WELLNESS • RECOVERY • RESILIENCE

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

NEW PARENT TLC

Sonoma County Innovation
2021-2024 Plan Proposal

New Parent TLC

The proposed Sonoma County-wide MHSA Innovation project, **New Parent TLC** (*Talk, Link, Confirm*) will ingeniously employ a gatekeeper training model similar to **QPR** ***(****Question, Persuade, Refer*) to intervene early with new parent mental health issues, the unaddressed progression of more serious depression and/or suicide, the exposure of infant Adverse Childhood Experiences (ACEs) resulting from parental depression and the associated disruption of optimal infant/toddler brain development. The model increases access to mental health services to underserved groups including new parents of all types: biological, non-biological, adoptive, gay, or straight (Beck, 2014). As described below, most parents are not connected with a health care or mental health care provider during the most crucial times after having a baby, leaving them underserved for the period at which new parent depressive symptoms peak. **New Parent TLC** promotes interagency and community collaboration related to mental health services with the innovative model that engages child care providers, cosmetology service providers, and employees of medium to large employers as peers as "gatekeepers," with a robust outreach method to raise awareness of new parent depressive symptoms, and help get parents linked to mental health services.

Primary Problem

The primary problem that this project intends to address is 3-fold:

1. The high prevalence of postnatal mental health issues for new mothers and fathers;
2. Postnatal mental health issues very often go unidentified, untreated and unmitigated;
3. Untreated parental mental health issues pose a significant risk of exposure to ACEs to thousands of Sonoma County children in the first year of life when the brain is most vulnerable to such exposure.

Innovative Model New Parent TLC

The model will train those who have the highest contact with new parents during the peak time of new parent depression, child care providers, cosmetology service providers, and employees of medium to large employers as gatekeepers to utilize a three-part method:

1. *Talk* - casual conversation between a trusted gatekeeper and new parent in natural, every-day contexts

2. *Link* - updated referrals for parents, linking parents to community-based supports

3. *Confirm* - an informal method of checking back in with the parent to confirm their follow-through to access support

SECTION 1: Innovations Regulations Requirement Categories

General Requirement

	Introduces a new practice or approach to the overall mental health system, including prevention and early intervention
X	Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
	Applies a promising community driven practice or approach that has been successful in non-=mental health context or setting to the mental health system

Primary Purpose

X	Increases access to mental health services to underserved groups
	Increases the quality of mental health services, including measured outcomes
X	Promotes interagency and community collaboration related to mental health services or supports or outcomes
	Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

SECTION 2: Project Overview

Primary Problem

The primary problem that this project intends to address is 3-fold:

4. The high prevalence of postnatal mental health issues for new mothers and fathers;
5. Postnatal mental health issues very often go unidentified, untreated and unmitigated;
6. Untreated parental mental health issues pose a significant risk of exposure to ACEs to thousands of Sonoma County children in the first year of life when the brain is most vulnerable to such exposure.

Although there is a recent push for more consistent screening of parental depression during prenatal and postpartum visits, there is still room to improve in the identification and referrals for parents with depressive symptoms, leaving many new parents with depressive symptoms untreated, and ultimately leaving their infant at risk of exposure to ACEs and the associate disruption of optimal infant/toddler brain development.

Maternal and paternal depression and anxiety, including Perinatal Mood & Anxiety Disorders (PMADs), Postpartum Depression (PPD), and Paternal Postnatal Depression (PPND) impact new parents at alarmingly high rates. In Sonoma County, one in five women suffer from a maternal mental health disorder (California Health Interview Survey, 2017; Sonoma County Maternal & Infant Health Assessment Data Snapshot, CDPH, 2013-2015), a rate that is consistent at the state and national level as well (American Psychological Association, 2006).

According to Winsner, Sit, McShea, et al. (2013), approximately one in seven women experience depression in the first 12 months after childbirth, with one in five of those with depression also experiencing suicidal ideation. In the postpartum period, suicide is the second leading cause of death, resulting in one out of five postpartum period deaths due to suicide (Winsner, Sit, McShae, et al., 2013). Studies also showed that low-income women without a college education are at an 11 times higher risk to experience PPD (Postpartum Depression, 2019).

Approximately 70% to 80% of women will experience sub-clinical "baby blues". While not necessarily harmful to the mother in the long-term if symptoms resolve, this "mild" condition has been proven to be damaging to the infant's development and leaves the infant at risk of exposure to Adverse Childhood Experiences (ACEs) (Postpartum Depression, 2019). With a birth rate in Sonoma County of approximately 5,000 births per year, this could mean up to 4,000 babies annually are exposed to at least one significant Adverse Childhood Experience (ACEs) in the very first year of life as a result of unidentified, untreated symptoms of maternal depression.

In addition to women experiencing symptoms of perinatal depression, between 10% and 25% of fathers experience Paternal Postnatal Depression (PPND) after the birth of a child (Barnett and Ungerger, 2000; Goodman, 2004). The Journal of the American Medical Association found approximately 10% of new fathers experience post-birth blues related to hormone changes and sleep deprivation at about three to six months after their baby is born (Courtenay, 2010), and approximately half of men who have a partner with postpartum depression will go on to develop depression themselves (Postpartum Depression, 2019).

Research shows that symptoms traditionally known as "postpartum" depression can also be known as early parenthood depression, as these symptoms are found in all types of parents, which include biological, non-biological, adoptive, gay, or straight (Beck, 2014). Non-birth parents reporting symptoms of depression may include fathers, same-sex co-parents, and adoptive parents. Payne, Fields, Meuchel, Jaffe, and Jha (2010) calculated rates of significant depressive symptoms in adoptive parents of infants under 12 months of age with a modified version of the Edinburgh Postnatal Depression Scale and found depressive symptoms in 27.9% of subjects at 0-4 weeks, 25.6% at 5-12 weeks, and 12.8% at 13-52 weeks post adoptions. The findings further described the depressive symptoms related to environmental stress, and not associated with family or personal psychiatric history (Payne et al., 2010).

Postpartum mood disorders not only put the parent at risk, but also have a negative impact on the behavioral, cognitive, physical, and emotional development of the infant (Courtenay, 2010). Parental depression has been associated with delays in the child's development in areas of communication, gross motor and personal-social domains as measured by the Ages and Stages Questionnaire (ASQ) as well as health problems, an increase in a child's overall difficulties and disruption in the development of healthy attachment (Abdollahi, Abhar, Zargami, 2017; Ikeda, Hayashi, Kamibeppu, 2014).

Perhaps most concerning and a core problem that this project intends to address is the finding that 50% of postpartum depressed mothers do not seek treatment, leaving their infants at risk

of adverse outcomes (American Psychological Association, 2006). Black and Latina women are even less likely to seek treatment (Kozhimannil, Trinacty, Busch, Huskamp, and Adams, 2011). Maternal depression is also found to increase the frequency of spanking (Coyl, Roggman, Newland, 2002). Parental depression in both men and women adversely impacts child development and increases the rates of poor cognitive performance and insecure attachment (Winsner, Sit, McShae, et al., 2013), as stated above, and those negative outcomes result in ACEs for the infant and other children of the depressive parent.

With the findings of depressive symptoms and mood disorders so significant in every type of new parent, regardless of gender, identity, birth or non-birth parent, for the purpose of this project all new parents will be identified as "new parent(s)" or "parent(s)".

The structure of the health care system plays a significant role in the lack of identification and referrals for parents for treatment of parental depression. Traditionally, a depression screening is only administered in a healthcare setting, or with behavioral health professionals. Mothers visit their medical provider between four and eight weeks after birth for a postpartum visit, but after this initial period the health care focus shifts to the infant, and the mother is no longer seen by a maternal health care professional unless she initiates service, or is already showing signs of PPD identified by the medical provider. Co-parents, regardless of sex or identity, and adoptive parents are not traditionally seen at all by a health care professional throughout the prenatal and postpartum periods, unless they personally initiate services based on a self-identified or pre-diagnosed condition.

A recent study with Sonoma County parents shows more than half of the Latinx parent responses indicate information about child vaccinations and well-child checks would be very helpful. Local health care providers are very concerned with the high rate of infants who are not being seen for vaccinations and well-child checks since the pandemic hit the community. Many parents are unaware providers are seeing patients for non-emergency services, or preventative care, which results in more parents going longer periods of time without interactions with a medical professional. In the same study, approximately 25% of parent respondents stated mental health support would be very helpful. Now more than ever, new parents are isolated and unaware of where or how to seek help through for mental health through the pandemic.

The initial thought to address the lack of parental depressive screenings was to raise awareness of the importance of screening, and to improve the consistency of screening by medical professionals. However, there are still parents who are missed during their most vulnerable time, even if every mother is screened at her postpartum appointment. As the system currently exists, after the initial postpartum visit the mother is no longer seen as a postpartum patient, and there is no further opportunity for screenings by a medical professional, missing the highest risk period. The infant continues as the patient for well-child checks, but even if the pediatrician is informally checking-in with the parents about depressive symptoms, there are significant limitations for any services beyond that simple conversation, and no opportunity for a formal screening. In the pediatric appointment the infant is the patient, therefore screening

the parent is not reimbursable, and there is no access to record the information or potential need for a referral in the parent's medical record. With medical record legalities, and billing restrictions there is not currently an accessible fix to these barriers. The pandemic has impacted well-child checks significantly as well. With local health care providers prioritizing immediate need patients first, leaving minimal times to schedule preventative appointments such as well-child checks. There is also a lack of communication disseminated in certain communities about availability of well-child checks, such as the Latinx community, as indicated in the parent survey administered by First 5 Sonoma County during the pandemic to better understanding parenting during COVID-19 that showed 36% of Latinx parents say information on child vaccinations and/or well-child checks would be very helpful, compared to only 6% of White parents.

