

Butte County, California
Mental Health Services Act Community Services and Supports

Program and Expenditure Plan

Fiscal Years 2005-2006, 2006-2007, 2007-2008

The following Plan is in response to the California Department of Mental Health document titled: Mental Health Services Act, Community Services and Supports, August 1, 2005, THREE-YEAR PROGRAM AND EXPENDITURE PLAN REQUIREMENTS. The full document, containing the questions, definitions, requirements, and guidelines can be found at:

<http://www.dmh.ca.gov/DMHDocs/default.asp?view=letters#L0505>

Key definitions used in the California Department of Mental Health THREE-YEAR PROGRAM AND EXPENDITURE PLAN REQUIREMENTS are listed below, to assist in understanding the responses to the questions asked by the California Department of Mental Health. The following section (in Times New Roman font) is taken from the THREE-YEAR PROGRAM AND EXPENDITURE PLAN REQUIREMENTS.

Essential Elements for All Three-Year Program and Expenditure Plans

There are five fundamental concepts inherent in the MHSAs that must be embedded and continuously addressed throughout the Program and Expenditure Plans submitted by counties. These include:

- **Community collaboration:** Community collaboration refers to the process by which various stakeholders including groups of individuals or families, citizens, agencies, organizations, and businesses work together to share information and resources in order to accomplish a shared vision. Collaboration allows for shared leadership, decisions, ownership, vision, and responsibility. The goal of community collaboration is to bring members of the community together in an atmosphere of support to systematically solve existing and emerging problems that could not easily be solved by one group alone.
- **Cultural competence:** Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer providers, and family member providers to work effectively in cross-cultural situations. (Source: DMH Cultural Competence Plan Requirement adapted from Cross, Bazron, Dennis, and Isaac, *Towards a Culturally Competent System of Care*, Volume I, 1998.)

Cultural competence includes language competence and views cultural and language competent programs and services as methods for elimination of racial and ethnic mental health disparities. There is a clear focus on improved quality and effectiveness of services. Service providers understand and utilize the strengths of culture in service delivery. Culturally competent programs and services are viewed as a way to enhance the ability of the whole system to incorporate the languages and cultures of its clients into the services that provide the most effective outcomes and create cost effective programs. Identification, development, promulgation, and adoption of culturally competent best practices for care must be an integral part of ongoing culturally competent planning and implementation of the MHSA.

- **Client/family driven mental health system for older adults, adults and transition age youth and family driven system of care for children and youth:** Adult clients and families of children and youth identify their needs and preferences which lead to the services and supports that will be most effective for them. Their needs and preferences drive the policy and financing decisions that affect them. Adult services are client-centered and child and youth services are family driven; with providers working in full partnership with the clients and families they serve to develop individualized, comprehensive service plans. Individualized, comprehensive service plans help overcome the problems that result from fragmented or uncoordinated services and systems.

Many adults with serious mental illness and parents of children with serious emotional disturbances¹ have limited influence over the services they or their children receive. Increasing opportunities for clients and families to have greater choices over such things as types of service, providers, and how service dollars are spent, facilitates personal responsibility, creates an economic interest in obtaining and sustaining recovery, and shifts the incentives towards a system that promotes learning, self-monitoring, and accountability. Increasing choice protects individuals and encourages quality. (Source: The President's New Freedom Commission on Mental Health – *Achieving the Promise Transforming Mental Health Care in America*.)

- **Wellness focus, which includes the concepts of recovery and resilience:** Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. For some individuals, recovery means recovering certain aspects of their lives and the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery in service planning encourages and supports hope.

Resilience refers to the personal qualities of optimism and hope, and the personal traits of good problem solving skills that lead individuals to live, work and learn with a sense of mastery and competence. Research has shown that resilience is fostered by positive experiences in childhood at home, in school and in the community. When children encounter negative experiences at home, at school and in the community, mental health treatments,

¹ Throughout this document, the phrases “children who may have” and/or “who have been diagnosed with serious emotional disturbances” include children/youth who may have and/or who have been diagnosed with serious mental illness.

which teach good problem solving skills, optimism, and hope can build and enhance resilience in children. (Source: California Family Partnership Association, March 2005.)

- **Integrated service experiences for clients and their families throughout their interactions with the mental health system:** This means that services are “seamless” to clients and that clients do not have to negotiate multiple agencies and funding sources to get critical needs met and to move towards recovery and develop resiliency. Services are delivered, or at a minimum, coordinated through a single agency or a system of care. The integrated service experience centers on the individual/family, uses a strength-based approach, and includes multi-agency programs and joint planning to best address the individual/family’s needs using the full range of community-based treatment, case management, and interagency system components required by children/transition age youth/adults/older adults. Integrated service experiences include attention to people of all ages who have a mental illness and who also have co-occurring disorders, including substance use problems and other chronic health conditions or disabilities. With a full range of integrated services to treat the whole person, the goals of self-sufficiency for older adults and adults and safe family living for children and youth can be reached for those who may have otherwise faced homelessness, frequent and avoidable emergency medical care or hospitalization, incarceration, out-of-home placement, or dependence on the state for years to come.

