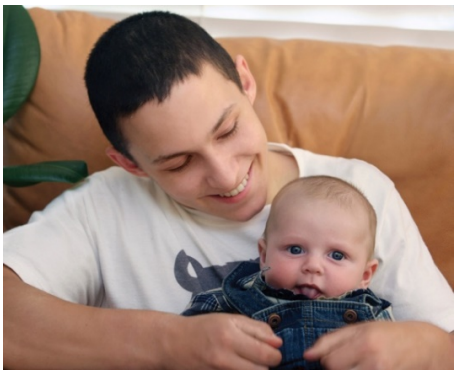
sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

WELLNESS • RECOVERY • RESILIENCE



Instructions Not Included:

Home Visiting for new Fathers and Partners

Sonoma County Innovation 2021-2024 Plan Proposal

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Instructions Not Included – Home Visiting for New Fathers

GENERAL REQUIREMENT AND PRIMARY PURPOSE

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
	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

PRIMARY PROBLEM

The primary problem we will address is the lack of mental health education, prevention and early intervention services in Sonoma County that specifically target the needs of new fathers and engage them in the care of their child and partner from the very beginning. Currently, in Sonoma County there are no services that specifically include screening for **male** postpartum depression (PPD) nor targets the emotional experience of a new father. Further, there is not a PPD screening tool that is specifically for screening male postpartum depression. Fathers are also not routinely included in screening for Adverse Childhood Experiences (ACEs), which we know contributes to parent's overall resiliency. [1]

Instructions Not Included (INI) specifically targets male PPD and provides ACEs screening for fathers as a way to support three priority community challenges: 1). Reduction of familial and intergenerational Adverse Childhood Experiences (ACEs); 2). Reduction in parental depression and risk of suicide; and
3). Reduction of Substantiated Child Abuse Cases.

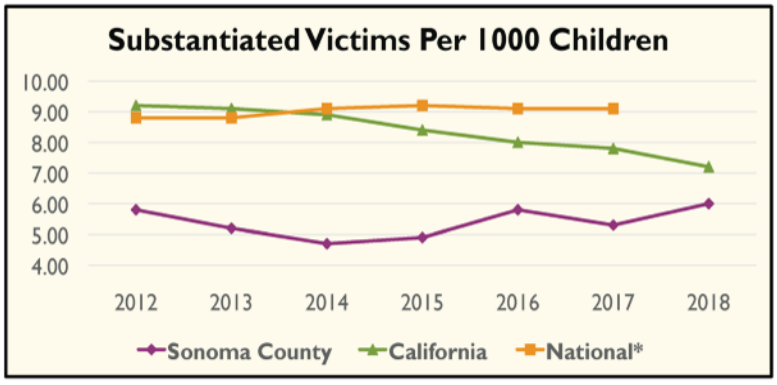
Childhood experiences, both positive and negative, have a tremendous impact on resilience, future violence victimization and perpetration, and lifelong health and opportunity. As such, early experiences are an important mental health and public health issue. Much of the foundational research in this area has been referred to as Adverse Childhood Experiences (ACEs). A 2014 study from the San Francisco-based

Center for Youth Wellness shows that 20 percent of adults in Sonoma County experienced at least four ACEs. People who experience four ACEs, research shows, are 12 times more likely to attempt suicide, 10 times more likely to use intravenous drugs, seven times more likely to suffer from alcoholism, five times more likely to suffer from depression and twice as likely to experience heart disease, stroke or cancer. Research also indicates an inter-generational transfer of trauma from those with high ACE scores to their children unless an intervention is conducted. The simple act of providing ACEs screening to parents and then discussing findings has shown to be an effective first step in breaking this cycle.

Additional research shows that undetected and untreated parental depression places millions of children in the United States at risk each day. Parental depression can be especially damaging for the growth and healthy development of very young children, who depend heavily on their parents for nurture and care. In two large population-based cohorts, depressive symptoms in fathers during childhood were associated with adolescent depression aged 13-14. This association was independent of, and as strong as, maternal depressive symptoms. It was not affected by confounding factors. [2]

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: All New Fathers including Latinx new fathers. Sonoma County has community-wide support for "upstream" programs that make an investment in the wellbeing of community members prior to psycho-social/socio-economic factors become disabling.

Data from the UC-Berkeley California Child Welfare Indicators Project shows the California state rates of substantiated victims of child abuse is declining, however Sonoma County's rates are increasing.



*National data unavailable for 2018

The development of this program originally grew from the intersection of three things: 1) multiple requests from the community to provide home-based support for ALL first time parents and 2) growing body of research on male PPD and impact of Father's ACE score on child/family functioning; 3) A specific request from a 1st time father who lost his wife to suicide due to PMD. He felt that he did not have the knowledge, support or resources he needed that could have used to help himself or his family.

Based on this, the population to be served was also consulted for this program. In three separate focus groups held by the Early Learning Institute in August and September of 2019, mothers and fathers of children less than a year old were queried about the supports they received, both before and after the birth of their first child. Each group independently identified that the Father received less preparation and early support and that the mother was the primary focus of support and monitoring after the birth. Interestingly, when the focus groups were split into separate Father/Mother groups, most of the fathers were far more forthcoming about how hard the first 6 months of the child's life was for them. One father said, "I wish I had known more about all the postpartum feelings that dad's get. I thought I was supposed to feel jealous of the baby. Instead, I felt terrified and weepy – I would stay at work later and later trying to get grounded and feel like I had control of something." Another father spoke of his need to "hit" stuff. He said he spent hours at the gym because he was afraid hurting his wife or baby. Of the 30 Father's interviewed, only two had initiated couples-counseling and one had starting working individually with a therapist. Four fathers were currently separated from their partners. When asked to identify, on a scale of 1 –to-10 with 10 being high, what they had heard, read or knew about Paternal Postpartum Depression, the average score was "3", with a high of "5" and a low of "0". More than 50% of fathers in our focus group said they would like to, or be willing to, participate in a "first time parent" home visiting program with their partners. 24% indicated they would be willing to participate in a home visiting program without their partners.

One final point: currently in Sonoma County a child abuse report is made every hour and a half. While not all of those are substantiated, in 2018, total economic burden of child maltreatment in Sonoma County was $270 thousand PER case. If you take that number and multiply it by the number of substantiated child abuse cases (565) that translates into a lifetime burden of $158 million to the county incurred during 2018. Reducing this burden would allow for a community reinvestment of these funds into other mental health support services.