Considering the most common time period for women with PPD is between three and twelve months after birth, between three and six months after birth for fathers and co-parents, and 0-4 weeks after adoption of an infant, the traditional screening process completely misses the highest risk time periods, and allows for the majority of parental depressive cases to be unidentified and untreated in all types of new parents (Robertson, Celasun, and Stewart, 2003; Courtenay, 2010).

The proposed county-wide project, **New Parent TLC** (*Talk, Link, Confirm*), will significantly increase the identification and referrals for parents with parental depressive symptoms. By focusing on the opportunity in identification, referral and mitigation of symptoms through an innovative approach utilizing trusted gatekeepers, **New Parent TLC** aspires to ensure wellness, recovery and resiliency for new parents and the best start possible for Sonoma County's 5,000 babies born annually. Preventing infant exposure to ACEs caused by parental depression, will promote healthy attachment and optimal brain development and will ultimately set the youngest residents of Sonoma County on a trajectory for long-term health and mental health outcomes.

Sonoma County has prioritized this mental health challenge and proposed solution as it begins to address multiple underserved and unserved populations with the promise of having a far-reaching impact on the overall wellness for families in the long term. This application addresses the following unserved and underserved populations: New parents and adoptive parents belonging to all demographics in Sonoma County, with specialized services that are culturally responsive for Latinx and LGBTQ+ parents. Sonoma County has community-wide support for "upstream" programs that make an investment in the wellbeing of community members so that psycho-social/socio-economic factors do not become disabling.

Proposed Project

A) Brief narrative overview description of the proposed project

The proposed Sonoma County-wide MHSA Innovation project, **New Parent TLC** (*Talk, Link, Confirm*) will ingeniously employ a gatekeeper training model similar to **QPR** ***(****Question, Persuade, Refer*) to intervene early with new parent mental health issues, the unaddressed

progression of more serious depression and/or suicide, the exposure of infant Adverse Childhood Experiences (ACEs) resulting from parental depression and the associated disruption of optimal infant/toddler brain development.

The model will train gatekeepers to utilize a three-part method:

1) *Talk* - casual conversation between a trusted gatekeeper and new parent in natural, every-day contexts

2) *Link* - updated referrals for parents, linking parents to community-based supports

3) *Confirm* - an informal method of checking back in with the parent to confirm their follow-through to access support

Medical providers are currently the main source of screening and identification for postpartum depression. However, there are still new parents with depressive symptoms who are not being identified, as postpartum medical appointments discontinue after the primary appointment that normally occurs between six and eight weeks after birth for a birth mothers, and a postpartum visit for any co-parent or non-birth parent does not exist.

After the birth of a new baby, parents may typically have regular and frequent points of contact with childcare/preschool providers, coworkers and cosmetology service providers. Anecdotal and conventional wisdom points to these individuals as "trusted gatekeepers": individuals who are uniquely positioned to observe parents under duress, engage that parent in an informal and respectful private conversation and to offer help that may alleviate that stress.

The implementation of the proposed project has the opportunity to increase identification of any form of new parent depressive symptoms or mood disorders and is partnered with referrals to supports and services. This community-based early intervention innovation can prevent suicide, infant exposure to ACEs resulting from parental depression, and even lay the groundwork for cost-effective and high-impact policy change, such as universal participation by licensed childcare providers to recognize parental depression symptoms.

B) Implementation of general project requirement

The proposed project makes a change to <u>two existing successful practices</u> in the field of mental health and utilizes a community-based approach to address parental mental health concerns. The two existing practices include the evidence-informed **QPR** (*Question Persuade Refer)* model and **HaiR-3R's** *(Recognize, Respond, and Refer).* The QPR model was initially developed as suicide prevention in the military. HaiR-3R's is a model for hairdressers to identify and refer domestic violence victims. Both models employ a gatekeeper theory for identifying and addressing concerns. The **New Parent TLC** model will combine and adapt the relevant components of these two models and develop a unique curriculum targeting the specific gatekeeper populations of childcare providers and cosmetology service providers as trainees to recognize maternal and paternal mental health symptoms.

Elements of the existing evidence-informed QPR gatekeeper training model will be adapted for specific relevance to parental depression including Perinatal Mood Disorder (PMD), Postpartum

Depression (PPD), Paternal Postnatal Depression (PPND), and post adoption depression. QPR is an evidence-informed suicide prevention model that is widely used across cultures in the United States, and in both English and Spanish languages (Quinnett, 2012). The QPR model employs training for "gatekeepers" to recognize warning signs and implement three-steps, similar to the life-saving CPR intervention, to identify new and untreated cases of those at-risk of suicidal thoughts and behaviors in communities. The term *gatekeeper,* as used in the field of suicide prevention, is defined as, "individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine," (Burnetter, Ramchand, and Ayer, 2015, p. 2).

After seeing increases in suicide rates in the military, policies and programs were set in place to focus on prevention with the utilization of service members, typically noncommissioned officers (NCOs) as *gatekeepers* to identify and refer at-risk individuals (Burnetter, Ramchand, and Ayer, 2015). Quinnett (2012) stated, when QPR is implemented as a population-based approach, fewer suicides occur when greater percentages of any specific community are successfully trained in the approach to recognize and refer those at-risk.

A similar model, HaiR-3R's, (*Recognize, Respond, and Refer*) was implemented as an innovative approach to utilize hairdressers to identify domestic violence (Jackson, 2018). The approach, successful with hairdressers, uses community education and training, and is a sustainable way to promote community safety and focus on long-term behavior change (Jackson, 2018).

Although QPR has previously been used as a mental health intervention specifically for suicide prevention, there is recent movement that supports this model as an early recognition and referral public health intervention for those persons sending non-suicidal detectable distress signals as well (Quinnette, 2012). By combining and adapting these two successful models, QPR and HaiR-3R's, and developing curriculum specifically targeting those who have the most contact with new parents, and are in positions of trust, more parents with depressive symptoms can be identified and linked to services, ultimately resulting in better developmental outcomes for infants. The combination and adaptation of these two models support a population-based approach that is a sustainable way to address a significant mental health issue.

Gatekeepers to be trained in **New Parent TLC** will be lay individuals who have regular, day-to-day contact with new parents and who are in positions of trust, such as childcare providers (including family day care home providers, playgroup leaders and preschool teachers), co-workers and cosmetology service providers. The adaptation utilizes the relationship of trust to open the discussion of parental depressive symptoms and assist those parents with linkages to services. The proposed widespread public health education and training for child care providers, cosmetology service providers, employees of medium to large employers and other individual community members will also increase general community awareness of the prevalence of perinatal mental health issues and normalize the conversation between trusted peers and any parent who has had a baby within the last 12 months, reducing parental depression stigma, and increasing identification, referral to resources, and treatment.

The proposed project, **New Parent TLC**, will develop gatekeeper training curriculum and deliver training specifically focused on early identification of parental depressive symptoms in new parents, better prepare these gatekeepers to have meaningful discussions with new parents, make referrals and follow up to facilitate linkage. Key components will include: the identification of parental depressive symptoms; how to talk and comfortably discuss potential symptoms; how to refer to appropriate supports and services specific to that individual's needs; and, how to follow-up with any parent who has demonstrated symptoms of parental depression to confirm that parent is actively seeking or participating in services after a referral has been made. Although the gatekeeper will be trained to follow-up to confirm each parent has completed a linkage to services, this confirmation is based on the self-reported information from the parent. Gatekeepers will be trained in confidentiality and HIPAA requirements, as well as how to inform and assure the new parent of that confidentiality.

Trained gatekeepers will be encouraged to identify themselves as a trained gatekeeper for transparency. In cases where parents may refuse services the gatekeeper can participate in an individual consultation with the training consultant to determine next steps. Gatekeepers will be encouraged to maintain a philosophy of open communication and encouragement even if a parent does not follow-through with a referral.

Licensed child care providers are already mandated reporters, and even though the co-workers of many medium to large organizations, and cosmetology service providers are not normally mandated reporters they will be trained on mandated reporting as part of the gatekeeper training to ensure they are aware of when to seek professional help in the case of a child potentially being in danger or if they believed a parent was going to harm themselves or someone else.

Gatekeeper training curriculum will be developed utilizing consultants who are clinical subject matter expert(s) in perinatal mental health issues, and culturally competent in mental health for the specific population. The curriculum will adapt elements of QPR and HaiR-3R's with a gatekeeper model to identify symptoms and refer to services. In addition, the **New Parent TLC** model will infuse the Five Protective Factors to support building resilience and strengthen families. The five protective factors include parent resilience, knowledge of parenting and child development, social and emotional competence of children, social connections, and concrete support in times of need (www.strengtheningfamilies.net, 2019). The strengthening families protective factors model is used in early home visiting programs, Family Resource Centers, and other family centered, strength based services.

New Parent TLC aims to train childcare providers, cosmetology service providers, and employees of medium to large organizations in an effort to reach as many new parents as possible to identify parental depressive symptoms across all demographics. However, understanding the complexities of the population of new parents in Sonoma County is fundamental to creating culturally responsive curriculum for participants. More than one in four residents in Sonoma County are of the Latinx population (U.S. Census Bureau, 2013-2017 American Community Survey 5-year Estimates, 2019), and Sonoma County is ranked number 2

in the nation for same-sex couples (Sonoma County Pride, 2018). To ensure that the training curriculum and approach is culturally responsive particularly for the Latinx community and LGBTQ+ families, a cultural community advisory group will be convened. The cultural community advisory group will be composed of Latinx individuals and LGBTQ+ individuals with lived experience, and local experts in culturally responsive mental health approaches, including Humanidad, Raizes Collective, Positive Images and Life Works.

The county-wide model will include convenient times and locations for gatekeeper trainings to accommodate each group and encourage participation. Trainings can be held on-site for the participating organizations with no cost for the space. Food will be provided for trainings that are held at the location of the employers, with the understanding that line-staff members of medium to large employers often cannot take time off for non-mandatory training. In addition, evening trainings can be provided for childcare providers to accommodate schedules and encourage participation with the least amount of disruption to participants' working environment. The location of these trainings can be both in the First 5 large training rooms, or at the local Child Care Resource and Referral agency at no cost for either training space. Food and childcare will be provided as an incentive to participate, and to reduce any barriers. Cosmetology Service Providers may also come to training locations at First 5 with food and childcare provided.