Three Types of System Transformation Funding Available

- *Full Service Partnership Funds – funds to provide “whatever it takes” for initial populations*

With the initial implementation and funding of the MHSA, DMH will take the first step in funding counties to develop full service partnerships with identified initial populations. These partnerships shall be culturally competent and shall include individualized client/family-driven mental health services and supports plans which emphasize recovery and resilience, and which offer integrated service experiences for clients and families. In selecting initial populations, specific attention should be paid to populations and individuals that are currently unserved, and to reducing racial/ethnic disparities. The goal will be to eventually provide all needed cost-efficient and effective services and supports for all those in need of mental health services and their families, consistent with the individualized plans.

Funding for the services and supports for Full Service Partnerships may include flexible funding to meet the goals of the individual services and supports plans. Access to generic community services should be obtained whenever feasible and appropriate. Mental Health Services Act funds are for community services and supports when access to these services cannot be obtained from other sources and such expenditures are consistent with other MHSA requirements.

- *General System Development Funds – funds to improve programs, services and supports for the identified initial full service populations and for other clients consistent with the populations described in Part II. (See complete THREE-YEAR PROGRAM AND EXPENDITURE PLAN REQUIREMENTS).*

General system development funds are needed to help counties improve programs, services and supports for all clients and families (including initial Full Service Partnership populations and others) to change their service delivery systems and build transformational programs and services. Strategies for reducing ethnic disparities should be considered. Examples for this kind of funding are client and family services such as peer support, education and advocacy services, mobile crisis teams, funds to promote interagency and community collaboration and services, and funds to develop the capacity to provide values-driven, evidence-based and promising clinical practices. This funding may only be used for mental health services and supports to address the mental illness or emotional disturbance. (Mental health services and supports include mental health treatment, rehabilitation services including supportive housing and supportive employment, and personal service coordination/case management. In collaborative programs, the cost of the mental health component only is allowable; for positions with blended functions, only the proportion of costs associated with the mental health activities are allowable. Costs for community supports such as rental subsidies, other treatment such as health care or substance abuse treatment, and respite care are not allowable under General System Development. These examples are allowable under Full Service Partnerships.)

- *Outreach and Engagement Funding – funds for outreach and engagement of those populations that are currently receiving little or no service.*

This funding is established in recognition of the special activities needed to reach unserved populations. Outreach and engagement can be one component of an overall approach to reducing ethnic disparities. Examples of this type of funding would be funding for racial ethnic community-based organizations, mental health and primary care partnerships, faith-based agencies, tribal organizations and health clinics; organizations that help individuals who are homeless or incarcerated, and that link potential clients to services; funds for clients and families to reach out to those that may be reluctant to enter the system; funds for screening of children and youth; and school-and primary care-based outreach to children and youth who may have serious emotional disorders. This funding may only be used for those activities to reach unserved populations. Some individuals may have had extremely brief and/or only crisis oriented contact with and/or service from the mental health system and should be considered as unserved.

In this initial plan, counties may request ongoing funding for any or all of the three categories and may request one-time-only start-up funds in any of these funding areas. For the three-year planning period, DMH requires that counties request a majority of their total CSS funding for Full Service Partnerships, in order to begin to provide full service to as many individuals/families as possible.

Analyzing Mental Health Needs in the Community

For purposes of this document the following definitions apply:

- Unserved – persons who may have a serious mental illness and children who may have serious emotional disorders, and their families, who are not receiving mental health services. Some individuals, may have had extremely brief and/or only crisis-oriented contact with and/or service from the mental health system and should be considered as unserved.
- Underserved/inappropriately served – individuals who have been diagnosed with serious mental illness and children who have been diagnosed with serious emotional disorders, and their families, who are getting some service, but whose services do not provide the necessary opportunities to participate and move forward and pursue their wellness/recovery goals. This category would also include individuals who are so poorly served that they are at risk of situational characteristics such as homelessness, institutionalization, incarceration, out-of-home placement or other serious consequences.
- Fully served – People who have been diagnosed with serious mental illness and children/youth who have been diagnosed with serious emotional disorders and their families, who are receiving mental health services through an individual service plan where both the client and their service provider/coordinator agree that they are getting the services they want and need in order to achieve their wellness/recovery goals. Examples of people who may be fully served include individuals in AB 34 or 2034 programs and children and families receiving Wraparound services within a comprehensive Children’s System of Care.

**Butte County Mental Health Services Act, Community Services and Supports,
PROGRAM AND EXPENDITURE PLAN**

Section I: Identifying Community Issues Related to Mental Illness & Resulting from Lack of Community Services & Supports

1. Major community issues identified through our community planning process, by age group. Which community issues have been selected to be the focus of MHSA services over the next three years? (Place an asterisk next to these issues)

The community planning followed the course of action described in the state-required “Butte County Funding Request for the Mental Health Services Act (MHSA), Community Program Planning” (aka the “Plan to Plan”)

Involvement of Consumers and Family Members

Consumers and family members were involved from the initial community meeting, through the decision-making meetings. They participated in meetings, facilitated large sessions and conducted focus groups.