PROPOSED PROJECT (Research Citations in Appendix A)

Who We Are:

The Early Learning Institute (ELI) is a 501c3 nonprofit, incorporated in November of 1998. We are proud to be celebrating nearly 21 years of service to Sonoma County. When we opened our doors in 2009, early brain development was just beginning to impact the way we cared for infants and toddlers and their families. We now know that providing developmental supports as early as possible make a critical difference. Instructions Not Included aligns perfectly with ELI's mission and increased emphasis on early child-find activities and prevention by providing direct support to parents, especially fathers. We serve nearly 1,500 children per year across all our programs -- about 500 children at any one time in our weekly home visiting programs. We are a vendored program with the Department of Developmental Services as well as a contractor of the Department of Education. We serve all the SELPA children (through the County Office of Education) who are eligible for their early intervention home visiting services. Seven years ago, First 5 Sonoma Conducted a survey among children serving nonprofits to see who they interacted with the most, on behalf of their clients. ELI's WMG program, the umbrella program for INI, was the most cited program, landing solidly in the middle of the referral bull's eye. We are the organization that helps parents navigate very complicated systems with warm hand-offs to community partners. We plan to continue this with INI. ELI has partnerships/MOUs with many other organizations, such as Public Health, Child Welfare, Child Parent Institute, Petaluma People Services, 4Cs, etc. as well as members of the medical community. These partnerships provide a two-way system of referral -- both into our programs and out to expedited entry into other services, should that be necessary. Like most nonprofits, ELI's Board of Directors provides oversight to the Agency as a whole and guides fulfillment of the Mission. The programmatic operations follow a traditional model of Executive Director oversight with a Program Manager providing support and supervision to the field staff. The Executive Director (Michele Rogers) plays both an administrative function (fiscal oversight) as well as a hands-on function to INI. Michele Rogers is a certified lactation specialist and holds a PhD is Psychology. She will provide consultation and reflective supervision to the INI staff as needed. (All ELI staff are required to participate in reflective supervision.) General oversight and supervision of INI staff will be provided by Tina Moss, the WMG Program Manager. Tina is an Early Intervention Specialist and has been with ELI for 20 years. She provides clinical support and expertise on the intake team, with a particular expertise in newborn development. Her role is mostly supervisory at this point but she will take on particularly complex cases as needed.

ELI's policy and philosophy is to serve all parents regardless of gender identity. So, while INI focuses on "fathers" – classically thought of as the male parent-- this program will be open to all new parents who seek out the service. Evaluation elements will only include parents who self-identify as male.

The Problem and the Project:

In Sonoma County, there are several home visiting programs (administered by community partners, not ELI) for new moms that include early screening and

identification of maternal postpartum depression (PPD) or perinatal mood disorder (PMD). But no home visitation program specifically includes screening for male PPD or PMD nor targets the emotional experience of a new father. There is not a PPD screening tool that has been developed specifically for use with fathers. Fathers are also not routinely included in screening for Adverse Childhood Experiences, which we know contributes to parent's overall resiliency. [1]

ELI's Instructions Not Included, (INI) will be the first program to target new fathers in a mental health focused home visiting intervention as well as develop a standardized screening tool for male PPD. ELI's evidence-based home visiting program will incorporate the strength of three main curricula: Promoting First Relationships, Partners for a Healthy Baby and Nurturing Fathers. Descriptions of all three can be found in Appendix B. INI is unique in that it will include ACES and depression screening for dads and it will consciously utilize the lessons of father recruitment and retention from the National Father's Initiative (NFI). NFI is a non-profit, non-partisan, non-sectarian organization that aims to improve the well-being of children through the promotion of responsible fatherhood. Headquartered in Germantown, Maryland, United States, its mission is to improve the well-being of children by increasing the proportion of children with involved, responsible, and committed fathers. ELI has utilized the trainings available through NFI to train staff and learn from other programs serving dads. NFI is NOT directly providing services to parents in Sonoma County. Mothers/Partners of the fathers, while not our specific target population are included in the screenings as part of a known best practice approach. Screening both caregivers lowers stigma and normalizes the need for screening. It is also a reasonable, responsible addition to this program as INI home visitors will have access to mothers who may not get screened otherwise. As a community, Sonoma County is engaged in an intent to reduce ACES through generational transmission as well as have multiple ways to identify and support caregivers who may have undiagnosed PMD.

Referrals to INI will be taken from Community Partners, Medical Professionals, and self-enrollment. Outreach will be done at birthing classes, Obstetricians, MH partners and other places likely to be seen by new parents.

The structure of INI will be to conduct 5 home visits with fathers with 5 open to both parents, strategically placed to coincide with known vulnerable periods during an infant's first year of life:

- VISIT 1: 4-6 weeks after birth; sooner if requested.
- VISIT 2: 3-4 months after birth; (administer new PPD screening to father.
- VISIT 3: 9 months after birth; (administer ACEs screening to father and mother.)
- VISIT 4: 12 months after birth
- Father Only Visit – 6 months after birth or earlier if requested by father.

Visits schedule will be somewhat flexible to meet the needs of fathers and families enrolled.

Visits were chosen based on the developmental tasks of infants and parents as follows:
At 4-6 weeks of age, a baby begins to “wake up” and engage more with parents. This is a critical period of setting up attachment security for the baby, who relies on his/her parents to meet all needs. Research has shown over and over again that all learning for babies happens within the context of a relationship. This is a window of opportunity to establish a secure relationship for both the infant and the parents. Parents have settled somewhat into the demands of parenting and typically are beginning to read the baby’s cues fairly well. Home visits delivered at this vulnerable point in time can scaffold cue reading, support fathers in their engagement and bonding with their infant and begin to establish trust between the father and the home visitor.
At 3-4 months of age, infants are beginning to move (roll over, sit up, etc), are awake for longer periods of time and have distinct likes and dislikes. Brain growth is rapid at this age and is enhanced by appropriately stimulating activities, consistent care and nurturing. Fathers who may have been more tentative about caring for their newborns are now seen to be more firmly engaged in daily activities like bathing, feeding, diapering and playing. Research shows that this is a vulnerable time for fathers to develop PPD, which is why the screening is placed here. Fathers suffering from PPD can be guided to support services as early as possible and any intervention or redirection needed can be supplied. Home visitors can supply anticipatory guidance to fathers around child development, appropriate discipline, home safety concerns and other typical parental concerns.
At 9 months old, babies have often gained some kind of mobility – rolling, crawling, pulling up, and perhaps even starting to walk. This is a period of rapid growth and development as language begins to emerge, sleep patterns change and routines are disrupted. Separation anxiety also emerges, which can add stress to caregivers. Appropriate activities (screens? No screens?) and discipline strategies (too young for time out?) are top of the mind for parents. Home visitors will use the ACE screening as a way to engage in a reflective discussion of the father’s childhood experiences and how these may impact their choices around their parenting style. It is important to screen both parents at this visit, both to normalize the experience (not single out fathers) and to also create a reflective space for parents to compare notes and anticipate potential conflict of ideas and parenting styles. The home visitor can help fathers navigate this time by providing solid developmental education, which has been shown to reduce inappropriate expectations of many fathers, which in turn has been shown to reduce harsh disciplinary techniques.
At 12 months, babies are working on multiple emerging skills and are often described as “getting into everything.” Fathers will be given additional child development resources and encouraged to seek out community supports and resources, both for the child and for themselves. As the last visit, the home visitor will be facilitating reflection of the first year, gentle reminders of the impact of a high ACE score if appropriate and ongoing surveillance for PPD.
The private visit offered to fathers is placed on the schedule at 6 months as this is an appropriate time to check in between the second and third visits. It provides the opportunity to also do surveillance on any previously identified PPD symptoms, follow up with community referrals. This visit will primarily be guided by the fathers concerns and questions and needs for support, if any.

Each visit has its own focus but will be largely driven by the needs and questions of the parents, with an emphasis on including the new father. In other words, there is nothing that precludes administering additional PMD or PPD screenings, if warranted. Home Visitors will be well trained to be alert to subtle and not so subtle signs of PMD and PPD and will respond accordingly.