Trainings in at least the first year of the project will be offered virtually to ensure public health safety with social distancing requirements. Larger groups can be facilitated through Zoom with interactive training, breakout groups for a smaller group environment, and learning teams.

As an extra incentive to participate in the gatekeeper training, First 5 Sonoma County will utilize the agency's strong social media presence to promote the small businesses and medium to large employers who participate in the gatekeeper training. Small family childcare businesses, cosmetology service providers, and medium to large employers could all greatly benefit from the recognition and acknowledgement of their participation in the training.

C) Appropriateness of selected approach

The selected approach for addressing under-identified parental depression was discovered through a process that included multiple efforts to gather and analyze data within the local community, both with community members and professionals in the field. Community research efforts included focus groups, interviews, and surveys.

In the development of this project, First 5 Sonoma County convened a focus group of key stakeholders to explore the systems that address early relational mental health issues. Among those participants were several individuals who have experienced postpartum depression, and individuals who have personally been significantly impacted by postpartum depression, leaders from County of Sonoma maternal home visiting programs (Nurse Family Partnership, Field Nursing, Teen Parent Connections), private maternal mental health and dyadic therapy clinicians (Alison Murphy, MFT of Mother's Care and Jenni Silverstein, LCSW), local community-

based leaders in the fields of maternal mental health, and developmental screening and early intervention for infants, (Child Parent Institute & Early Learning Institute).

One community member, Greg Ludlams, shared openly about losing his wife to suicide after months of unrecognized, untreated symptoms of postpartum depression following the birth of their second child. He described how his wife's symptoms went completely undetected in spite of regular scheduled medical appointments, that she made great efforts to appear "put together" and to mask her symptoms. Greg noticed changes in his wife's mood, but had no idea what the cause was, how severe the symptoms could be and did not recognize any signs of suicidality. After her death, Greg learned from their infant son's childcare provider that his wife had shared with her a small hint of her struggle with depression. One day when she dropped off their son at the provider's home on her way to work, she mentioned to the childcare provider that she was feeling "overwhelmed." A short time after that disclosure, Greg's wife took her own life.

Greg strongly encouraged First 5 Sonoma County to consider these daily, frequent, non-clinical contacts as opportunities to connect struggling parents with supports that could ease the weight of maternal and paternal depression and anxiety that is far too common and too often unrecognized and untreated. His story greatly inspired this innovation project.

Through the proposed training, First 5 Sonoma County aims to normalize the conversation, educate parent peers who are the most likely to have contact during pregnancy and through the first 12 months after birth, to share the potential severity of postpartum depression so that no other child loses a parent to postpartum depression. In Greg's case, the childcare provider was the only person his wife shared her feelings of overwhelm with. This identifies a major opportunity to reach other parents at risk.

In addition, the focus group generated vital information about current practices and processes in the area of screening, identification, referral to treatment, and available services. Through this process a major opportunity within the system was identified, and a method to reach these un-served parents through the most common touchpoints was developed. The ultimate goal is to reach those parents at the highest risk time, when they are not receiving any other mental health services in an effort to prevent suicide and infant exposure to ACEs as a result of parental depression.

First 5 conducted informal research in the community to test the potential feasibility and effectiveness of leveraging gatekeeper interactions as a method to reach new parents with depressive symptoms who are not already seeking services. Informal interviews of cosmetology service providers were conducted (four hairdressers, a nail technician and two lash extension providers). Providers were asked whether a client as a new parent had ever disclosed concerns about depression and/or anxiety to them during the course of receiving a service. All six responded affirmatively that such disclosures are a common, frequent occurrence in their daily interaction with clients and provided multiple examples of clients sharing personal disclosures related to relationship troubles, challenges with child rearing and other personal experiences.

When asked if they would be interested in learning about how they might help new mothers connect to supports, all six were enthusiastically interested.

First 5 Sonoma County also conducted a confidential, written survey of parents who participate in Spanish-speaking parent education program and parent-child playgroups. The survey results supported the inclusion of training for co-workers, as there are often close relationships developed in the long hours spent at work. Both the survey and Greg Ludlams' story suggest the significance of a childcare provider's contact with both parents, implication for training these gatekeepers to talk about potential parental depressive symptoms and the identification of those symptoms in a spouse.

Additional informational interviews with parents also supported the idea that the childcare provider as a main support for resources and cosmetology service providers as individuals who young parents are most likely to share recent personal experiences with. After being trained in the **New Parent TLC** model, childcare providers, coworkers, and cosmetology service providers will know how to look for symptoms, be comfortable talking about these symptoms, and know how to make referrals for parents.

Included in the focus group was a discussion of available services in the community for parental depression. The service providers and community members identified a general lack of bi-lingual, culturally appropriate mental health services for the Spanish-speaking population in Sonoma County. The 2017 U.S. Census estimates show over 26% of Sonoma County's population is Latinx. However, there are far less than 26% of the mental health services in Sonoma County that are culturally responsive, leaving the Latinx population underserved.

At each of the federally qualified health clinics in Sonoma County that accept Medi-Cal and see prenatal and postpartum patients there are an average of about two mental health providers who speak Spanish. There is one bilingual service provider through Child Parent Institute, and one bilingual service provider through Petaluma People Services Center who are qualified to serve the perinatal/postpartum mental health population. Child Parent Institute and Petaluma People Service Center are local non-profit service providers in the field. If a parent is not currently under the care of a medical or mental health professional, then postpartum depression often goes undetected. Through the proposed project, **New Parent TLC**, peers within a person's own community can help identify and refer when needed, preventing suicide, and ACEs as a result of a parent's postpartum depression can be prevented as well.

Lare-Cinisomo, Wisner, Burns, and Chaves-Gnecco, (2014) found the preferred coping for postpartum depression in Latinas is a woman's own cognitive coping strategies, not seeking professional intervention. However, the second-level preferred approach included formal support from home visitors or lay community health workers, preferably introduced by a trusted friend, which significantly supports the proposed **New Parent TLC** gatekeeper model (Lare-Cinisomo, et.al., 2014).

Additional formal research was conducted through a literature review on parental depressive rates, diagnosed and undiagnosed disorders, treated and untreated depressive symptoms, help seeking methods, and family structure and dynamics to support this proposal.

First 5 Sonoma County currently holds an MHSA Prevention and Early Intervention (PEI) services contract for prevention and early intervention services for children prenatal to age five and their families with the County of Sonoma Department of Health Service's Behavioral Health Division, which is profoundly different than the proposed innovative **New Parent TLC** gatekeeper model. Under MHSA PEI 0-5, First 5 is the lead agency, and holds subcontracts with community partners for the service delivery. First 5 not only holds administrative responsibilities in administering these subcontracts, but also supplements the funding for the services, coordinates Positive Parenting Program (Triple P) training for mental health professionals for the MHSA-PEI 0-5 grantees. The services provided under the MHSA PEI 0-5 funding also include developmental and social-emotional screenings of at-risk children, case management and referrals for children for whom a screening identifies potential delays, Triple P services to strengthen parent-child relationships and build parents' knowledge and skills, one call navigation that connects families to services in the community, and makes referrals to mental health and developmental services as needed for children. MHSA PEI 0-5 is specifically an intervention service delivery model, while the innovation project, **New Parent TLC** gatekeeper model is about outreach, raising awareness for parental depression, increases access to underserved groups, and promotes interagency and community collaboration related to mental health services or supports.

The innovation project fits within the First 5 agency, with strong committed partnerships already in active with service providers in the domain of parental depression. First 5 can expand on the partnerships of service providers to create the safety-net of providers that the local childcare providers, cosmetology service providers, and peers can refer parents experiencing depressive symptoms to.

D) Number of individuals expected to be served annually

All new Sonoma County parents from the prenatal stage through the first 12 months of their child's life are the targeted population to be reached through the trained gatekeepers. Low-income parents are at higher risk, but other than being aware of and acknowledging the increased risk, this is not an element considered by gatekeepers before deciding to complete the **New Parent TLC** model.

With approximately 5,000 new babies born per year in Sonoma County, we can expect 20% (1,000) mothers, and 10% (500) fathers or co-parents within the first 12 months of their infant's life to experience clinically defined parental depression, of which half (750) will likely not seek treatment (Winsner, Sit, McShea, et al., 2013; Barnett and Ungerger, 2000; Goodman, 2004; American Psychological Association, 2006). Including the 70% to 80% of mothers with non-clinical depression in the postpartum period (Postpartum Depression, 2019), which can be just as damaging to the infant, the number of parents at-risk is approximately 4,500 per year.

Although the target population in this project includes the 4,500 new parents who may experience parental depression, the individuals expected to be ***served*** in this project include the "gatekeepers" who will participate in the training for the **New Parent TLC** model. The three-year dissemination plan for **New Parent TLC** will include a total of 40 trainings with approximately 30 attendees per training, totaling 1,200 trained gatekeepers after the three-

year project. The first year will include approximately 8 trainings, with 240 trained gatekeepers. Second and third year will include approximately 16 trainings with 480 gatekeepers trained each year.

Recruitment for gatekeeper training participation will include referrals to the training from the local resource and referral service in Sonoma County for childcare providers. Co-worker recruitment will start with the organizations that are currently participating in an initiative that supports family friendly workplaces and policies, and cosmetology service providers will be recruited by the First 5 Program Coordinator who will also support training implementation.