Between March and April 2005 six large community meetings were held throughout Butte County:

1. Butte County Department of Behavioral health (BCDBH) Contractors and County Department Directors

2. Community Based Organizations
3. Gridley/Biggs Community Meeting
4. Oroville Community Meeting
5. Paradise Community Meetings
6. Chico Community Meeting

A total of 441 Community Members signed in at these meetings. Childcare, transportation and dinner were provided, as the meetings were typically held during the evening. Flyers were posted in businesses, schools and local papers as well as being posted in all offices. E-mails were also circulated to all county staff.

Translators were provided for community meetings and focus groups when needed. Flyers were also translated into Spanish and Hmong.

In addition to the large community meetings, focus groups were conducted with community members, including consumers and family members, who did not attend the large group meetings. Participants in focus groups received a \$20 gift card to a local grocery store. A total of 290 gift cards were distributed. Another data collection method used in the initial phase was personal questionnaires or surveys. However, this method was determined to be inadequate to provide usable information.

After the community meetings were concluded a Stakeholder Committee for Community Services and Supports was selected from applications received throughout the public input process. The Stakeholder Committee was made up of 24 active individuals of whom 11 identified their affiliation as being consumers and/or family members. Consumer and family member stakeholders were paid an hourly stipend for their involvement. Meetings were held in June and July 2005, during which dinner was served.

A team of BCDBH staff also met on a consistent basis to keep up-to-date on MHSA news and requirements as they were being published by the State Department of Mental Health. At the conclusion of the Stakeholder Committee meetings, two family members and one consumer became members of the BCDBH MHSA Team to ensure that the intent of the Stakeholder Committee recommendations was clearly represented.

Targeted Input

The "Plan to Plan" proposal identified 14 groups with whom to conduct focus groups. As these groups have unique needs, and are not frequently accessing BCDBH services, it was determined that enhanced outreach to contact them would be necessary. Focus groups were held from May-August 2005 in the following communities:

- Ethnic groups-Hmong, Latino, African American, and Native Americans
- Low income people
- Undocumented people
- Youth
- People with disabilities
- Homeless adults

- Homeless youth
- Rural area occupants, including isolated regions in the mountains, and farming areas
- Farm laborers
- Older adults
- Transition youth
- Youth and adults in the criminal justice system and their families
- Family members and caregivers of consumers

Once we began to implement our planning process we began to see some overlap among these groups and also to experience difficulties in accessing members of these communities. For many, their hesitation was due to a past history dealing with “agencies.” The need to build or re-build relationships with individuals in the community who are disenfranchised and in need of, but not currently accessing our services was identified. In particular, developing relationships with individuals of the gay, lesbian, bisexual, and transgender community.

County/Community Issues Identified in the Public Planning Process			
Children/Youth	Transition Age Youth	Adults	Older Adults
1. School Based Programs 2. Parent Programs 3. Crisis Services*	1. Housing/ Independent Living skills; Shelter & Permanent Housing serving county-wide* 2. Youth PHF 3. Consumer driven alternative to medical model* 4. Comprehensive, county-wide AOD programs & detox* 5. Residential treatment* 6. Assessment, Counseling & non-residential Services*	1. Detox facility* 2. Add PHF in Oroville 3. Expand PHF* 4. Education / training: teachers, medical personnel, police	1. Transportation* 2. Socialization 3. Independent Living-Magalia 4. Socialization in outlying towns (Bangor, Berry Creek)

*Selected to be the focus of MHSA services over the next three years

2. *Factors or criteria that led to the selection of the issues starred above to be the focus of MHSA services over the next three years. How were the issues prioritized for selection?*

Input from the community meetings and focus groups was presented to the Stakeholder Committee for review and discussion during a series of meetings. This group selected the needs in the chart above as those having the highest priority in each age group.

The community input was presented in the form of “issues”. This information was used to develop the three programs being proposed for MHSA funding. The issues listed in the chart above will be addressed in the age groups and programs seen in the chart below.

MHSA Programs to Address County/Community Issues Identified in the Public Planning Process			
Children/Youth	Transition Age Youth	Adults	Older Adults
<p><u>Community Issue:</u></p> <p>Crisis Services*</p> <p><u>New MHSA Programs:</u></p> <p>1. LINK Youth Center and Housing Program</p> <p>2. 23-hour crisis stabilization program</p>	<p><u>Community Issues:</u></p> <p>a. Housing/ Independent Living skills; Shelter & Permanent Housing serving county-wide*</p> <p>b. Consumer driven alternative to medical model*</p> <p>c. Comprehensive, county-wide AOD programs & detox*</p> <p>d. Residential treatment*</p> <p>e. Assessment, Counseling & non-residential Services*</p> <p><u>New MHSA Programs:</u></p> <p>1. LINK Youth Center and Housing Program</p>	<p><u>Community Issues:</u></p> <p>a. Detox facility*</p> <p>b. Expand PHF*</p> <p><u>New MHSA Programs:</u></p> <p>1. Homeless mentally ill program in Oroville</p> <p>2. 23-hour crisis stabilization program</p>	<p><u>Community Issue:</u></p> <p>a. Transportation*</p> <p><u>New MHSA Programs:</u></p> <p>1. 23-hour crisis stabilization</p>