ACEs screenings for adults are typically only done once unless there is cause for suspicion of withheld information (mostly due to trust issues.) The reason for this is that an adult's ACE score would not change over time – the score is for things that happen in childhood. As you can see from the schedule listed above, the ACEs screening is targeted for the 3 visit, at about 9 months after birth, so that trust is established. This is also a known time where discipline questions begin to emerge, as the baby is much more active and parenting becomes differently challenging. Research has shown that this is an effective time to build ACE awareness and link parent education to caregiver prior experiences.

All screening tools will be discussed with the parents, so that they understand the purpose and intention to obtain consent. The Father Only visit (#5 above) is offered to allow full discussion of feelings, questions or other needs privately, based on the feedback of our father focus groups.

INI home visitors will administer the screenings, at the appropriate visits. These are screenings, thus are not diagnostic tools. They do not need advanced training or credentials to administer. INI home visitors are required to have at least an Associates Degree (majority of staff currently hold a Bachelor's degree) and at least 5 years of experience working with parents. Our team has a variety of backgrounds in psychology, early childhood education, social work, teaching, etc. All home visitors are trained to do both in-person and virtual* home visits and have received training in all the chosen curriculums. There are bilingual, bicultural home visitors on the team and the INI home visitors have access to interpreters for languages beyond English and Spanish, as needed. All INI home visitors have all been trained, or will be trained by accessing available trainings from qualified partners, such as Sonoma County Public Health Nurses or through other relevant paid trainings. Michele Rogers, Executive Director, is a certified Master ACE's Trainer and is part of the Sonoma County ACEs training team. She will conduct internal trainings for the INI team in this area. Please see Appendix D for ELI's comprehensive employee training program. INI will be part of ELI's Watch Me Grow portfolio of programs. Staff hired into this department are all paid professional staff. Many have the lived-experience of being parents and/or having personal PPD issues but it is not a requirement to be a "peer" for this program.

If a new father is found to have a PPD/ACES score that warrants additional support, the home visitor will discuss community-based services, make a referral and support the connection to that referral. The home visitor will follow-up either with a phone call or at the next visit to determine if the new father was able to connect with those support services. All home visits will be documented into an electronic record for case management, the program evaluation process and to measure outcomes. Families are

enrolled in the program over the course of their child's first year of life. As babies turn a year old, the family can choose to enroll in ELI's broader Watch Me Grow program and received bi-annual child development and social-emotional screenings and family check in. This gives the INI Home Visitor an opportunity to support referrals made during the last visit. However, this is a volunteer participation program. If a parent chooses to not seek resources offered, we cannot make them. There is no penalty for not following through, all home visits will still be delivered. All ELI employees are mandated reporters and receive annual training about child abuse observation and reporting. If they feel there is something to report, a protocol and MOU is in place with our Child Welfare partners.

*COVID-19 precautions and adaptations

Services for young children quickly and successfully adapted to the service changes demanded by the COVID-19 pandemic. All visits are now available to parents in a variety of ways: conducted outside, with masks on; conducted inside at ELI's children center, utilizing recommended enhanced cleaning protocols; or virtually, over a secure platform. Based on ELI's experience running other home visiting programs the past 6 months, parents of young children actually appreciate the flexibility that virtual visits offer and both parents are more often in attendance. Our Early Start program, for example, serving children birth to three years old, has lost less than 10% of previously enrolled clients using these adaptations. ELI has developed an entire set of safety protocols – listed in Appendix C.

As noted earlier, Instructions Not Included© makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population. The selected approach of screening for paternal PPD and ACEs in the innovation. Doing this in the home is appropriate based on the research of general home visiting programs traditionally used as a public health intervention. Home Visiting programs offered to first time parents have shown to have positive outcomes in the areas of child health and safety (for example, well-child and dental visits, number of injuries, and emergency room visits). Traditional programs strive to alter parenting behaviors such as responsivity, sensitivity, and harshness, as well as to improve the quality of the home environment and maternal mental health. These programs have been shown to have positive effects on children's well-being. [3]

We estimate the numbers of individuals expected to be served annually to include 450 fathers. We arrived at this number based on the following known factors: Sonoma County has approximately 1800 births per year to first-time parents. Based on community program reports, 25% of these parents are already enrolled in some type of support service. Another 25% will refuse the service. That leaves approximately 900 families to serve with this program each year. If we get 900 families participating, we anticipate that only approximately 50% of the fathers will complete all five of the visits offered in the program. Each father will receive two screenings: one PPD and one ACEs over the course of the program year.

INI will specifically target first-time fathers. According to the Sonoma County Public

Health Birth Census report, 54% of first-time parents identify Spanish as their primary language spoken at home. Our typical client for this program will be mid-20s to mid-30s. One or both members of the family will be working. This family will likely be renting, will possess at least a high school diploma and may be involved with the child-welfare system. They will also likely have some form of transportation. ELI is prepared to serve both English and Spanish speaking households (and other less common languages, with interpreters) with bilingual and bicultural Developmental Specialists. Enrollment is limited to those with a Sonoma County address. Visits will be conducted at times convenient for both parents.

Outreach and engagement to new parents will include traditional outlets, such as building relationships with labor and delivery departments in the three local hospitals, pre-natal education classes, notifications to agencies such as WIC (Women, Infants and Children) programs, health fairs, and through local Mom's playgroups. In addition, information about the new service for new Fathers will be posted on social media and the ELI website.

RESEARCH ON INN COMPONENT

The unique combination of screening first time fathers for both paternal postpartum depression (PPD) and ACEs during home visits distinguishes INI from other similar projects. Sonoma County offers multiple home visiting programs for parents of children birth to 5 years old. The vast majority of these programs serve mothers, or the children, as primary clients. These include (not an exhaustive list): Nurse Family Partnership; Healthy Families; Public Health Nursing; CPI's Perinatal Mood Disorder Program; Petaluma People Services Perinatal Mood Disorder Program. All of these programs strive to strengthen the capacity of parents to care for their young child and some may include screening for maternal depression. None of these programs screen fathers (or partners) for PPD or ACES.

Extensive research, both on the web and with informational interviews, to investigate existing models or approaches for parents beyond Sonoma County resulted in the discovery that the majority of home visiting programs for new parents were really focused on the new mom. There are several research studies and reports about the importance of including fathers in home visiting, and some, like the Nurse-Family Partnership, have changed their protocol to include fathers, if the father is interested. However, none of the research studies seemed to find or comment on programs that specifically noted the inclusion of screening fathers for PPD/ACEs.

The 'Home Visiting: Approaches to Father Engagement and Fathers' Experiences' Study was a qualitative project by the Urban institute that collected information about innovative approaches used by existing home visiting programs to actively engage and serve fathers, and gather fathers' perspectives on participating in such programs. https://www.acf.hhs.gov/opre/research/project/home-visiting-approaches-to-father-engagement-and-fathers-experiences. This study provides insight into some of the

barriers experienced, particularly with young minor fathers and offered stronger engagement strategies.