The targeted individuals to be served are the gatekeepers who complete the training and who will then employ the **New Parent TLC model**. This includes:

- **600 Total Child Care providers (including family day care home providers, preschool teachers, playgroup leaders, kinder-gym, children's museum, etc)**
    - 120 childcare providers trained in Year One
    - 240 childcare providers trained in Year Two
    - 240 childcare providers trained in Year Three

- **500 Total co-worker/employees**
    - 100 co-worker/employees trained in Year One
    - 200 co-worker/employees trained in Year Two
    - 200 co-worker/employees trained in Year Three

- **100 Cosmetology Service Providers trained**
    - 20 Cosmetology Service Providers trained in Year One
    - 40 Cosmetology Service Providers trained in Year Two
    - 40 Cosmetology Service Providers trained in Year Three

E) Methodology for number of service providers

For the purpose of this project, childcare providers include licensed and unlicensed childcare providers, playgroup leaders, kinder-gym staff, children's museum staff, preschool teachers and staff, and religious organization childcare providers. Approximately half (480) of the training slots for this county-wide project will focus on childcare providers, as this population has the highest rate of interactions with new parents. There are currently 328 licensed family childcare providers, 165 licensed childcare centers with multiple staff members, and 113 exempt childcare providers in Sonoma County. In addition, there are many playgroups throughout the county, as well as family and friend childcare providers.

Coworkers/employees for the purpose of this project will come from major employers who are already engaged in the implementation of family-friendly policies and/or employer-supported childcare initiatives through First 5's longtime partnership with the Santa Rosa Metro Chamber of Commerce. Participating employers include Amy's Kitchen (988 FTE), The City of Santa Rosa

(over 1,000 FTE), MedTronic (1,000 FTE), and La Tortilla Factory (250 FTE), totaling 3,238 full-time employees. Approximately 400 training slots will focus on coworkers/employees.

Cosmetology service providers will include hairstylists, nail technicians, estheticians and others in the beauty industry that provide individual services to clients locally throughout the Sonoma County area. With the consideration that outreaching and convening this group will require a different approach, approximately 80 trainings slots will focus on cosmetology service providers.

By targeting these trusted peers with high rates of parental contact it is possible to reach those parents who experience symptoms, but are not currently receiving services, and prevent suicide and infant exposure to ACEs as a result of parental depression. The expected reach of these trusted peers as gatekeepers includes referrals for birth mothers, co-parents, parents in the Latinx community, and LGTBQ+ parents. First 5 anticipates an approximate ratio of three birth parents to each co-parent for expected engagement and referral through the **New Parent TLC** gatekeeper training model.

F) Population Description

Sonoma County is home to approximately 500,943 residents according to the 2017 U.S Census estimates, with approximately 32 percent of the population between the ages of 20 and 44. The average annual income for a family is $113,052, however approximately 26 percent of the residents are living at or below 200 percent of the federal poverty level. The 2017 U.S. Census estimates show over 26 percent of Sonoma County's population is Latinx. In addition, Sonoma County is ranked number 2 in the nation for same-sex couples (Sonoma County Pride, 2018). To meet the needs of the general population, and the specific needs in Sonoma County, additional culturally appropriate curriculum will be developed that focuses on sub-groups including the Latinx population and the LGBTQ+ populations to ensure equity for all families in the community. Approximately 30% of the trainings will be held in Spanish. Trained gatekeepers will all be over the age of 18 and be a member of one of the identified groups (childcare provider, coworker/employee, cosmetology service provider) targeting those gatekeepers who are currently trusted partners in the underserved populations.

Research on Innovation Component

A) Distinguishing aspects of project

Similar projects include the QPR model and the HaiR-3R's model. QPR was primarily developed as suicide prevention in the military population and has been used in many other populations including Police, and Spanish speaking populations. The adaptation from QPR will include utilizing the population-based approach and identification and referral processes, but changing the training to include identification of less drastic symptoms, expanding to include depressive symptoms instead of the primary suicidal signs, and focusing on parents within the first 12 months after the birth/adoption of a baby.

HaiR-3R's model is inclusive of hairdressers and focuses on identification of signs of domestic abuse and referrals. The **New Parent TLC** model expands the population of hairdressers to

include childcare providers, preschool teachers, coworkers, and a wide range of cosmetology service providers to identify parental depressive symptoms, become comfortable talking about these symptoms, and referring to appropriate services.

All models use a gatekeeper as a peer support for identification and referral, engage a population-based approach. By employing a train-the-trainer model the **New Parent TLC** model works toward a sustainable approach as well. After the initial curriculum is developed, and the first three years of training are implemented, the impact can expand and continue with champions in the community continuing to spread the scope of training.

B) Investigation of existing approaches

Research has been completed on multiple scholarly sites to identify the scope of use and populations for both models. No research was found that shows either model used with parental depression. Additional opportunities were identified in the mental health system of care through focus groups with professionals in the field and community members. A significant issue identified is the occurrence of symptoms after the time period in which a new parent interacts with their health care provider.

As stated above, it was found that mothers visit their medical provider between four and eight weeks after birth for a postpartum visit, but after this initial period the focus shifts to the infant, and the mother is no longer seen by a health care professional unless she initiates service, or is already showing signs of PPD identified by the medical provider. Co-parents and adoptive parents are not seen at all by a health care professional throughout the prenatal and postpartum periods, unless they personally initiate services based on a self-identified or pre-diagnosed condition. Considering the most common time period for women with PPD is between three and 12 months after birth, and between three and six months after birth for co-parents, the traditional screening process completely misses the highest risk time periods, and allows for the majority of postpartum depressive cases to be unidentified and untreated in both all new parents (Robertson, Celasun, and Stewart, 2003; Courtenay, 2010).

Ventura County has implemented an innovation project “Bartenders as Gatekeepers,” which provides gatekeeper training for bartenders to target middle-age men and prevent suicide. Ventura County acknowledged challenges in engaging bartenders for the gatekeeper training, even with incentives. Lessons learned from the Ventura County project will be considered while developing the outreach and recruitment plan for the **New Parent TLC** gatekeeper trainings.

Some of the differences between the programs includes the target population for the gatekeeper training, the setting in which the gatekeepers will interact with those potentially experiencing depressive symptoms, and the organization that is responsible for outreach and recruitment. These three differences help address the challenges experienced by Ventura County. As one of the lessons learned, Ventura County stated their county agency did not have the capacity to conduct outreach at the level needed for full participation, and that they would recommend contracting out to a nonprofit. **New Parent TLC** will be implemented by First 5 Sonoma County. First 5 Sonoma County operates similar to a nonprofit agency. As a small

public agency First 5 Sonoma County has the staffing capacity to conduct outreach and recruitment efforts, host training, and manage the coordination and facilitation responsibilities that are required to adequately promote the program and gain participation. First 5 is hiring an additional staff member to ensure adequate support and resources are provided for these efforts. First 5 Sonoma County also has strong relationships with the local childcare resource and referral agencies and with medium to large agencies that are currently working toward stronger family friendly policies. These strong relationships will help in the outreach and recruitment process.

Targeted gatekeepers for **New Parent TLC** include childcare providers who are already trained as mandated reporters for child abuse. The gatekeeper training allows them to have another tool in their tool belt to adequately support the children in their care. The setting of the interactions between the new parents and the trained gatekeepers is also very different from the bartender setting. Childcare providers are often looked to for parenting advise and other matters of new parents. Cosmetology service providers have a one-on-one captured audience with the time they spend with their client while providing the service. Peer-to-peer relationships in the workplace can also be one of the only contacts a new parent has while training to balance working and a new baby. Each of these three settings are crucial in the effort to identify and refer new parents with depressive symptoms. Collaborations with the local Economic Development Board and the Santa Rosa Chamber of Commerce will be proposed to identify and reach employers and cosmetology service providers.

Learning Goals/Project Aims

A) Learning goal and priority over the course of the project.

The learning goals for **New Parent TLC** are directly aligned with the two primary purposes of the project: 1) increase access to mental health services to underserved groups; and 2) promote interagency and community collaboration related to Mental Health Services or supports or outcomes.

Learning Goal 1:
What is the difference, if any, of the number of referrals for parents for services for parental depressive symptoms by trained gatekeepers?

Sub-goal 1a: Is there a statistically significant difference in the rate of referrals between the three groups of childcare providers, coworkers/employees, and cosmetology service providers?

Data for learning goal one will be collected quarterly.

The number of completed referrals will also be tracked. However, this data point is more difficult to track, and will not be tested for a statistically significant difference between groups at this time. The completion of referrals is self-reported by the new parent to the trained gatekeeper. The gatekeeper will be trained and is responsible for creating a feedback loop to

confirm the new parent has engaged in seeking support through the gatekeeper's referral. At this time the data point will not formally be part of the measurement of "success" for the project, but the collected information will help determine areas that may need improvement or adjusting.

Learning Goal 2:
What is the experience of parents experiencing depressive symptoms, trained gatekeepers, and postpartum service providers who have participated in the New Parent TLC pilot project?

Sub-goal 2a: What factors contribute to completed linkages to services and a positive experience for parents, and trained gatekeepers?

Sub-group 2b: What factors were identified as barriers for referrals made that were not successfully completed?

Data for learning goal two will be collected quarterly.

The initial priority is to measure the increase, if any, in referrals to services for parental depressive symptoms by trained gatekeepers. Below, in the evaluation section, a method is provided to measure this expected increase, if any. Referrals and self-reported completed referrals will be documented by a sample of the participants and provided to the evaluator quarterly throughout the span of the project in the form of a survey. An increase in referrals initiated by trained gatekeepers to appropriate services for those parents who are not currently receiving services will show progress in the purpose area one (increase access to mental health services to underserved groups). Completion of referrals will also be used to measure progress, in addition to lessons learned and quality improvement going forward.

The second learning goal will contribute to lessons learned, and quality improvement through the span of the project, and thereafter should the project continue. Gatekeepers, postpartum service providers, and parents can reflect on his or her collaborative experience with **New Parent TLC**, what worked and what did not, what should be added or removed from the training, identify barriers, and approaches to address those barriers. The first year of the project will be used as the main pilot, with more intense data collection and a quality improvement plan for the following two years. Monthly emails will be sent to trained participants for them to have the opportunity to share their experience with any **New Parent TLC** interaction with a parent. A coaching session can be provided for those willing for constant quality improvement through the process. Formal interviews will be scheduled quarterly for the qualitative data collection, and an annual report will be completed each year. For privacy reasons the identity and all personal identifying details will not be included in the monthly email, unless the gatekeeper has prior permission from the new parent.