	<p>2. 23-hour crisis stabilization program</p>		
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The Stakeholder Committee recognized the challenge of meeting the broad array of community needs with limited MHSA funding. It was determined that the highest priority should be to provide services that link the needs identified in the community process with those people who are unserved. The three groups meeting this definition are: homeless youth, people of all ages in short-term crisis, and homeless adults having mental illness in the Oroville area. Providing the proposed programs will also meet the state requirements for:

- 1) Serving unserved populations
- 2) Addressing the essential program elements of: community collaboration, cultural competence, client/family driven mental health system, wellness focused program, and integrated service experience for client and their families
- 3) Providing at least half of the funding for “full service partnerships”
- 4) Reducing the long-term adverse community impacts of untreated mental illness

To meet the need for a detox facility, which was identified as a community need, the most appropriate use of the funding was determined to be a program for people with mental illness living on the streets of Oroville. This group is being targeted as having the most need for mental health services and substance treatment. In the current homeless program in Chico, at least 60% of the consumers are dependent on substances; this figure is estimated to be even higher in Oroville. Services for these homeless adults will address the dual problem of mental illness and substance addiction, helping them to acquire and remain in stable, permanent housing. These two illnesses must be addressed simultaneously in for this to happen.

Older adults will be one of the age groups served in the 23-hour crisis stabilization program. Through this program, unnecessary emergency room visits and 911 calls will be reduced, and connection with outpatient services will be made possible. The older adult population will receive crisis stabilization services through the 23-hour program, and will receive appropriate discharge into current specialty senior services. This will effectively increase services to this un-served population, thereby reducing their isolation and providing transportation to needed socialization programs.

Expansion of the Psychiatric Health Facility (PHF) services was identified as a need in our community. The 23-hour crisis stabilization program will offer an alternative to this

level of care, which will provide services to individuals in crisis, and in essence, expand PHF services to individuals experiencing psychiatric crises.

3. Specific racial, ethnic and gender disparities within the selected community issues for each age group, such as access disparities, disproportionate representation in the homeless population and in county juvenile or criminal justice systems, foster care disparities, access disparities on Am. Indian rancherias or reservations, school achievement, drop-out rates, and other significant issues.

It has not been possible to determine specific gender, racial, and ethnic disparities within the populations that will be served by the selected programs. These are: youth and adults in crisis due to mental illness, homeless youth and homeless adults. However, we know that generally Latino and Asian children and youth are underserved, and that Latino adults are underserved in Butte County Behavioral Health programs. This is a situation related to access to services, which will be mitigated through efforts in each of the selected MHSA programs.

In the Butte County adult population, Latinos are the most underserved in Behavioral Health services. This access problem will be addressed through efforts described in the two programs for adults: 23-hour stabilization and the homeless mentally ill program in Oroville. By early 2007, a comprehensive homeless count will inform us of the ethnic, age and gender characteristics of people who are homeless in Butte County.

Section II: Analyzing Mental Health Needs in the Community

(Answer as pertaining to the mental health needs assessment completed as part of the MHSA public planning process.)

1. Narrative analysis of the unserved populations in Butte County by age group. Specifically address racial ethnic disparities.

Children and Youth; and Transitional Aged Youth:

In Butte County, there is an insufficient number of emergency beds for homeless youth, and transitional aged youth, as well as limited services focusing specifically on homeless youth and young adults. There are four beds now available in a foster home, but are unsuitable to meet the needs of homeless youth. Many of the homeless youth have been through the foster care system, and are distrustful of the foster home setting. There are after school programs for youth who attend school, but for those who do not, the street is where they socialize. A small program for runaway youth has been operational for almost 15 years, through the BCDBH Homeless Runaway Emergency Effort (HERE) but the number of available emergency beds is so limited that the program is hampered in its efforts. Young people in Butte County face crises such as conflict at home, troubles at school, exposure to domestic violence, physical & sexual abuse, and poor independent living skills that occur in every community, every neighborhood, and every culture. The result is young people running away from home, becoming homeless, and facing dangers for which they are not prepared. Nation-wide

statistics generated from federal runaway and homeless youth programs (Basic Center Programs, 1998-99 fiscal year) indicated that over 50% of the youth served presented with symptoms of depression, with 14% having made at least one suicide attempt.

During a twelve-month period (April 2004-March 2005) Butte County Behavioral Health's Homeless Emergency Runaway Effort (HERE) Program provided counseling services to 235 runaway or homeless youth. We know the actual number of homeless youth in Butte County is much higher because they are often not visible or easy to count. They don't tend to hang out on city streets but instead find refuge in our large natural parks or in our mountain communities where methamphetamine production is plentiful. They often exchange sex for a place to eat and sleep in the college dorms or stay at homes of acquaintances until they are told to move on. Additionally, far too many of these youth leave the county, heading to the popular urban centers such as San Francisco, or Hollywood where our rural youth find themselves horribly unprepared for the dangers of urban street life.