A report from the University of Chicago cites the following findings: “Beyond specific program adaptations and enhancements to better fit the challenges mothers face in their parenting, however, the field of home visitation as a whole has largely overlooked the major role that fathers play in young children’s developmental outcomes, and in configuring home visiting services to address this role. It is rather startling to note, for example, that none of the home visitation models that have been rigorously evaluated have been designed to target fathers as primary service recipients, none were designed to address the array of father-related influences on children’s well-being, and none have yet included fathers as subjects of study. This is an especially significant oversight: A growing body of evidence has indicated that fathers play a central role in the development of young children, influencing a variety of critical outcomes for later life.” https://web.archive.org/web/20130910093611/http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/Father_Involvement_report.pdf

On the other hand, research on male PPD is growing and indicates that fathers are experience postnatal mood disorders at alarming and surprising rates. A study in the Journal of American Medicine found that 10 percent of men showed signs of depression from the first trimester of their wives’ pregnancies through six months after the child was born. The number increased to 26 percent during the three- to six-month period after the baby’s birth. The study also found a positive correlation between paternal depression and maternal depression. [4] Postnatal mental health of fathers is reported to have various effects on the health of the whole family. Research shows that paternal depression decreases father involvement and engagement with infant children and may increase father-child conflict when children are older. Father engagement, positive attitudes about fathering, and interest in providing care can decrease fathers’ parenting stress after the birth of a child. Positive father involvement can also mediate the effects of maternal depression and maternal parenting stress on children, even if the mother and father are no longer together. Positive father involvement can also lower infant distress.[8 -15]

A recent pilot study evaluated *Dads Matter*, a curriculum for father involvement within the context of standard home visiting services. Preliminary trends indicated the potential benefit of the *Dads Matter* service enhancement: (1) improved mother–father relationship quality, (2) increased father involvement with the child, and (3) decreased father-reported parenting stress and child-related problems [16]. Other research shows that home visiting may reduce the incidence of intimate partner violence [16] and that father involvement may indirectly promote the success of home visiting; in one study mothers were more likely to remain involved with the program when their partners were engaged in services. [17] None of the home visit programs studied had added paternal PPD or ACEs screening to the visits, even if they were trying to engage fathers more directly.

Depression Symptoms in Men When men experience depression, their symptoms can

look different than women's depression symptoms. Women experienced four symptoms at significantly greater rates than men: stress, crying, sleep problems, and loss of interest or pleasure in things they usually enjoy. The same study found that men experienced the following symptoms at significantly higher rates than women: anger attacks/aggression, substance use, and risk-taking behavior.[19]

The American Academy of Pediatrics (AAP) also reports men are more likely to present with symptoms of substance use, domestic violence, and undermining breastfeeding instead of sadness. Chart below outlines the difference in "typical" depressive symptoms and those experienced by men.[20]

Classic Symptoms of Depression	Symptoms of Men's Depression
• Depressed, sad mood • Loss of interest or pleasure • Significant weight loss or gain • Trouble sleeping or over-sleeping • Restless feelings and inability to sit still or slow down • Fatigue, loss of energy, or tired all the time • Worthless or guilty feelings • Impaired concentration and difficulty making decisions • Recurrent thoughts of death or suicide	• Increased anger and conflict with others • Increased use of alcohol or other drugs • Frustration or irritability • Violent behavior • Losing weight without trying • Isolation from family and friends • Being easily stressed • Impulsiveness and taking risks (i.e., reckless driving and extramarital sex) • Feeling discouraged • Increase in complaints about physical problems (i.e., headaches, digestion problems or pain) • Problems with concentration and motivation • Loss of interest in work, hobbies, and sex • Working constantly • Increased concerns about productivity and functioning at school or work • Fatigue • Experiencing conflict between how you think you should be as a man and how you actually are • Thoughts of suicide

Research on PPD screening tools currently available have found that the widely recommended *Edinburgh Postnatal Depression Screen* (EPDS) is not sensitive to male cultural norms, timing of the screen, and the differences in symptoms experienced by men. For example, question 9 on the EPDS is, "I have been so unhappy that I have been crying." While crying could be a symptom experienced by fathers, they are not as likely to cry as to become aggressive. Additionally, men may be less expressive about their feelings than women, thus, fathers are likely to score lower in the self-reported screening.[21]

LEARNING GOALS/PROJECT AIMS

Sonoma County hopes to learn whether a home visiting program for new parents can

successfully engage new fathers in education, screening and support to reduce mental health challenges and increase resiliency. Additionally, we hope to develop a postpartum screening tool specifically for fathers who identify as male. The following learning goals have been defined for Instructions Not Included:

1) What percentage of new fathers are engaged in the INI home visiting program and complete both the PPD and ACEs screenings offered?
    a. Our estimates are that 50% of fathers will participate in PPD and ACEs screening. This is a priority as we would like to increase the accuracy of our estimates.

2) Identify the rates of paternal PPD and referrals to key community resources (or lack there of) utilized by fathers.
    a. This is a priority as we may need to develop further community resources to meet the need as it develops.

3) Track ACE screening completion and referrals made to key resources if needed for fathers based on the results of their ACES screening.
    a. This is a priority as we may need to develop further community resources to meet the need as it develops.

4) Develop and test a postpartum mood disorder screening tool specific for use with fathers (who identify as male.)
    a. Edinburgh Postnatal Depression Scale 1 (EPDS), demonstrates validation when screening for paternal PPD. The EPDS research suggests modification of the scoring to adjust for male screening. We will use this tool as part of the validation process for the new tool.
    b. Development of a new screening tool is a priority as we will be able to share outcomes with other existing community programs who can incorporate our lessons learned into their programs. This is a sustainability strategy for continued screenings and services for fathers.

All of the learning goals relate to our goal of offering first-time fathers screenings for paternal PPD and ACEs. The goals will also help us know how many target clients engaged in the home visits so we can accurately expand or contract the program. By collecting data on fathers who accepted both the screenings and followed up on referrals made, we can support the planning for future services in our community and influence public policy throughout the state, possibly the country. As we improve our understanding of how best to serve fathers within the context of home visiting, we will share this information with community partners such as First Five Sonoma County, Health Action and the Upstream Portfolio, and the Behavioral Health Division of the Department of Health Services. Incorporating these lessons into existing programs, instead of only expanding this pilot program, strengthens all home visiting programs in a cost-effective manner.

EVALUATION OR LEARNING PLAN

The following data collection tools will be used to measure the achievement of four stated learning goals.

1. Percentage of new fathers are engaged in the INI home visiting program and complete all home visiting sessions and both the PMD and ACEs screenings offered. DATA COLLECTION:
    - Persimmony, a secure web-based data program will document all INI participants' demographic data and home visit record logs. Only home visiting staff and management will have access to these electronic records.
    - Home visit record logs include data items such as topics of interest, general items about length of visit, unusual questions, concerns or crisis reports. In addition, cancellations and program attrition, are noted in the home visit record logs.
    - All outreach efforts will be coded for tracking and will be part of initial intake questionnaire.
    - Completion of PPD and ACEs screenings and corresponding scores will be documented.
    - Tracking system of referrals to program will be utilized, to better inform strategies of recruitment. (I.e. keep track of what works). All outreach efforts will be coded for tracking and will be part of initial intake questionnaire.