B) Relation of learning goals to key elements/approaches that are new, changed or adapted in the project.

Key elements that are new, changed, or adapted in this project include: a shift from identification of signs of suicidal ideology or domestic violence, and concentrate on identifying

parental depressive and anxiety symptoms, along with the linkage to appropriate services; create curriculum that is grounded in cultural responsiveness and equity; and promote a community collaboration to improve the identification of parental depressive systems, and link those parents to services.

Learning Goal 1 will show the effectiveness of the adaptations by determining if there was an increase in referrals for parents with depressive symptoms.

Learning Goal 2 will show the effectiveness of the community collaboration, share what is working, what is not, recommendations for quality improvement changes, and identify where barriers need to be addressed.

EVALUATION PLAN

Learning Goal 1 Evaluation Plan

<u>Research Question 1:</u> What is the difference, if any, in the number of referrals to services for parental depressive symptoms by the entire group of trained gatekeepers?

***H_0*1:** There is no statistically significant difference in the number of referrals to services for parental depressive symptoms by entire group of trained gatekeepers.

***H_1*1:** There are statistically significant differences in the number of referrals to services for parental depressive symptoms by entire group of trained gatekeepers.

<u>Research question 2:</u> What is the difference, if any, in the number of referrals to services for parental depressive symptoms by the group of trained childcare provider gatekeepers?

***H_0*1:** There is no statistically significant difference in the number of referrals to services for parental depressive symptoms by the group of trained childcare provider gatekeepers.

***H_1*1:** There are statistically significant differences in the number of referrals to services for parental depressive symptoms by the group of trained childcare provider gatekeepers.

<u>Research question 3:</u> What are the differences, if any, in the number of referrals to services for parental depressive symptoms by the group of trained coworker/employee gatekeepers?

***H_0*1:** There is no statistically significant difference in the number of referrals to services for parental depressive symptoms by the group of trained coworker/employee gatekeepers.

***H_1*1:** There are statistically significant differences in the number of referrals to services for parental depressive symptoms by the group of trained coworker/employee gatekeepers.

<u>Research question 4:</u> What are the differences, if any, in the number of referrals to services for parental depressive symptoms by the group of trained cosmetology service provider gatekeepers?

***H_0*1:** There is no statistically significant difference in the number of referrals to services for parental depressive symptoms by the group of trained cosmetology service provider gatekeepers.

***H_1*1:** There are statistically significant differences in the number of referrals to services for parental depressive symptoms by the group of trained cosmetology service provider gatekeepers.

Learning Goal 1 population and sample size

The population for learning goal one evaluation includes the gatekeeper groups of 600 trained childcare providers, 500 trained coworker/employees, and 100 cosmetology service providers over the course of three years. With a confidence level of 95%, margin of error of 5% and population proportion of 50% the appropriate sample size is 235 childcare providers, 218 coworker/employees, and 80 cosmetology service providers over the course of the three-year project. Sample sizes will also be evaluated quarterly based on the number of training participants in each group to ensure a sufficient sample size.

Data collection method

Data for Learning Goal 1 will be collected by means of self-administered questionnaire that will be developed by the evaluator with First 5 Sonoma County, and tested by the evaluator with First 5 Sonoma County, the cultural community advisory group, and community members. The questionnaire will be administered either by electronic form through Survey Monkey, or in paper form for those who prefer the use of paper. The questionnaire will be available in both English and Spanish. Survey responses will be collected quarterly from each of the participants from the gatekeeper training.

At the time of registration (approximately 30 days before each scheduled training) the prospective gatekeeper will be given an initial survey to determine a baseline. The survey will measure if the prospective gatekeeper has identified any signs of parental depressive symptoms in the month before the training, if the prospective gatekeeper engaged in a conversation about any identified symptoms, and if the prospective gatekeeper made a referral for services. The survey will also include questions on a Likert scale to measure prospective gatekeepers' level of comfortableness in participating in the discussion about parental depressive symptoms, and their confidence level in their knowledge on where to refer any particular parent expressing depressive symptoms.

The follow-up survey will include questions about how often the gatekeeper used each of the three aspects of **New Parent TLC** (*Talk, Link, Confirm*). The survey will ultimately measure if a referral was made after a gatekeeper identified parental depressive symptoms in an effort to identify the extent of an increase as a result of the **New Parent TLC** gatekeeper training. Each follow-up survey will also measure prospective gatekeepers' level of comfortableness in participating in the discussion about parental depressive symptoms, and their confidence level in their knowledge on where to refer any particular parent expressing depressive symptoms.

A comparison of results from the baseline, against the follow-up survey are expected to show an increase in referrals, level of comfortableness in the discussion about parental depressive symptoms, and confidence level in their knowledge on where to refer any particular parent expressing depressive symptoms.

The baseline data collection, and the follow-up date collection will control for interactions with new parents, in questions such as, "Have you had any interactions with a parent who has an infant under 12 months of age in the last…" In the baseline survey prospective gatekeepers will answer for the last month. In the quarterly follow-up survey trained gatekeepers will answer for the last three months.

Quantitative Data analysis

Data will be analyzed quarterly, semi-annually, and annually over the three-year project term. First each group will be evaluated against the baseline data to identify and measure an increase in referrals, level of comfortableness in the discussion about parental depressive symptoms, and confidence level in their knowledge on where to refer any particular parent expressing depressive symptoms. With sufficient sample data collected an analysis of variance (ANOVA) test will be used to compare the number of referrals made in each group of childcare providers, coworkers/employers, and cosmetology service providers. The ANOVA is appropriate for identifying differences between categorical groups, and if a significant difference is identified, then a post-hoc test will be completed to identify where the differences exist.

The proposed analysis will conclude if there were increases in referrals for those participating gatekeepers, and it will show if one group is more effective than another in making referrals for services. The analysis will also show self-reported completed referrals. The expectation is that as a result of the gatekeeper training, referrals will increase.

Learning Goal 2 evaluation plan

<u>Learning Goal 2:</u> What is the experience of trained gatekeepers, postpartum service providers, and parents experiencing depressive symptoms who have participated in the New Parent TLC pilot project?

The evaluation plan for learning goal two includes qualitative data in the form of interviews. At least two trained gatekeepers in each group, childcare providers, coworker/employees, and cosmetology service providers will be interviewed quarterly. In addition, postpartum service providers, and parents who have reported parental depressive symptoms will be interviewed each year as well.

The interviews will explore the experience as either a trained gatekeeper, service provider, or parent who has been part of the training, provided services, or received a referral based on reported symptoms. Exploration will include factors of completed referrals, and barriers when referrals were not completed.

Qualitative Data Analysis

The qualitative data gathered in this process will contribute to lessons learned, and quality improvement through the span of the project, and thereafter should the project continue. Trends will be identified and explored. Gatekeepers, postpartum service providers, and parents can reflect on his or her collaborative experience with New Parent TLC, what worked and what did not, what should be added or removed from the training, identify barriers, and approaches to address those barriers. Interviews with participants will be recorded and transcribed. A qualitative data analysis software, NVivo, will be used to analyze the qualitative data. The software allows qualitative data to be organized in ways that allow for trends to be easily identified and explored. Within each group of participants trends will be identified, and then the data from each group can be synthesized for the final report.

Annual report

An annual report will be developed and disseminated through multiple channels including an email to all trained gatekeepers, to the cultural community advisory group members, posted on the First 5 Sonoma County website, distributed to relevant County Health Department personnel, including Behavioral Health Division, shared with other First 5 Commissions, and a link to the report will be included in the newsletter when complete at the end of each year. The report will not include any personal information with unique identifiers or individually identifiable health information, to ensure the privacy of new parents who may have been identified with depressive symptoms and referred to services, and to ensure all HIPAA provisions are met.

SECTION 3: Additional Information for Regulatory Requirements

Contracting

Sonoma County Department of Health Services (DHS) will contract with First 5 Sonoma County for the proposed three-years of Innovation funding award. First 5 has an internal staff evaluator to lead and conduct the evaluation.

The MHSA Coordinator of the Sonoma County DHS Behavioral Health Division will be the main point of contact to monitor progress of **New Parent TLC** and assure contract compliance per County and State regulations. The County may provide technical support in program delivery and evaluation, fiscal reporting and program reporting to the County. Project coordination meetings will be held quarterly to establish expectations in reporting and to assure compliance with MHSA and Innovation regulations. In addition, First 5 will be expected to submit quarterly reports that include quantitative (number of clients served, demographics) and qualitative data (narrative reporting that includes findings, challenges, and solutions).
As the administrator for the **New Parent TLC** project, First 5 will contract with an educational consultant for the curriculum development, training and co-facilitation for the gatekeeper training sessions. Mental health professionals, such as a Marriage and Family Therapists and/or

Licensed Clinical Social Workers with clinical expertise in perinatal/postnatal mood disorders, anxiety and depression will be used as subject expert in the development of the curriculum. Other than the curriculum development and co-facilitation for gatekeeper training there will be no other outside contracting.

Community Program Planning

The County has robust stakeholder engagement in the MHSA Community Program Planning process. This includes the MHSA Steering Committee, Stakeholder Committee, county staff and contractors and any other interested parties. The County's MHSA Steering Committee is a key stakeholder and the committee is comprised of 27 diverse community members, including consumers, family members, TAY, ethnic and LGBTQ+ representation, various public sector personnel and advocates (see Appendix A for membership representation).