HERE Program Outreach Interns surveyed about 70 youth in Oroville and Chico to identify needs. These youth were those who gather in outdoor areas to socialize and "hang out". The average age of youth who were surveyed in Oroville was 17.5 years and in Chico 18.2 years. In Oroville, 63% were male, while in Chico, only 41% were male. Around one-third of the youth in Chico were homeless, and 25% in Oroville had run away in the past. In Chico 68% had run away from home in the past. Essentially all youth who had run away, did so due to family dynamics. In Oroville, one quarter of the youth surveyed knew a youth who was homeless, and in Chico 32% knew a homeless youth.

During federal fiscal year 2004-2005, a total of 187 Lethality Assessments for minors were conducted by BCDBH. Of those, 103 were hospitalized for at least one night due to lethality. At least half of those hospitalizations could have been avoided through the use of a 23-hour stabilization program, due to the short-term nature of their crisis.

Adults:

The need for 23-hour crisis stabilization has been a long standing issue as seen by the frequent inability to answer the demand for admissions into the Psychiatric Health Facility (PHF). This 16-bed facility is not able to serve all people in crisis, and many individuals experiencing a crisis do not fit the criteria of danger to self or others. In addition, local hospital emergency rooms are overwhelmed with people having mental health crises, who could be discharged to an appropriate mental health program. In 2004-2005 approximately 50% of all people admitted to the PHF were only one-day admissions, indicating a need for a 23-hour crisis stabilization program.

In Butte County there is no program for adults who are homeless and have a mental illness in the Oroville area. The homeless population is estimated to be around 500 individuals, with about a third having mental illness or a co-occurring disorder. The Butte Homeless Task Force has recently identified this area of the county as needing

more homeless services, and has been awarded a Community Development Block Grant (CDBG) to provide technical assistance to do a comprehensive study of the number and characteristics of homeless people in the County. When this count is completed in early 2007, a much clearer picture of the homeless number, characteristics, and needs in Oroville will be known.

Older Adults:

This population is underserved throughout the county. Specialty services have been developed for serving this population more effectively, however, due to isolation and the stigma attached to accessing mental health for this age group, these services continue to be underutilized. Older adults are more likely to be identified as needing mental health services through emergency room services, public health, and law enforcement contacts.

Many individuals in this population have complicated medical and neurological issues, which make crisis evaluation and discharge planning more difficult. This population also tends to have a lack of mobility to independently access services. A 23-hour program would provide the additional time needed for evaluation, and more intensive discharge planning into existing community services.

All Age Groups:

There is no data to articulate the ethnic disparities in the two homeless populations that will be served (youth and adults). This will be corrected by the upcoming homeless count described above.

2. Use Chart A, to show estimated total number of persons needing MHSA mental health services who are already receiving services, including those currently fully served and those underserved/inappropriately served, by age group, race/ethnicity, and gender. Also show total County and poverty population by age group and race ethnicity.

Chart A: Service Utilization by Race/Ethnicity

These figures are based on the BCDBH fiscal year 04-05 data system. "Fully served" is defined as receiving "all services needed" for recovery, through an individual service plan. Only participants in the following BCDBH programs are counted as "fully served": SEARCH (AB2034) program for homeless mentally ill adults in the Chico area, SMILE and ROOF programs for chronically mentally ill adults, and the COMPASS program for children and youth. "County Population" figures are from the California Department of Finance population trends estimates for 2005.

The "Total Served" percentage column indicates the proportion of people in the age group as compared to the total number served during the year. The total number served is 6,420 for all age groups.

The numbers represent the count of unique people served. There are services provided in addition to those listed in the chart, but which are not captured in the data base system due to the fact that a case is not opened. These include the outreach services provided by the Prevention Unit to students of all ethnicities in schools in all parts of the county. Also, the SEARCH (AB2034) program for homeless mentally ill people conducts outreach to many more people than those who meet mental health criteria for the program. They are frequently linked to other services in the community, but are not considered open cases in BCDBH. In addition, a small percentage of clients were not yet entered into the data system at the time of data analysis.

The age groups are defined as:

- Children and Youth: 0 through 17 years
- Transition age youth: between ages 16 and 25
- Adults: 18+
- Older adults: 60 years and older

CHILDREN AND YOUTH	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population <200%		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
TOTAL	24	27	1276	1052	2379	37.06	24,666	28.70	46,552	21.45
African American	3	3	53	45	104	4.37	462	1.87	1,152	2.48
Asian Pacific Islander	1	0	14	22	37	1.56	2332	9.45	3,133	6.73
Latino	0	3	103	92	198	8.32	5039	20.43	9,098	19.54
Native American	0	2	65	75	142	5.97	741	3.00	1,783	3.83
White	20	18	1018	785	1841	77.39	14818	60.08	29,296	62.93
Other	0	1	23	33	57	2.39	1275	5.17	2,090	4.49

TRANSITION AGE YOUTH*	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population <200%		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
TOTAL	28	16	496	536	1076	N/A	15038	17.52	37520	17.29
African American	0	1	19	20	40	3.72	435	2.89	1091	2.91
Asian Pacific Islander	1	0	10	11	22	2.04	1422	9.46	2400	6.39
Latino	3	1	47	40	91	8.46	3078	20.47	5766	15.37
Native American	1	1	24	24	50	4.65	451	3.00	956	2.55
White	23	13	391	433	860	79.93	9023	60.00	26338	70.20
Other	0	0	5	8	13	1.21	629	4.18	969	2.58

*These figures duplicate numbers in the youth and adult charts.