2. Rates of paternal PPD and referrals to key community resources (or lack thereof) utilized by father. DATA COLLECTION:
    a. Completion of PPD screenings and corresponding scores will be documented on home visit record log.
    - Follow up on referrals to community-based services made during home visits will also be part of the record log. Home visitors will gather information on success of referral, lack of needed services, wait times, barriers to access and/or client reasons for non-acceptance of MH service/referral.

3. Track ACE scores and referral outcomes to key resources made for fathers based on the results of their ACES screening.
    - Completion ACEs screenings and corresponding scores will be documented.
    - Follow up on referrals to community-based services made during home visits will also be part of the record log. Home visitors will gather information on success of referral, lack of needed services, wait times, barriers to access and/or client reasons for non-acceptance of MH service/referral.

4. Develop and test a postpartum mood disorder screening tool specific for use with fathers (who identify as male.)
    a. Script language for tool using validated male expressions of depression.
    b. Use the Edinburgh Postpartum Depression Scales, with modified scoring, as part of the validation process for the new tool.
    c. A post screening survey will be developed to look at fathers' and home visitors' opinions on key questions about things like ease of use, felt accuracy and referral follow up.

Additionally: All clients may complete a pre and post ***Nurturing Skills Competency Scale (NSCS)***; or may be given *The Nurturing Quiz*. The NSCS is an inventory designed to gather information, both past and current, about individuals and their families in order to alert professionals about potential on-going conditions that could lead to the initial occurrence of child maltreatment. The Nurturing Quiz is an informal multiple-choice inventory given pre and post intervention designed to measure knowledge parents have of appropriate parenting practices. The Nurturing Quiz is easy to score and provides useful information regarding gains in knowledge the participants made.

Annual program evaluations will use all this data to show basic program counts (clients, including demographics; visits conducted; referrals complete/incomplete), client comments (value of program, reasons for drop out, etc.). Evaluations will also look at changes in NSCS (see above) and/or AAPI scores from beginning to end of visits in an attempt to quantify parental changes. The Adult-Adolescent Parenting Inventory (AAPI) is designed to assist professionals and paraprofessionals in assessing the parenting and child rearing attitudes of adolescent and adult populations. Developed from the known parenting and child rearing practices of abusive and neglecting parents, data generated from the administration of the AAPI indicate degrees of agreement and disagreement with maladaptive parenting behaviors. As such, responses on the AAPI provide an index of risk (high, medium, low) for practicing abusive and neglecting parenting and child rearing behaviors. The AAPI is useful in assessing individual strengths and weaknesses involved in child rearing. This tool is still under consideration as its use may be redundant give the NSCS scale is very similar.

Clients will receive follow up surveys via email (or in-person if enrolled in ongoing WMG services) that attempt to assess contact with child-welfare system, marital security and an ACEs screening for their child. These surveys will continue annually until the child reaches Kindergarten. Community indicators of child-abuse and neglect will be tracked over the same 5-year period. This 5-year follow up will allow us to see if changes made initially during the home visiting year continue to provide protective factors longitudinally. Minimal cost for this follow up is the data input costs (personnel) of the returned surveys. Data input is already included in the 3-year budget. ELI general fund will cover these costs after the conclusion of the INI 3-year program.

MHSA REGULATORY REQUIREMENTS

CONTRACTING AND COMPLIANCE

Sonoma County Department of Health Services (DHS) will contract with Early Learning Institute (ELI) for the proposed three-years of Innovation funding. ELI will develop a sub-contract with an outside third-party evaluator. ELI currently works with Sonoma State University personnel on another evaluation project and will consider engaging the same team for Instructions Not Included.

The MHSA Coordinator of the Sonoma County DHS Behavioral Health Division will be the main point of contact to monitor progress of Instructions Not Included and support for the Early Learning Institute (parent agency, community-based non-profit). Support may include connecting the project personnel to appropriate resources in the community, technical support in program delivery and evaluation, and quarterly 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, ELI 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).

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**
Sonoma County Public Health Maternal Child and Adolescent Health	**Trauma-Informed Approach in Public Health Nursing**

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 with 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 new fathers for depression and ACEs and providing warm hand offs to appropriate referrals.

	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. This is discussed on page 5 and again below:

The development of this program originally grew from the intersection of three things: 1) multiple requests from the community to provide home-based support for ALL first time parents and 2) growing body of research on male PPD and impact of Father's ACE score on child/family functioning; 3) A specific request from a 1st time father who lost his wife to suicide due to PMD. He felt that he did

not have the knowledge, support or resources he needed that could have used to help himself or his family.

Based on this, the population to be served was also consulted for this program. In three separate focus groups held by the Early Learning Institute in August and September of 2019, mothers and fathers of children less than a year old were queried about the supports they received, both before and after the birth of their first child. Each group independently identified that the Father received less preparation and early support and that the mother was the primary focus of support and monitoring after the birth. Interestingly, when the focus groups were split into separate Father/Mother groups, most of the fathers were far more forthcoming about how hard the first 6 months of the child's life was for them. One father said, "I wish I had known more about all the postpartum feelings that dad's get. I thought I was supposed to feel jealous of the baby. Instead, I felt terrified and weepy – I would stay at work later and later trying to get grounded and feel like I had control of something." Another father spoke of his need to "hit" stuff. He said he spent hours at the gym because he was afraid hurting his wife or baby. Of the 30 Father's interviewed, only two had initiated couples-counseling and one had starting working individually with a therapist. Four fathers were currently separated from their partners. When asked to identify, on a scale of 1 – to-10 with 10 being high, what they had heard, read or knew about Paternal Postpartum Depression, the average score was "3", with a high of "5" and a low of "0". More than 50% of fathers in our focus group said they would like to, or be willing to, participate in a "first time parent" home visiting program with their partners. 24% indicated they would be willing to participate in a home visiting program without their partners.

MHSA GENERAL STANDARDS

A) Community Collaboration

Instructions Not Included has been developed and will be implemented through a community collaboration that includes new parents, child development experts, community-based providers supporting new parents and mental health clinicians.

B) Cultural Competency

The parent organization, Early Learning Institute, works with a multicultural review team that consists of bi-lingual/bi-cultural representation from a variety of Central and South American ethnic community members. In addition, parents from the adoption community, grandparents, LGBTQ+ and parents of special needs children are represented on the review team. This community group will support the implementation, evaluation and community connection

to assure a high level of cultural competency in the project.

C) Client-Driven

Home visitor logs will include documentation of parent's topics of interest and response to home visits. Notes will track attendance and follow-up with referrals. If barriers are noted, solutions generated will be developed with the parents taking the lead to promote ownership of solution.

D) Family-Driven

The project, as a whole is family-driven as both parents are included in the service provided. Date/time of home visit appointments will be set with the family's schedule in mind. Topics discussed and resources brought forth are also driven by the family's self-stated needs.

E) Wellness, Recovery, and Resilience-Focused

The project is based on philosophy promoting wellness, recovery and focused on resilience. All screening tools, PPD, PMD and ACES are geared for early identification of risk factors. Community resources will all be focused on strengthening protective factors and supporting the family to mitigate any acute/chronic mental health issues.