Since January of 2019, The MHSA Steering Committee has met at least quarterly to participate in shaping the mental health system of care funded by MHSA. In the summer of 2019, the MHSA Steering Committee established an Innovation Subcommittee to develop an inclusive community process that would solicit innovative project proposals, develop and apply a selection criterion for the incoming proposals and make a recommendation to award Innovation funds to selected projects. The Community Program Planning process is outlined below:

2019	Task
May-June	Understand Innovation regulations and requirements, discuss and define community planning process.
July	Develop and adopt community application, scoring criteria and FAQs to solicit Innovation Project Ideas.
Aug	Establish a calendar of community meetings for outreach and to inform the community about the Innovation opportunity; develop community presentation; conduct outreach for community meetings.
Sept	Conduct five community meetings in strategic geographic locations throughout the county to inform interested parties about MHSA and Innovation opportunity, including requirements, application form and selection criteria.
Oct	Received sixteen Innovation applications from the community; Innovation Subcommittee members reviewed and scored all applications based upon previously agreed upon selection criteria; Innovation Subcommittee held 2 full day meetings to discuss applications and arrive at consensus on prioritized projects and developed recommendation for funding.
Dec	Presented recommendation to MHSA Steering Committee and Mental Health Board (public meeting). Recommendation forwarded to the Behavioral Health Director and the Department of Health Services administration. Innovation applicants notified of status; meetings convened with approved projects to further develop their proposals.

In the table below the dates and locations of the community meetings are provided:

Date	Time	Location
September 4, 2019	10:30am – 12:30pm	Guerneville Regional Library 14107 Armstrong Woods Rd., Guerneville (West County)
September 4, 2019	3:00pm – 5:00pm	Sonoma Valley Regional Library 755 West Napa Street, Sonoma (East County)
September 11, 2019	9:00am – 11:00am	DHS Administration Santa Rosa Conference Room, 1450 Neotomas Ave., Santa Rosa (Central County)
September 11, 2019	1:00pm – 3:00pm	Petaluma Health District, 1425 N. McDowell Blvd., Rm 100, Petaluma (South County)
September 13, 2019	1:00pm – 3:00pm	Healdsburg Library 139 Piper St., Healdsburg (North County)

The table below provides the 16 applicant names and project titles.

Applicant	Project Title
Action Network (Sonoma County Indian Health Project, Redwood Coast Medical Services, Community Wellness Coalition)	Implement Community Resilience Leadership Model on the Rural Redwood Coast
Brief and Strategic Integrated Counseling Services (BASICS) [First Responder Support Network (FRSN)]	Approach to address workplace trauma among Sonoma County's first responders

Buckelew Programs (Aldea Children and Family Services, On the Move/VOICES)	Early Psychosis Intervention Care EPIC Program (EP LHCN)*
Center for Innovation and Resources	Effective, Equitable, Expanded (3E) Mental Health in Sonoma County Project
Early Learning Institute	Instructions Not Included (INI) with Dads Matter*
First 5 Sonoma County	Promoting Early Relational Mental Health: New Parent TLC*
Hanna Institute [Center for Well Being (CWB), International Trauma Center (ITC)]	"Bridging Gaps in Mental Health Care in Vulnerable Communities"
On the Move/VOICES (La Plaza, Humanidad, Latino Service Providers, Raizes Collective and North Bay Organizing Project)	Nuestra Cultura Cura Social Innovations Lab*
Petaluma Health Center	Psychiatric Nurse Practitioner Residency
Petaluma People Services Center	Manhood 2.0
Side by Side	New Residents Resource Collaborative
Social Advocates for Youth	Innovative Grief Services
Social Advocates for Youth	Street-Based Mental Health Outreach
Sonoma County Human Services Department Adult & Aging (and Santa Rosa Community Health)	Collaborative Care Enhanced Recovery Project: Advancing Older Adult Depression Care through Extended Supportive Services (CCERP)
Sonoma County Indian Health Project	Primary and Behavioral Health Care Integration Program with Traditional Native Healing Practices

The table below details the timeline of events in 2020 regarding preparing the Innovation projects proposals for public review and appropriate approvals from local and state authorities.

2020	Task
Feb-Mar	Prepared draft proposals for submission to Mental Health Services Oversight and Accountability Commission (MHSOAC) for technical assistance.
Mar	Submitted draft proposals to MHSAOC for review and technical assistance
Apr	Posted MHSA 2020-2023 Three-Year Plan with the five prioritized Innovation proposals for 30 days
May	Held public hearing at the Sonoma County Mental Health Board meeting. No substantive comments were received about the Innovation proposals.
June	Sonoma County Board of Supervisors approved the MHSA 2020-2023 Three-Year Plan that included the five prioritized Innovation proposals.
Sept/Oct	Received feedback and technical assistance from MHSOAC and incorporated feedback into proposals.
Nov	Posted Innovation proposals for 30-day public review period. On November 13, 2021.
Dec	Held public hearing at the Sonoma County Mental Health Board meeting on December 15, 2020. No substantive comments were received about the Innovation proposals.
2021	Task
Jan	Resubmit projects to MHSOAC for approval.
Feb	February 23, 2021 submit board item for Board of Supervisors review and approval.

On November 13, 2020, the County posted 4 proposed Innovation Projects, Instructions Not Included, CCERP, New Parent TLC and Nuestra Cultura Cura for the 30-day public review period. Followed by a public hearing hosted by Sonoma's Mental Health Board on December 15, 2020. No substantive comments were received on any of the projects during the 30-day review period or at the public hearing.

For the review period, the County's process is to post the project proposal on the Department's website/Behavioral Health Division webpage and send notification out to MHSA Steering Committee members, MHSA Stakeholder Committee, contacts on the MHSA Newsletter list) (over 2000 contacts), County staff and contractors and any other interested parties.

NOTE: The county is proposing two projects that support new parents: New Parent TLC and Instructions Not Included. While both of these programs aim to support new parents and identify parents with symptoms of depression, they are completely different and require different types of service providers and skill sets.

New Parent TLC is training the community that comes into contact with new parents, and does not work directly with parents. It is based on a community suicide prevention training model. Gatekeepers are trained about the signs and symptoms of postpartum depression and how to talk to a new parent about what they are noticing and provide them with referrals.

Instructions Not Included is working directly with new fathers, and trained professionals are screening for depression and ACEs

	New Parent TLC	Instructions Not Included
Description	Providing gatekeeper training: TLC (which is like QPR) for the community that interacts with new parents	Providing in home or virtual visits to new fathers and screening for post-partum depression and ACEs.
Target Population	childcare providers, cosmetologists and peer to peer workers	New fathers
Contact with parent	No	Yes
Providing referrals for new parents	Yes	Yes

In addition to the County's community program planning process, each of the applicants were required to develop their proposed projects with consumer and community input to validate the need among the population and that the innovation proposed was a feasible and strategic approach to the defined community/mental health challenge.

In the last quarter of 2020, the County will post the proposed Innovation Project, New Parent TLC, for a 30-day public review period. The County's process is to post the project proposal on the Department's website/Behavioral Health Division webpage and send notification out to MHSA Steering Committee members, MHSA Stakeholders, County staff and contractors and any other interested parties. The public review period will culminate with a public hearing at the Sonoma County Mental Health Board meeting, held the third Tuesday of every month (Planning for December 15, 2020). A final step in the County's process is approval by the MHSOAC prior to contracts being issued.

In addition to the County's community program planning process, each of the applicants were required to develop their proposed projects with consumer and community input to validate the need among the population and that the innovation proposed was a feasible and strategic approach to the defined community/mental health challenge.

Thus, the community, specifically those impacted by PPD and/or PPND were the major driving force and inspiration for the program planning of New Parent TLC. The community was engaged in multiple ways throughout the program planning and development process including focus groups, interviews, and survey responses. First 5 Sonoma County convened a focus group of key stakeholders to explore the perceived challenges and needs in the area of early relational mental health issues. Among those participants were several individuals who have personally been significantly impacted by postpartum depression, leaders from County of Sonoma maternal home visiting programs (Nurse Family Partnership, Field Nursing, Teen Parent Connections), private maternal mental health and dyadic therapy clinicians (Alison Murphy, MFT of Mother's Care and Jenni Silverstein, LCSW), local community-based leaders in the fields of maternal mental health, and developmental screening and early intervention for infants, (Child Parent Institute & Early Learning Institute). Once the initial idea was developed based on the experiences and needs of the community members impacted by PPD, PPND and/or other forms of parental depression, continuous community input was gathered through the program planning development process in the form of surveys, interviews with those in the potential gatekeeper positions such as cosmetology services providers, and interviews with parents. The data collected from community members throughout the program planning process were consistently used in the development of the larger structure and within the details of how to best serve and reach underserved communities.

In addition to the program planning that has already been completed, there will continue to be multiple steps that include the cultural community advisory group to ensure the services and evaluation of those services are culturally appropriate. The cultural community advisory group will ensure culturally competent curriculum with a curriculum review process that will also include culturally appropriate referrals and resources for specific communities. The cultural community advisory group will also support the development and review of evaluation, and any lessons learned or quality improvement after the first pilot year is complete and evaluated. The continued participation of the cultural community advisory group will ensure cultural competency throughout the development, implementation, evaluation, and program improvement process of the project.

MHSA General Standards

A) Community Collaboration

New Parent TLC is adapted from two successful community collaboration models. The community collaboration includes parental peers (gatekeepers), who already have trusted relationships with new parents, and high rates of contact with new parents. These gatekeepers identify parental depressive symptoms, participate in open-comfortable conversations with the parents, and make referrals as needed. Referrals are made to a variety of culturally appropriate services, which may include peer support groups, clinical services, or home visitors (just to name a few). The **New Parent TLC** model empowers community members to identify symptoms, make referrals, and check back in with the parent to confirm a linkage to service. The model includes non-traditional supports to a community mental health issue.

B) Cultural Competency

New Parent TLC supports cultural competency in many ways. In Sonoma County, over 26% of the population is Latinx, and Sonoma County is ranked number 2 in the nation for same-sex couples (Sonoma County Pride, 2018). Lare-Cinisomo, Wisner, Burns, and Chaves-Gnecco, (2014) found the preferred coping for postpartum depression in Latinas is a woman's own cognitive coping strategies, not seeking professional intervention. However, the second-level preferred approach included formal support from home visitors or lay community health workers, preferably introduced by a trusted friend, which significantly supports the proposed New Parent TLC gatekeeper model (Lare-Cinisomo, et.al., 2014).