ADULT	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
TOTAL	168	104	1360	2042	3674	57.23	48,460	50.53	125,424	57.79
African American	6	2	46	65	119	3.24	959	1.98	2406	1.92
Asian Pacific Islander	3	0	92	207	302	8.22	2318	4.78	5514	4.40
Latino	7	4	88	103	202	5.50	6615	13.65	16693	13.31
Native American	4	2	42	69	117	3.19	1135	2.34	3390	2.70
White	148	95	1070	1558	2871	78.14	35820	73.92	94761	75.55
Other	0	1	22	40	63	1.71	1613	3.33	2657	2.12

OLDER ADULT	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
TOTAL	12	4	118	233	367	5.72	12,706	20.77	45,077	20.77
African American	1	0	1	1	3	0.82	121	0.95	427	0.95
Asian Pacific Islander	0	0	21	25	46	12.53	212	1.67	753	1.67
Latino	0	0	4	8	12	3.27	496	3.9	1,760	3.9
Native American	0	0	2	3	5	1.36	172	1.36	614	1.36
White	11	4	86	190	291	79.29	11516	90.63	40,853	90.63
Other	0	0	4	6	10	2.73	189	1.49	670	1.49

3. Discussion/analysis of the ethnic disparities in the fully served, underserved and inappropriately served populations in Butte County by age group as identified in Chart A.

The number of “Fully Served” people is comparatively low (339) for all age groups and all ethnicities, using the assumption that only those served in the four programs listed above receive “full service”. Of the adults and older adults who are fully served, there are far more males fully served than females, even though there are slightly more females in the population.

No ethnic group reaches the target for fully served.

However, it can also be assumed that many more service recipients receive “full service” in other programs, based on the following definition:

Individuals who at discharge were employed/in school/involved in job training, and had housing, and their treatment goals had been met per mutual client and staff agreement. Using these criteria, an additional 384 clients were “fully served”.

Looking at the information in Chart A, certain ethnic disparities can be noted. As an orientation, the information indicates:

- The total unique number of people receiving services from BCDBH during FY04-05
- The total number and percentage of people in Butte County whose income is at or below 200%, of the federal poverty level. An example of this amount is \$38,700 for a family of four people. These estimates were taken from the University of Texas Medical Branch estimates adjusted to reflect the California Department of Finance 2005 population projections.
- The total county population

In Children and Youth, African Americans, Native Americans and Whites are served at a higher rate than their population ratio for people living in poverty. Asian/Pacific islanders are served at a much lower rate than their representation in poverty-9.45% are in poverty, while they make up only 1.56% of the people served in Behavioral Health services. Latinos make up over 20% of the children and youth in poverty in the County, but they are only 8.32% of those served.

When taking into account the “Estimates of Need for Mental Health Services” (aka “prevalence rates”), as determined by the University of Texas Medical Branch, (http://psy.utmb.edu/p5profile%5Fhtm/California/p5wsmi01_ca007.htm) a similar picture is seen. In Children and Youth, Latinos and Asians show the highest disparity in services delivered. Based on estimated prevalence rates, 257 young Asians need services, but 37 received services; and 655 Latinos need services while 198 were served.

In Adults, the only group that is not served at a rate higher than its representation in the County Poverty Population is Latino, with Latino adults making up 13.65% of the adults in poverty, but representing only 5.5% of those served.

Based on prevalence, African Americans and Asian/Pacific Islanders are served at a rate only slightly lower than their rate of need. However, Latinos show a need of 966 cases while 202 were served.

In Older Adults, it can be noted that Asian/Pacific Islanders represent only 1.67% of the poverty population, but they are 12.53% of the population served through BCDBH services. Older adult whites are 90.63% of the older population in poverty, but they receive 79.29% of the services.

As a group, the older adults' estimated need is 2,022 people, while 367 older adults received services. All, except Asian, of the older ethnic groups are served at a much lower rate than the estimated need.

When comparing all age groups, adults are served at a rate of 7% higher than their representation in County Poverty Population, Children and Youth are served at a rate of 8% higher than their representation in the poverty population, and **Older Adults are served at a rate of 15% lower than their representation in the poverty population.** Older adults also show the most need for more services based on prevalence rates.

4. Identify objectives related to the need for, and the provision of, culturally and linguistically competent services based on the population assessment, the county's threshold languages and the disparities or discrepancies in access and service delivery that will be addressed in his Plan.

In the children and youth age group, Latinos and Asians have the most need, based on estimated mental health prevalence data, as compared to services provided.

The selected programs will address these disparities as part of the program activities. All efforts will be made to hire Latino and Asian staff to do outreach in their communities and to work within the two youth-serving programs being proposed for MHSA funding.

Having the 23-hour crisis stabilization program located in-county will prevent youth of all ethnicities from going out of county for crisis services. The availability of this local program will encourage families to access services without the fear that family members will have to leave the area and therefore become inaccessible to family support.