F) Integrated Service Experience for Clients and Families

By providing community referrals with a warm handoff and follow-up to assure a smooth transition in accessing additional services, it is expected that families will have an integrated service experience.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

All materials, including evaluation surveys and tools, will be available to participants in their native language, validated for an accessible literacy level and will be administered with assistance, as needed. Surveys and other tools will be vetted by ELI's multicultural review team, for word choices and appropriate phrasing of questions prior to use in the program. The multicultural review team is a standing committee of the Agency made up of volunteers with different backgrounds to vet different elements of all ELI programs. Currently this committee has members from Mexico, Peru, and Nicaragua who are bilingual as well as members from California and South Africa who are not. The committee has parents and nonparents who represent the adoption community; LGBTQ community; traditional family community; parents of special needs children and grandparents parenting again. The committee meets quarterly or as needed.

Feedback from program participants about the data collection and evaluation elements will be solicited and tracked. Evaluation modifications will be made based on input. All program participants will have the option of providing anonymous feedback and/or of opting out of data markers (race, language, etc.) All surveys will allow for self-identification of gender and race and will have a "decline to state" option.

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 ELI Leadership and look holistically at the success of the project. Key indicators include the ability to engage target participants; successful outcomes of participants (as indicated on surveys and interviews), community resource information, and utilization in community mental health/support services. Also consideration will be given to success of early identification of depression, ACE understanding and amelioration; and percentage of CPS involvement of INI participants as compared to overall community percentage.

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, a criteria will be developed to determine if this 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 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. 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 INI as we are not targeting this population. However, there is definitely a potential overlap as the entrance criteria is being a first-time parent in Sonoma County. All participants will receive supportive navigation to other services as needed. If a parent with serious mental illness is accessing INI services at the end of the project's final year, case management will work closely with the County BHD and community mental health services to assure an appropriate and smooth transition.

COMMUNICATION AND DISSEMINATION PLAN

A final program report will include key findings and recommendations, including those that can be integrated into other existing home visitation programs. This report will be disseminated to all First Five County Commissions with a presentation to the State First Five Commission. Presentations will also be made at partner hearings and roundtable

meetings, such as County Board of Supervisors; First 5 Sonoma County; Mental Health Board; MHSA Contractors, Maternal Child Adolescent Health Board, North Bay Regional Center Early Start Meetings, Health Action Chapters, ACEs Collaborative and Sonoma County Office of Education operators. We will also disseminate our key findings and recommendations through electronic channels and in the form of news articles and press releases. The multicultural review team will contribute to the development and dissemination of a “parent friendly” version of the findings as a way of encouraging continued participation and support for this project in our community.

KEYWORDS for internet-based search

- Home Visiting with Fathers
- New Fathers
- Male PPD Depression Screening
- Parenting and ACEs

TIMELINE

Instructions Not Included is expected to start actual home visits 5/1/2021.The total timeframe of the INN Project will be three years from July 2021 through June 2024. This timeline is contingent upon scheduling public review and hearing and approval by MHSOAC Commission.

Project Planning and Development will begin with training the staff during the months of March and April 2021. Curriculum development, paperwork and evaluation data gathering tools will also be completed during this period.

During the first and second quarter of the Project, (June – December 2021), project planning will commence and refinement of paperwork and data collection will take place. Outreach efforts will also be enhanced as soon as notification of award takes place. Engagement plans include presentations and referral forms available to childbirth education classes; health providers (including mental health); child-welfare partners; Facebook-Twitter-Instagram and other social-media outlets that new parents are known to frequent.

Home visits and data collection is projected to commence in early May and is an ongoing activity through the duration of the funding. Data entry will be done weekly, to ensure accuracy and timely reporting.

Evaluation reports will be published annually in the second quarter of each fiscal year. A final evaluation report will be published after the end of the Project: June 2024. Half – year interim reports will also be published during the month of December (2021, 2022 and 2023) to be used as a guide for project adjustment or design revision, as needed.

Project results and lessons learned will be disseminated annually, projected for June 2022, 2023 and 2024. Reports will be circulated and presented to community partners, stakeholders, client groups and other interested parties. ELI staff will be available for Project presentations at the request of the Behavioral Health Department and the MHSA Coordinator for as long as deemed necessary.

	Q3 2021	Q3/4 2021	Q4 2021	Q4 2021	Jan - Mar Q1 2022	Apr - Jun Q2 2022	Jul - Sept Q3 2022	Oct - Dec Q4 2022	Jan – Mar Q1 2023	Apr - Jun Q2 2023	Jul - Sept Q3 2023	Oct - Dec Q4 2023	Jan - jun Q1 & 2 2024
• Award of Innovation Project(s) • Begin Innovation Project	X												
Project Planning and Development *Training and curriculum building will be completed by Sept 2021. Home visiting will commence upon completion of contract. New Screening tool will be developed by Oct 2021.*	X	X											
Community Engagement *Recruitment will begin as soon as notification of award takes place. Engagement plans include childbirth education classes; Health providers (including mental health); child-welfare partners; Facebook; Twitter; Instagram and other social-media outlets.*	X	X	X		X		X		X		X		FINAL REPORT 6/24
Project Implementation – *Home Visiting will commence as soon as contracts are in place and will be ongoing for three years.*		X	X	X	X	X	X	X	X	X	X	X	x
Evaluation – *Data collection will happen monthly. First evaluation will take place at year end, 2021 and will be done annually. "Mini" evaluation reports will also be done every 6 months and used as a guide for program design revisions, as needed.*			X	X 12/21	X	X 6/22	X	X 12/22		X 6/23		X 12/23	X 3/24
Dissemination of Results *Results will be published in March, 2022, 2023 and 2024. Report will be circulated based on input from MHSA coordinators*												X	X

BUDGET NARRATIVE

NOTE: 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 *Instructions Not Included*, 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.

ELI's Instructions Not Included has total budget of $1,094,860. The Innovation fund request is for a total of $689,861 for a three-year project that spans three fiscal years (July1 – June 30th -- 2021/22, 2022/23 and 2023/24). The annual Innovation fund budget ranges from $116,563 in Year 1; $227,639 in Year 2; $228,832 in Year 3; and $116,820 in Year 4.

The balance of $405,000 in revenue for the project is provided by the Chiat Foundation at $100,000 per year for 3 years and a donation pledge from Morton and Bassett Foundation at $35,000 for the next 3 years with potential extension. ELI will use these matching funds to provide program management support (.5 FTE @ $38064 per year plus $8,374 indirect costs); operational overhead, typically 15% of program costs ($48,060) and parent stipends ($2000/year). The rest ($38,462) will be kept in reserve for unanticipated start-up costs.

After the initial 3-year program, should results be promising, ELI does plan to request an extension of innovation funding for an additional two years. (see process above under sustainability.) When the project innovation period has ended, this home visiting program should have the research and data to prove its worth as a Prevention and Early Intervention (PEI) Program, potentially funded through local MHSA dollars. Additionally, First 5 Sonoma funds children's services and INI fits within their service category of supports for new parents. Finally - there exists the potential to market the new screening tool, to create a self-funded program.

Line 1: Personnel costs - $198,224 annually

There is the potential to reach 900 families with 5 visits a year = 4500 home visits. However, there is an expected 25% attrition rate, which will result in 3375 home visits needed in a year. Caseload formula assumes 22 visits per week, per home visitor. To reach our goal, we need 3 FTE Home Visitors = 66/week x 50 weeks = 3300 HV/year. INI will be part of ELI's Watch Me Grow portfolio of programs. Staff hired into this department are all paid professional staff. Many have the lived-experience of being parents and/or having personal PPD issues but it is not a requirement to be a "peer" for this program.