To meet the specific needs of the populations in Sonoma County, culturally appropriate curriculum will be developed that focuses on the Latinx population and the LGBTQ+ population to ensure equity for all families in the community. In addition, through the curriculum development process a robust team of consultants will be used to ensure all components of the curriculum are infused in cultural responsiveness and equity. The team of cultural consultants will form the cultural community advisory group, and include leaders from Humanidad, Raizes Collective, Positive Images, and Life Works. At least 30% of the gatekeeper trainings will focus on members of Latinx population and be available in Spanish. Curriculum infused with culturally responsive communication strategies, culturally appropriate community resources and referrals for services will be fundamental in supporting these underserved populations in seeking and receiving the support they need to address depressive symptoms. Because traditional counseling or therapy is not the top preferred service for the Latinx community, the cultural community advisory group will be vital in identifying and defining appropriate services that are effective in reducing depressive symptoms, and that the population is more likely to participate in.

C) Client-Driven

The entire development of the New Parent TLC project was client-driven. The project originated from a combination of date gathered from interviews, survey, and a focus group where a father shared his story. Greg Ludlams, shared openly about losing his wife to suicide after months of unrecognized, untreated symptoms of postpartum depression following the birth of their second child. He described how his wife's symptoms went completely undetected in spite of regular scheduled medical appointments, that she made great efforts to appear "put together" and to mask her symptoms. Greg noticed changes in his wife's mood, but had no idea what the cause was, how severe the symptoms could be and did not recognize any signs of suicidality. After her death, Greg learned from their infant son's child care provider that his wife had shared with her a small hint of her struggle with depression. One day when she dropped off their son at the provider's home on her way to work, she mentioned to the child care provider that she was feeling "overwhelmed." A short time after that, Greg's wife took her own life.

Greg strongly encouraged First 5 Sonoma County to consider these daily, frequent, non-clinical contacts as opportunities to connect struggling parents with supports that could ease the

weight of maternal and paternal depression and anxiety that is far too common and too often unrecognized and untreated. His story greatly inspired this innovation project.

In addition, interviews were conducted with parents who expressed the need for the **New Parent TLC** project, as most parents interviewed did not discuss their depressive symptoms with a medical professional, and did not seek help on their own.

A survey was also conducted with parent participants at a Spanish speaking child education group. The survey data supported the inclusion of co-workers as a main support or person to confide in about parental depressive symptoms.

D) Family-Driven

Approximately 70% to 80% of women will experience sub-clinical "baby blues". While not necessarily harmful to the mother in the long-term if symptoms resolve, this "mild" condition has been proven to be damaging to the infant's development and leaves the infant at risk of exposure to Adverse Childhood Experiences (ACEs) (Postpartum Depression, 2019). With a birth rate in Sonoma County of approximately 5,000 births per year, this could mean up to 4,000 babies annually are exposed to at least one significant Adverse Childhood Experience (ACEs) in the very first year of life as a result of unidentified, untreated symptoms of maternal depression.

In addition, 50% of postpartum depressed mothers do not seek treatment leaving their infants at risk of adverse outcomes (American Psychological Association, 2006). Employing the community-based gatekeeper approach aims to identify parental depressive symptoms that would otherwise go untreated, ultimately improving the potential for healthy development and attachment for those infants and improving outcomes for the entire family.

E) Wellness, Recovery, and Resilience-Focused

Early intervention, self-care, and linkages to culturally appropriate services support resilience. Through the curriculum development, aspects of five protective factors: parent resilience, knowledge of parenting and child development, social and emotional competence of children, social connections, and concrete support in times of need will be included. This framework promotes wellness and recovery and is used in early home visiting programs, Family Resource Centers, and other family centered, strength-based services.

F) Integrated Service Experience for Clients and Families

The integrated services in the **New Parent TLC** model include the linkage between gatekeepers, parents, and services in the community, and is inclusive of all types of new parents. Traditional mental health services do not include parental peers, such as childcare providers, coworkers, or cosmetology service providers. **New Parent TLC** educates the community, normalizes the conversation about parental depressive symptoms, and raises awareness as well.

Cultural Competence and Stakeholder Involvement in Evaluation

The evaluation includes a quantitative portion and a qualitative portion. In the quantitative portion of the evaluation a survey will be used to collect data. The survey will be tested for validity and reliability in both English and Spanish. The survey will be prepared at an eighth-grade reading level and tested with multiple community members from varying cultural groups. Parents from two-parent households, single parent households, custodial and non-custodial, LGBTQ+, geographical ranges, and a wide range of age differences will all participate in survey testing. Spanish community members will participate in the testing process for the Spanish version of the survey to ensure cultural competence, and that the Spanish version is accurately measuring the same outcomes as the English version.

In the qualitative portion of the evaluation, any Spanish-speaking participants will be interviewed in Spanish. The cultural community advisory group will also be used as experts to consult through the evaluation process. They will participate in testing the measurement instrument (survey), reviewing recordings of interviews, and ensuring translation is culturally accurate to the statements made and trends identified.

Innovation Project Sustainability and Continuity of Care

The MHSA Coordinator, with the assistance of the MHSA Innovation Subcommittee, will host an annual meeting to review progress of the active Innovation Projects. Each Innovation Project will be required to submit an annual evaluation report on findings to date. These annual reports will be reviewed and discussed among the Innovation Subcommittee members who will focus on successful outcomes and challenges that may prompt the need for technical assistance and additional resources.

Specific to this proposed project, the Sonoma County Behavioral Health Division will work in collaboration with the First 5 leadership and look holistically at the success of the project. Key indicators include the ability to engage and train gatekeepers; successful referrals and positive experiences of all community members engaged.

Data driven decision-making will determine if the project is promising and additional time is indicated to further develop definitive results for the project. If necessary, criteria will be developed to determine if an Innovation project should be extended for up to two years with continued Innovation funding (up to five years total) or supported with alternative funding. Once Innovation funding has ended, the project may be considered for MHSA Prevention and Early Intervention funding and/or pursue funds from other Community Based Organizations and/or public grants. The three local hospital systems: Kaiser Permanente Community Benefits, Sutter Health and St. Joseph's Health System often pool funding to support local projects that are within their respective mission statements. Projects can be supported in whole or focused on specific gatekeepers that are particularly successful in addressing the mental health challenge for the community of new parents. It will be necessary to consult with the full MHSA Steering Committee, Behavioral Health Division administration, and/or other community resources such as local foundations, and the Board of Supervisors.

It is not anticipated that individuals with a serious mental illness will receive services from **New Parent TLC** as we are not targeting this population. However, there is definitely a potential overlap as the entrance criteria is being a new parent in Sonoma County. All participants will receive supportive navigation to other services as needed. Gatekeepers will be trained and keep up to date resource and referrals cards that will include a list of local parental depression services and groups. The contractor will develop the resource and referral cards as part of the gatekeeper training curriculum materials. If a gatekeeper identifies a parent with serious mental illness at the end of the project's final year, First 5 will work closely with the County Behavioral Health Division and community mental health services to assure an appropriate and smooth transition.

With a local First 5 in all 58 counties in California, the lead agency on this project, First 5 Sonoma County is in a prime position to share this project with all 58 other county level First 5s once the project is established as a best or promising practice. The First 5 Network already has strong partnerships with the First 5 Association, First 5 California, and local level First 5s across the state. It is common practice for First 5s to share service models for dissemination after a pilot period, complete with implementation, evaluation, and improvement plans for partnering First 5s to duplicate the model, opening an opportunity for statewide expansion of the program.

Efforts to promote change and sustainability will focus on policy development at the local and state levels. Program evaluation for **New Parent TLC** will be used as support for policy change, such as universal participation by licensed childcare providers to recognize parental depression symptoms. With policy support, gatekeeper training could be a requirement for childcare licensing, such as CPR training is currently. With sufficient participation, this program can be easily transitioned into a "train the trainer" model, with champions in the community that will support sustainability for the program to continue and expand.

Communication and Dissemination Plan

A) Dissemination of information to stakeholders

An annual report will be created to share the annual data analysis, lessons learned, and any plan for quality improvement through the duration of the project. The annual report will be sent to all trained gatekeepers through electronic mail, to members of the cultural community advisory group, posted on the First 5 Sonoma County website and in the monthly newsletter, shared with other First 5 Commissions with a presentation to the California First 5 Commission, and shared with the California Department of Social Services, Childcare Licensing Office. In addition, the Health Department, Behavioral Health Division, MHSA Steering Committee and Mental Health Board will receive copies of all evaluation reports and program updates that are available to the public.

As stated above, the strong partnerships within the First 5 Network position the lead agency, First 5 Sonoma County, for statewide dissemination of not only the annual reporting, but the service model as well. First 5s actively share models, and the **New Parent TLC** model focuses

specifically on the target population of First 5: new parents, children under three years, and child care providers. The model perfectly fits within the First 5 statewide goals of improved family functioning, improved child development, improved child health, and improved systems of care. The **New Parent TLC** sustainable model can be easily scaled to fit the population size needs of each local First 5 Commission, making this model prime for implementation in all 58 California counties.

B) KEYWORDS for search:

- Gatekeeper training,
- Perinatal mood disorder (PMD),
- Postpartum depression (PPD),
- Paternal Postnatal Depression (PPND),
- Post Adoptive Depression, and
- Adverse Childhood Experiences (ACEs)

Timeline

A) The expected start date for **New Parent TLC** is July 1, 2021. The expected end date for **New Parent TLC** is June 30, 2024.
B) The total timeframe of the Innovation project is three years.
C) Key activities, milestones, and deliverables by quarter are listed below.