We will use peer specialists from Latino and Asian communities to work in the 23-hour program and assist with linkage between their communities and the program.

For adults, Latinos are the most in need of services. People of Latino ethnicity will be hired as staff to provide outreach and engagement in the Latino community, helping to assure that people know about the new programs, and will feel comfortable in accessing them.

For both youth and adult programs, Peer Specialists and youth workers will include Latinos.

As a group, older adults make up over 20% of the county population, but they receive less than 6% of the total services. Among the ethnic groups of older adults, all ethnicities except Asians are underserved. Older adult whites are served at a much lower rate than their population ratio. They make up over 90% of the older adult population, while only 79% of the county services to older people are to whites. Older adults state transportation to services as a major need. Transportation services to the 23-hour crisis stabilization program in Chico will be available for seniors.

Butte County Department of Behavioral Health (BCDBH) is a leader among rural California counties in providing culturally competent services through its Cultural Competence Advisory Team, insuring that all new programs are consistent with the Behavioral Health Cultural Competence Plan revised in March 2004. This plan has the following goals:

- An ongoing mechanism for gathering and analyzing data that accurately reflects the cultural needs of adults and children served and the community will be developed.
- BCDBH will continually assess and improve its capabilities to respond to all community members served by the agency.
- BCDBH will expand its efforts to recruit culturally competent staff.
- Staff with language skills will be culturally and linguistically competent with respect to mental health treatment concepts.
- BCDBH will be improved to provide culturally competent services at the community level.
- BCDBH programs will be held accountable for providing culturally and linguistically competent services.
- Consumer and family members will receive information of services available in Spanish, Hmong, Mien, Laotian and English.
- BCDBH and contract agency staff will enhance their understanding of consumers' cultures.

Section III: Identifying Initial Populations for Full Service Partnerships

1. Based on analysis of community issues and mental health needs in the community, identify which initial populations will be fully served in the first three years? Describe each population in terms of age and the situational characteristics described: youth in the juvenile justice system, transition-age youth exiting foster care, homeless adults, older adults at risk of institutionalization

Two of the three proposed programs will provide Full Service Partnerships for participants. These are: SEARCH South (homeless mentally ill) and LINK (Youth Center and Housing).

The SEARCH South program will serve 35 homeless mentally ill adults per year in the Oroville area, in full service partnerships. In addition, outreach will be conducted to 100 people per year. There is no program in Oroville to provide housing for homeless

people with mental health illnesses. The area has a high rate of poverty and the count of homeless people is estimated at 500, living in four major encampments.

The LINK program, a multi-service drop-in center and housing services for youth who are homeless or at risk of being homeless, aged 14-24 will serve the following:

- A multi-service Drop-in Center will host 10-20 youth per day for a total of over 4,000 visits per year
- Overnight emergency shelter will house 4-6 individual youth aged 14-18 per night. In one year, approximately 1,825 shelter nights will be provided (average of 5 youth sheltered per night)
- Overnight emergency shelter in motels will be provided for at least two youth aged 18-24 per night. In one year, 730 nights of voucher-paid motels will be provided.
- Funding for assistance to secure permanent housing and supportive services will be provided for 25 youth aged 18-24

2. Describe what factors were considered or criteria established that led to the selection of the initial populations for the first three years. (by age group, if applicable)

The Stakeholder Committee identified the needs for youth as: Housing/ Independent Living skills; Shelter & Permanent Housing, Consumer driven alternative to medical model; and Assessment, Counseling & non-residential Services

In addition, the Youth Work Group of the County's Homeless Task Force has been meeting for almost two years to identify ways to house and serve young people who are homeless. At a recent community forum on this topic the following information was delivered by Kathleen Kaiser, Professor of Sociology at Chico State University:

Poverty and the lack of affordable housing are the main cause of family homelessness. 36% of the people living in poverty are children and the poverty rate of 17.6% for children under 18 is significantly higher than for any other age group.

Domestic violence also leads to homelessness: 44% of the cities surveyed by the US Conference of Mayors in 2004 identified Domestic violence as a primary cause of homelessness. Nationally about half of all women and children who are homeless are fleeing domestic violence.

Homeless Youth: here the three prime causes are interrelated: family problems, economic problems, and residential instability. Many youth leave home after years of physical and sexual abuse, strained relationships, addiction of a family member and parental neglect. More than half in one study either said their parents told them to leave, or knew they were leaving and did not care. In a separate study, 46% reported being physically abused and 17% were forced into sexual activity by a family or household member.

Some youth are forced with their families into homelessness but then become separated by shelter, transitional housing or child welfare policies. These frequently restrict older, opposite gender children (male usually, from staying with a parent, who is receiving assistance).

A history of residential instability also is a major factor: foster care is correlated to becoming homeless at earlier age and remaining homeless longer. Some are aged out—too old for foster care but not receiving housing or income support. One national study noted that over 20% of the youth arriving at shelters came directly from foster care and over 25% had been in foster care the previous year.

The consequences for homeless youth are many and severe—trading sex for food, clothes, and shelter may be seen by them as their only means of survival. Drugs are a common form of exchange in these situations. Mental health indicators are much more prevalent (three times the rate of severe depression, conduct disorder, and PTSD among runaways) along with many physical health issues, including a much greater risk of HIV+ infection.