The cost of home visitors is estimated to be $46,113 per year x 3 FTE home visitors = $138,339 per year in salaries.

INI will need a part-time (.5FTE) Data Entry Specialist which will cost: $21,825 per year

Program management (.5 FTE) @ $38,060 per year salary

Line 2: Direct Costs Personnel - $43,609 annually x 3 years = 130,827.
Taxes, insurance, healthcare, vacation, sick leave.

Line 5: Direct Costs Operational - $19,284 annually x 3 years = $57,852
Estimate costs for incentives (books, child safety items, growth charts, puppets, etc.) **$12,246/year.**

Mileage – Each Home Visitor is estimated to drive 100 miles per week. (Cost estimates are based on 46-week year –4600 miles per year per home visitor x 3 equals 13,800 program miles driven in a year. ELI reimburses Home Visitors .51/mile = **$ 7038/**year in mileage costs.

Line 6: Indirect Operating costs - $48,060 annually x 3 years = $144,180
Historically 15% of program cost which covers office space, computers, communication and internet costs.

Non Recurring costs: Total - $3,943
Line 8: Certificates/Training: Estimated Cost in year 1 = $1243; Estimated cost in year 3 (due to staff changes) = $1200.
Instructions Not Included will be utilizing several evidence-based screening tools: Edinburgh Postnatal Screening Tool, Parent Stress Index and the Adverse Childhood Experiences screening tool. The program will also use curriculum from Dads Matter, Parents as Teachers and the Gottman Institute's Bringing Baby Home. Home Visitors who are not already trained to use these tools and/or the curriculum programs will need 1x training. Total Training cost: $2443.

Line 9: Surface Tablets: Estimated one-time cost $1500
Given the field nature of the program, we do intend to use 4G-Tablets for the home visitors. Three Microsoft Surface Pro Tablets will be acquired through Tech-soup, a low-cost nonprofit supplier of technology. Cost will be for all three tablets. The 4G ongoing costs will be zero as the Agency already has a "block" contract and have not reached capacity in this.

Consultant Costs: $42,000
Line 11: $13,000 for year 1 and year 2, $16,000 for year 3.
ELI plans to hire an evaluation consultant for this project at a total cost of $42,000. Currently we are working closely with Sonoma State University on a different research

project and they have agreed to contract for the evaluation of Instructions Not Included. While the evaluation amount may seem like a low percentage overall of this project, existing relationships with allow us to leverage evaluation time and talent at a low cost.

Other Expenditures:
Line 14: $2,000 Annually
Annual involvement stipends will be used to reconvene stakeholder groups intermittently to ensure input into the evaluation process, outreach efforts and any course corrections that may be needed across the life of the project. Stipends are estimated to be $20 gift cards for 100 participants each year. Total cost: $6,000.

Line 15: Unanticipated Costs: $38,462 Annually.
As a new program, there is a strong possibility for as yet unknown costs to be incurred during the first few years. The most likely cost item is the potential to have more referrals and clients than anticipated, resulting in more salary hours, mileage, client incentives and stipends. Any unused funds from this line will roll over into the next year.

ELI's Instructions Not Included program has secured additional funding from Chiat Foundation of $100,000 per year for the next 3 years, with potential extension; Morton and Bassett Foundation at $35,000 secured for the next 3 years with potential extension.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Salaries	$198,224	$198,224	$198,224			$594,672
2.	Direct Costs	$43,609	$43,609	$43,609			$130,827
3.	Indirect Costs						
4.	Total Personnel Costs	$241,833	$241,833	$241,833			$725,499
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
5.	Direct Costs	$19,284	$19,284	$19,284			$57,852
6.	Indirect Costs	$48,060	$48,060	$48,060			$144,180
7.	Total Operating Costs	$67,344	$67,344	$67,344			$202,032
NON RECURRING COSTS (equipment, technology)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
8.	Certification/Training	$1,243	0	$1,200	0		$2,443
9.	Microsoft Surface Tables	$1,500	0	0	0		$1,500
10.	Total Non-recurring costs	$2,743	0	$1,200	0		$3,943
CONSULTANT COSTS / CONTRACTS (evaluation)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
11.	Direct Costs - Evaluator	$13,000	$13,000	$ 16,000			$42,000
12.	Indirect Costs						
13.	Total Consultant Costs	$13,000	$13,000	$16,000			$42,000
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
14.	Annual involvement stipends	$2,000	$2,000	$2,000			$6,000
15.	Unanticipated Costs:	$38,462	$38,462	$38,462			$115,386
16.	Total Other Expenditures	$40,462	$40,462	$40,462			$121,386
BUDGET TOTALS							
Personnel (line 1)		$198,224	$198,224	$198,224			$594,672
Direct Costs (add lines 2, 5 and 11 from above)		$75,893	$75,893	$75,893			$230,679
Indirect Costs (add lines 3, 6 and 12 from above)		$48,060	$48,060	$48,060			$144,180
Non-recurring costs (line 10)		$2,743	0	$1,200			$3,943
Other Expenditures (line 16)		$40,462	$40,462	$40,462			$121,386
TOTAL INNOVATION BUDGET		$365,382	$362,639	$366,839			$1,094,860

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

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**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	$217,382	$214,639	$215,839			$647,860
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	$135,000	$135,000	$135,000			$405,000
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 22/23**	**FY 23/24**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	$13,000	$13,000	16,000			$42,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**	$13,000	$13,000	$16,000			$42,000
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**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	$230,382	$227,639	$231,839			$689,860
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	135,000	$135,000	$135,000			$405,000
6.	**Total Proposed Expenditures**	$1365,382	$362,639	$366,839			$1,094,860
*If "Other funding" is included, please explain. Annually: $100,000 grant from Chiat Foundation; $35,000 pledge donation from Morton & Basset.							

APPENDIX A – Support for Innovative Practice

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ELI's evidence-based home visiting program will include first time fatherss incorporating three additional curricula: Promoting First Relationships, Partners for a Healthy Baby and Nurturing Fathers.

PROMOTING FIRST RELATIONSHIPS is a training program at Parent-Child Relationship Programs at the Barnard Center, at the University of Washington, dedicated to promoting children's social-emotional development through responsive, nurturing caregiver-child relationships. Service providers are trained in the use of practical, in-depth, effective strategies for promoting secure and healthy relationships between caregivers and young children (birth to 5 years). The Promoting First Relationships Curriculum covers issues critical to supporting and guiding caregivers in building nurturing and responsive relationships with children, including: Theoretical foundations of social and emotional development in early childhood (birth to 5 years); Consultation strategies for working with parents and other caregivers; Elements of a healthy relationship; Promoting the development of trust and security in infancy; Promoting healthy development of self during toddlerhood; Understanding and intervening with children's challenging behaviors; Developing intervention plans for children and caregivers; Individualizing Promoting First Relationships for your setting.