0-3 months

- Establish contract with Department of Health Services, administrative meetings to clarify reporting requirements
- Establish subcontract(s) with 1-2 clinical subject matter experts specializing in parental depressive disorders
- Form a cultural community advisory group to review curriculum for cultural responsiveness
- Hire clinical expert Consultant/Facilitator, and First 5 Program Coordinator staff (3-year project specific limited time employment)
- Refine plan for roll-out of training
- Develop referral resources and curriculum
- Develop outreach and engagement plan to recruit training participants
- Develop marketing and outreach materials for trainings

3-6 months

- Engage participating employers leveraging preexisting relationships established through Santa Rosa Metro Chamber of Commerce, and targeting the top employers in Sonoma County
- Launch outreach to childcare providers, cosmetology service providers, and employers to engage in gatekeeper training

- Develop training schedule & identify sites
- Develop pre-post survey for gatekeeper training participants

6-9 months

- Launch pilot trainings – 1 training for each gatekeeper group (January – March 2022)
- Collect baseline survey results & adjust training curriculum and approach if needed

9-12 months

- Continue engaging and training new childcare providers, cosmetology services providers, and groups of coworkers/employees to continue participation in trainings
- Collect second quarter survey responses
- Analyze second quarter data
- Complete interviews for qualitative evaluation
- Analyze annual qualitative data
- Evaluate first year process and create next steps
- Complete and disseminate the first annual report

12-24 months

- Continue engaging and training new childcare providers, cosmetology services providers, and groups of coworkers/employees to continue participation in trainings
- Continue collecting and analyzing quarterly data
- Complete year two qualitative data collection and analysis
- Complete year two annual report and disseminate as planned
- Begin compiling data from evaluations for policy change support

24-36 Months

- Continue engaging and training new childcare providers, cosmetology services providers, and groups of coworkers/employees to continue participation in trainings
- Continue collecting and analyzing quarterly data
- Complete year three qualitative data collection and analysis
- Complete year three annual report and disseminate as planned
- Work with Community Child Care Council and Child Care Planning Council to integrate **New Parent TLC** training into onboarding for new childcare providers
- At least three employers agree to continue **New Parent TLC** training for employees

SECTION 4: INN Project Budget and Source of Expenditures

INN Project Budget and Source of Expenditures

A) Budget Narrative

MHSA Innovation funding will cover the primary functions of the project over the three-year period. The project, **New Parent TLC**, will include the development of gatekeeper training

curriculum and training facilitation by clinical expert consultants, evaluation and coordination by First 5 Sonoma County evaluator, and outreach and training dissemination by First 5 Sonoma County Program Manager. First 5 Sonoma County will also leverage funding to cover indirect administrative costs for the program.

First 5 Sonoma County receives funding allocated from First 5 California through the California Children and Families Act (Proposition 10). The proposition was established through a voter approved initiative in 1998 to oversee the expenditures of tobacco tax revenues to support, promote, and optimize early childhood development through coordinated programs that emphasize child health, parent education, childcare, and other services and programs for children prenatal through age five. The goals of **New Parent TLC** are aligned with the goals of Proposition 10, and the funding can be leveraged to help support the program. Indirect administrative costs including .05 FTE Executive Director oversight, large training facility located in the First 5 Sonoma County leased office space, food and childcare provided for training participants as incentives for participation; ***an in-kind contribution of approximately $83,000 over three years.***

The total three-year cost to Sonoma County Department of Health Services not including the in-kind contribution from First 5 Sonoma County is $394,586.

- Personnel costs include salaries and benefits: $256,587
    - Program Director (supervision of coordinator, coordination of project, evaluation) .20 FTE first 6 months, .10 FTE 30 months
    - Program Manager/Coordinator (bilingual, gatekeeper trainer/facilitator) 1 FTE
- Operating costs include materials: $20,000
    - Printed training materials to distribute to each trainee.
- Consultant costs for clinical expert curriculum development & trainer(s): $116,400
- Qualitative data analysis software, NVivo ($1,599)

B) Budget Fiscal Year and Specific Budget Category

FY 2021-2022 (FY total $194,039)

Salaries and benefits: $95,973

- Program Director (first 6 months .20 FTE for development of evaluation and coordination of curriculum development and training plan) (second 6 months .10 FTE)
- Program Manager/Coordinator (bilingual) 1.0 FTE

Operating cost: $10,000
Initial cost of materials higher in first year for printing all curriculum and training materials
Consultant/facilitator cost: $58,800
Approximately $30,000 for the development of curriculum and $28,800 for facilitation
Qualitative data analysis software, NVivo: $1,599

FY 2022-2023 (FY total $114,107)

Salaries and benefits: $80,307

- Program Director .10 FTE

- Program Manager/Coordinator (bilingual) 1.0 FTE

Operating cost: $5,000

Consultant/facilitator cost: $28,800

FY 2023-2024 (FY total $114,107)

Salaries and benefits: $80,307

- Program Director .10 FTE
- Program Manager/Coordinator (bilingual) 1.0 FTE

Operating cost: $5,000

Consultant/facilitator cost: $28,800

Indirect Costs: $0 (In-kind)

Sonoma County has $822,000 in MHSA Innovation dollars that are subject to reversion on June 30, 2021. Sonoma County is submitting four Innovation proposals simultaneously, including this proposal for **New Parent TLC**, to the MHSOAC in December 2020 following the public hearing on December 15th at the Sonoma County Mental Health Board meeting. The combined total of the four Innovation proposals that are being submitted to the MHSOAC in December 2020 is $2,783,034.

Expenditures				
Personnel Costs (Salaries, wages, benefits)	**FY21/22**	**FY22/23**	**FY23/24**	**TOTAL**
1. Salaries	$86,684	$72,434	$72,434	$231,552
2. Direct Costs, benefits	$9,289	$7,873	$7,873	$25,035
3. Indirect Costs - IN KIND	0	0	0	0
4. Total Personnel Costs	$95,973	$80,307	$80,307	$256,587
Operating Costs	**FY21/22**	**FY22/23**	**FY23/24**	**TOTAL**
5. Direct Costs (materials)	$10,000	$5,000	$5,000	$20,000
6. Indirect Costs - IN KIND	0	0	0	0
7. NVivo Software	$1,599	0	0	$1,599
8. Total Operating Costs	$11,599	$5,000	$5,000	$21,599
Consultant Costs/Contracts (clinical, training, facilitator, evaluator)	**FY21/22**	**FY22/23**	**FY23/24**	**TOTAL**
9. Direct Costs	$58,800	$28,800	$28,800	$116,400
10. Indirect Costs – IN KIND	0	0	0	0
11. Total Consultant Costs	$58,800	$28,800	$28,800	$116,400

Budget Totals				
Personnel (line 1)	**$86,684**	**$72,434**	**$72,434**	**$231,552**
Direct Costs (lines 2+5+7+11)	**$79,688**	**$41,673**	**$41,673**	**$163,034**
Indirect Costs (lines 3+6+9)	**0**	**0**	**0**	**0**
Total Innovation Budget	**$166,372**	**$114,107**	**$114,107**	**$394,586**

C) Budget Context

Innovation funds will cover the primary functions of the project. First 5 Sonoma County will leverage Proposition 10 funding for the .05 FTE Executive Director for supervision time on the project, all administrative and indirect overhead costs, along with food and childcare expenses as incentive for child care providers, cosmetology service providers, and employees of medium to large organizations to participate in the trainings.

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**N/A**	**N/A**	**TOTAL**
1.	Innovative MHSA Funds	$150,706	$103,663	$103,663			$358,032
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	$27,667	$27,667	$27,666			$83,000
6.	**Total Proposed Administration**						
EVALUATION:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**N/A**	**N/A**	**TOTAL**
1.	Innovative MHSA Funds	$15,666	$10,444	$10,444			$36,554
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**						
TOTAL:							

C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 21/22	FY 22/23	FY 23/24	N/A	N/A	TOTAL
1.	Innovative MHSA Funds	$166,372	$114,107	$114,107			$394,586
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	$27,667	$27,667	$27,666			$83,000
6.	**Total Proposed Expenditures**	$194,039	$141,774	$141,773			$477,586
*If "Other funding" is included, please explain. First 5 in-kind contribution from Prop 10 funding							

APPENDIX A – SONOMA COUNTY MHSA STEERING COMMITTEE REPRESENTATION

First Name	Last Name	Industry	Representing
Claudia	Abend	Community at-large	Consumer, Family member
Mechelle	Buchignani	Law Enforcement	
Jessica	Carroll	MH, Social Services	Consumer, LGBTQ+
Sophie Marie	Clifford	Substance Abuse	Consumer, Latina, LGBTQ+
Mandy	Corbin	Education	Family Member
Christy	Davila	Social Services	
Angie	Dillon-Shore	0-5	LGBTQ
Jeane	Erlenborn	Education	
Cynthia	Kane Hyman	Education	
Ozzy	Jimenez	Businessman	LGBTQ, Latino
Erika	Klohe	MH, Community Benefits,	Family Member
Claire	McDonell	Education	Family Member, TAY
John	Mackey	Healthcare	Veteran
Shannon	McEntee		Consumer, TAY
Mike	Merchen	Law Enforcement	Family Member
Allison	Murphy	0-5	Family Member
Ernesto	Olivares	Social Services	Latino
Matt	Perry	Probation	
Ellisa	Reiff	Disabilities	
Kate	Roberge	MH, Disabilities, Workforce	Consumer, Peer

Kurt	Schweigman	Healthcare, MH	Native American
Kathy	Smith	Mental Health Board	Family member
Susan	Standen	Self-employed, MH peers	Consumer
Angela	Struckmann	Social Services	Family Member
Katie	Swan	Mental Health	Family Member, LGBTQ+, TAY
Sam	Tuttelman	Community at-large	Family member
Carol Faye	West	Peer	Consumer, Family member

26% Consumers, 41% Family members, 19% LGBTQ+, 11% Latinx, 4% Native American, 11% TAY