the Budget Worksheet forms in the Appendix to provide proposed expenditures for the PEI component 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 racial/ethnic and cultural communities with culturally appropriate and successful interventions
  - 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 in access, quality of services and individual/family outcomes
- 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, promising practices and community-defined evidence
- Advance learning about programs and non traditional approaches that effectively address the PEI needs of racial, ethnic and cultural populations and other groups that have been underserved or unserved
- Be objective; i.e., not unduly influenced by one stakeholder over another
- 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 "Potential Overall Outcomes of PEI Programs."

Evaluation Questions

Evaluation of local PEI activities will be designed to address the following evaluation questions[1].

- 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, mental health problems, or mental illness? (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, mental health problems or mental illness?

- Program/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 programs 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 programs that can be removed by local or state policy change?
  - Are PEI programs directed towards engaging and serving racial/ethnic and 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 conducted statewide, largely using secondary data sources, i.e., data already routinely collected typically at a population level (state, county, etc.) by government agencies, private foundations and research organizations.

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[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.

Evaluation Sections

The required evaluation sections follow:

A. Tracking of expenditures at the PEI project level
B. Semi-annual narrative reporting
C. Participation in on-site program reviews
D. Participation in surveying of required community program planning sectors (refer to Table 1, Page 13), PEI implementation, funding and collaborative partners
E. Participation in special evaluation of selected programs
F. Conducting a local outcome evaluation of the programs within one PEI project

These sections 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 PEI components 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. Any future evaluation activities involving counties will be developed in consultation with the counties.

Section A: Tracking of Expenditures

The purpose of this section is to describe how the PEI funds will be tracked. The information that will be required annually for each PEI project in the PEI component includes the following:

- Description of the target population for the PEI projects.
- The number who received the prevention and early intervention programs within the PEI project.
- Characteristics of those who received the early intervention programs within the PEI Project.
  - Age
  - Gender
  - Race/Ethnicity
  - Culture
- 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, community clinic or health center or other primary care clinic with whom the program 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 B: Narrative Reporting

Counties will be required to report no more frequently than semi-annually (in a format that corresponds to that of the PEI projects), in short narrative fashion, on at least the following:

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

Section C: 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 projects. The team will be on site from one-half day 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 projects
- Staff from partner agencies/organizations where or with whom interventions are occurring
- Individual persons and family members, particularly those from underserved racial/ethnic and 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 PEI projects and programs been implemented, compared to what was in the component?
- 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 projects and programs been to racial/ethnic and 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 D: 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 for Planning" in Table 1 on Page 13) 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 for Planning," 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 racial/ethnic and 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 E: Participation in Special Evaluation of Selected Programs

A number of programs will be selected at the state level for in-depth evaluation, including collection of data on outcomes with individual persons/families. It is anticipated that a joint coordinating committee comprised of CMHDA, CMHPC, DMH and OAC will determine the programs to be evaluated at the state level. The selection of these programs is likely to occur between January and June 2008.

These programs will meet the following criteria:

- Program will be well-specified
- Program will be of sufficient intensity and duration to generate a significant effect (understanding that this may be interpreted differently by various constituencies)

Selected counties will be required to participate, and other counties will have the option of applying to be included in one of these special in-depth evaluations. Participation will include the following:

- Agreement to implement the program in accord with the specifications (to ensure consistency of the intervention to be evaluated)

- Agreement to collect data as required by the evaluation, including outcome data at the person-level

In return for participating, the county may receive the following:

- Additional resources to cover the costs of data collection and other evaluation requirements
- Training and on-going technical assistance in the program

Depending on interest from the counties and DMH, there may be established a small special fund for counties to access to fund special county-level in-depth evaluations of PEI programs. Should this occur, such programs and evaluations would be expected to meet the same criteria as for the larger multi-county evaluations.

Section F: Conduct a Local Outcome Evaluation of One PEI Project

The county will be required to conduct an outcome evaluation of one PEI project of its choosing and provide an evaluation report to the State as part of the MHSA annual update. (If a county is selected to participate in a special evaluation effort as outlined in the above section this requirement would be waived.) This local outcome evaluation is optional for very small counties (population less than 100,000). Please refer to Form 7, "Local Evaluation of A PEI Project."

The county will specify in its component the following information:

1. PEI project to be evaluated and how the PEI project and programs were selected.
2. Person/family-level and program/system-level expected outcomes. Each program within the project may have distinct individual/family and program/system outcome indicators that will need to be measured separately and reported as the project outcomes.
3. Numbers and demographics of individuals participating in the programs.
4. How achievement of the outcomes will be measured.
5. How the data will be collected and analyzed.
6. How the programs and the evaluation will be culturally competent, including specific strategies, from the perspective of the targeted cultural communities, and how these strategies will operate in a culturally appropriate manner.
7. What procedure will be used to ensure fidelity in implementing the program and any adaptations.
8. How the report on the evaluation will be disseminated to interested local constituencies.

Selected example programs in the PEI Resource Materials identify research-based outcomes previously documented for the program. It is expected that a county using those programs will use the noted outcomes for local evaluation. If a county selects programs 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 PEI Component of the Three-Year Program and Expenditure Plan. The review and approval process for the PEI component by the OAC, and the review and comments by DMH, will occur as quickly as possible.

Specific information on the review process, review criteria, and review tool will be posted following OAC and DMH approval and will be promulgated in regulations.

Refer to the Appendix for the PEI Program and Expenditure worksheets.

Please submit an original county PEI component, which includes the original signature of the county mental health director, along with 10 copies plus an electronic format on CD, of the completed PEI component to:

PEI Component Prevention and Early Intervention Branch California Department of Mental Health 1600 9th Street, Room 350 Sacramento, CA 95814

Please submit one copy of the PEI component, plus an electronic format on CD of the completed PEI component to:

Mental Health Services Oversight and Accountability Commission Attention: Keely LaBas 1300 17th Street, Suite 1000 Sacramento, CA 95814

Program and Expenditure Plans must be unbound, 3-hole punched, with a binder ring in the upper left hole. Proposals will not be accepted via fax or e-mail. For ease of reading, please provide the proposed component typed in size similar to 12-point Arial font with one-inch margins or larger.

Instructions for Completing PEI Component of the Three-Year Program and Expenditure Plan

A. Complete Form No. 1: "Face Sheet"

B. Community Program Planning

Complete Form No. 2 "PEI Community Program Planning Process"

OAC and DMH will review this part of the component first. If it meets approval, the rest of the component will be reviewed. If it does not meet approval, the PEI component will be returned to the county for further development and resubmission.

C. PEI Projects

Complete Form No. 3: "PEI Project Summary", for each PEI project, including accompanying narrative (as needed).

D. Budget and Financial Information

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

E. Accountability and Evaluation

Complete Form No. 7: "Local Evaluation of a PEI Project"