PARTNERS FOR A HEALTHY BABY: features materials for home visitors and families that promote child development and family well-being. The curriculum is organized around children's ages and topics home visitors can use to support both age-appropriate learning and family development. The Partners curriculum addresses the multifaceted needs of expectant and parenting families. Partners is a "two generational" curriculum that addresses the needs of both the parents and the child. Partners covers a wide array of issues related to Family Development and Family Health & Safety, and includes content that addresses Preparing and Caring for Baby/Toddler; and Baby's/Toddler's Development. With 671 Purposes and corresponding Parent Handouts to choose from, Home Visitors can individualize visits to address the specific needs of each family.

NURTURING FATHERS: designed to teach parenting and nurturing skills to men, this psychoeducational program has strong evidence for developing attitudes and skills for male nurturance and has been shown to be effective in changing parental attitudes and behaviors for its participants (as measured by the AAPI-2*). Additionally, it has been shown to be particularly effective with Hispanic fathers in developing appropriate expectations, empathy, and role reversal. *The AAPI-2 provides an index of risk in five specific parenting and child rearing behaviors known to contribute to child abuse and neglect (Bavolek & Keene, 2001).

APPENDIX B – 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	Health, Community Benefits, MH	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%	7 consumers
41%	11 Family member
19%	5 LBGTQ+
11%	3 Latinx
4%	1 Native American
11%	3 TAY

APPENDIX C

HOME VISITING SAFETY PROTOCOLS

The following guidance is based on the most current Department of Public Health guidance. The health and safety of children, family, and staff are of the utmost importance. This guidance is not intended to address every potential scenario that may arise as this event evolves.

1. **Anyone planning an in-person home visit should contact families (by telephone, email, text) <u>prior</u> to the visit and ask about the following:**
    - **a.** Signs or symptoms of COVID 19
    - **b.** Potential contact with anyone confirmed positive or under investigation for COVID-19, or ill with a respiratory illness.
    - **c.** The immune status/risk of household members; those who have a weakened immune system, over the age of 60 years, have chronic health conditions (e.g. heart disease, lung disease, diabetes), or other COVID-19 risk factors.

    **See Brief Questionnaire below*

2. **Nothing is to be taken into homes, except essential items like keys, phone, and wallet.**
    - a. ELI recommends that these items are stored in small case/bag/container that can be wiped down.
    - b. Do not take in toys, mats, note taking materials, etc.
    - c. Consider removing shoes and wearing "booties."
    - d. Wear disposable shoe covers if you choose to keep shoes on.

3. **Minimize contact with frequently touched surfaces in the home.**
    - **a.** Wash your hands with soap and water for at least 20 seconds upon entering the home (if possible) and after exiting.
    - **b.** If soap and water are not available, use hand sanitizer.
    - **c.** Avoid touching eyes, nose and mouth, especially on the visit.

4. **Change clothing and wipe down shoes between home visits.**
    - **a.** All employees must wear clean "scrubs" (tops/bottoms) that can be easily stripped off after HV and secured in dry laundry bag until washed.
    - **b.** Change before entering car if possible.
    - **c.** If not possible, cover car seat with disable or washable cloths.
    - **d.** Wipe off shoes with sterile wipe or remove shoe covers and dispose.
    - **e.** Wash hands/use sanitizer after changing.

5. **Masks must be worn on home visits and social-distancing (6') maintained.**
    - **a.** Masks are recommended even during outside visits. However, when necessary, double-social distancing can substitute for facemasks. (12 feet)
6. **Temperature scans should be performed on adults and children in home before entering home.**
    - e. Use non-touch thermometers.
    - f. Visit must be cancelled if anyone has a temperature above 100.4.

7. **A few health questions must be re-asked prior to entering home.**
    - **a.** Is anyone in the home currently sick?
        - i. Home visitor has discretion to assess risk of any "yes" answers. For example – if child has had an ear infection, it is OK to visit.

g. Does or has anyone had a fever?
h. Has anyone unusual visited the home in the past 24 hours?
    i. If so, what is their health profile/status?

8. **Daily schedules must be kept on cloud file and up-to-date.**

9. **All potential exposures must be reported immediately to supervisors.**

*Brief questionnaire prior to all face-to-face visits

Be sure to ask about all household members:

1) Is anyone in your household experiencing any of the following symptoms:

- Fever or chills
- Headache
- Cough
- New loss of taste or smell
- Diarrhea
- Sore throat
- Fatigue
- Congestion or runny nose
- Muscle or body aches
- Nausea or vomiting
- Shortness of breath or difficulty breathing

2) Has anyone in your household had contact with anyone who has known or possible exposure to the COVID-19 in the last 14 days?

3) Is anyone in your household on home quarantine or isolation due to possible contact with someone with possible or confirmed COVID-19 or due to travel?

4) Please tell me about the immune status/risk of household members; those who have a weakened immune system, over the age of 60 years, have chronic health conditions (e.g. heart disease, lung disease, diabetes), or other COVID-19 risk factors.

If you become aware of a confirmed or presumptively positive case, please notify your supervisor. Anyone who answers "yes" to the screening questions should be urged to consult with their health care provider immediately.

APPENDIX D - Instructions Not Included Training

Procedures:

All new home visitors, and supervisors will receive role-specific training before working independently with families to ensure they have a thorough understanding of their role within the Early Learning Institute's Instructions Not Included program. The training is conducted by staff that has been intensively trained in that role. The training includes:

- Theoretical background of staff's role
- Shadowing of other staff in a similar role
- Training on forms and form use
- Hands on-practice (with observation and feedback)
- Inter-rater reliability related to documentation (home visit documentation, parent survey summaries and scores and/or supervision documentation)
- Use of the reflective strategies, strength-based tools and interviewing techniques

Training Plan/Policy

Policy: Every ELI program has a comprehensive training plan/policy that assures access and ongoing tracking and monitoring of required trainings in a timely manner for all staff.

Procedures:

- Staff discuss their annual training goals with their supervisor during the introductory period and annual performance evaluations.
- Staff maintain training records and document all training.
- Supervisors monitor and approve training received to ensure timely access and receipt of all required training.
- Supervisors provide new staff will orientation prior to staff providing services. This orientation is to include the following: goals, services, curriculum materials, policy and operating procedures, data collection forms and processes, and philosophy of home visiting/family support prior to direct work with families or supervision of staff.
- All new home visitors, supervisors and program managers receive role-specific stop gap training with their direct supervisor, or designee before working independently with families, or before their first supervision to ensure they have a thorough understanding of their role within the Early Learning Institute and Instructions Not Included.
- Within three months of date of hire, staff receive training in the following areas: infant care; child health and safety; and maternal and family health.
- Within six months of date of hire, staff receive training in the following areas: prenatal issues; infant and child development; role of culture in parenting; parent-child interaction; staff related issues; and mental health.
- Within twelve months of date of hire, staff receive training in the following areas: child abuse and neglect; family violence; substance abuse; family issues; the role of culture in parenting.
- All staff receive training on child abuse and neglect annually as scheduled by the program manager.
- All staff receive training designed to increase understanding and sensitivity of the unique characteristics of the service population annually as scheduled by the program manager.
- All staff who administer or supervise staff who administer developmental screenings are trained in the use of the tool, in accordance with developer requirements, before administering it.
- All staff who administer or supervise staff who administer the depression screen/tool have been trained in the use of the tool, in accordance with developer requirements, before administering it, and supervisors also receive this training.
- All staff are trained in other evaluation tools or screening/assessment tools as appropriate.