These are very serious consequences indeed for youth, whose access to services is severely constrained both by public policy and by their own issues and fears. Homeless youth may not fit our expectations or stereotypes: they are 13 yrs+ on average, with the majority around 15-16 yrs old. Most are female (52%), Caucasian (73%), and again they cite family conflicts as their number one reason for leaving home.

BCDBH, along with HUD, and the state Department of Mental health, has identified homeless mentally ill people as those having a critical need. For the adult homeless In Butte County there is no program for adults who are homeless and have a mental illness in the Oroville area. The homeless population is estimated to be around 500 individuals, with around a third having mental illness or a co-occurring disorder. The Butte Homeless Task Force has recently identified this area of the county as needing more homeless services, with the expansion of the SEARCH program in Chico as a logical first step to meeting the needs of this highly vulnerable population. This program will address the co-occurring disorder of substance abuse and mental illness that is expected in at least 60% of this population.

3. Discussion of how Butte County selections of initial populations in each age group will reduce specific ethnic disparities in Butte County.

In the selected programs strategies to reduce ethnic disparities will be interwoven into the program activities. The primary method to conduct outreach to and serve ethnic populations will be to have members of ethnic communities work on staff in the selected programs. For youth, the primary need is within the Latino and Asian communities. All efforts will be made to hire Latino and Asian staff to do outreach and work in the two youth-serving programs being proposed for MHSA funding.

Having the 23-hour crisis stabilization program located in-county will prevent youth of all ethnicities from being sent out of county for crisis services. The availability of this local program will encourage families to access services without the fear that family members will have to leave the area and therefore become inaccessible to family support. We will use peer specialists from Latino and Asian communities to work in the 23-hour program and assist with linkage between their communities and the program.

The LINK program for homeless youth will also be a primary service that keeps young people of all ethnicities near their families, encouraging reunification.

For adults, Latinos are the most in need of services. People of Latino ethnicity will be hired as staff to provide outreach and engagement in the Latino community helping to assure that people know about the new programs, and will feel comfortable in accessing them.

For both youth and adult programs, Peer Specialists and youth workers will include Latinos.

Section IV: Identifying Program Strategies

No separate response is required in this section, because it is in Exhibit 4-Program Work Plan Summary

Section V: Assessing Capacity

1. Analysis of Butte County Behavioral Health and service provider strengths and limitations in terms of capacity to meet the needs of racially and ethnically diverse populations in the county. Address the bilingual staff proficiency for threshold languages.

BCDBH staff are aware of the location of the ethnic and linguistic population bases within the County. Spanish is the only threshold language in the County; however, there are growing numbers of Southeast Asian beneficiaries, particularly Hmong. For this reason, whenever reasonable, Hmong is treated as a threshold language and the same efforts are put forth as are with Spanish language needs. In addition, there are African American and Native American beneficiaries in the County. The majority of Native American consumers receive their behavioral health services from Feather River Tribal Health, one of BCDBH's contractors. The Department works to recruit and hire bilingual/bicultural staff. Mental Health Counselor and Health Education Specialist are the classifications offering the most flexibility in hiring. It is into these direct service categories that individuals who are at a non-licensed, paraprofessional level can most easily be engaged. In the new category of Peer Specialists, even more progress will be made in this effort.

BCDBH continually explores ways to increase the pool of qualified, ethnic staff. One recent approach has been to include stipends in a SAMHSA grant application that will

provide paid internships for students at the junior college, university, and graduate levels. This training opportunity is expected to result in a greater number of bi-lingual/bi-cultural clinicians qualified to fill positions within the department and in their communities.

The total BCDBH staff and contractor bilingual ability is listed in the BCDBH Cultural Competence Plan as: Speakers of Spanish 53, Speakers of Hmong/Mien/Lao 13, and Speakers of Lakota 1. The literacy ability of the staff and contractors is 21 in Spanish and 6 in Hmong/Mien/Lao.

The Department also maintains a translator pool of contractors to be called on when the consumer and clinician’s languages are not the same. The chart below reflects the language capacity of current contracted translators for:

<u>Language Spoken:</u>	<u># of Translators who Speak</u>
Hindi	1
Hmong	4
Laotian	4
Mien	2
Punjabi	1
Spanish	3
Urdu	1

Additionally, the Department has one local ASL translator on contract and also a contract for all hearing impaired services with NorCal Center on Deafness. For emergency and urgent care situations, the AT&T Language Line is used.

Gridley is the primary agricultural center of Butte County. Twice as many Latino consumers live in South County (including Gridley and Oroville) than do in North County (Chico, Paradise). BCDBH opened a service center in Gridley – the Gridley Counseling Center -- making behavioral health services more accessible. BCDBH co-locates adult, older adult, and youth services in the Center. Additionally, BCDBH provides space to various community programs including Public Health, which provides health education in the area of STDs, and the Prevention Education Program which provides classes in Spanish, for individuals who have been arrested for drunk driving. The Center has been designated as a SafeHaven by Catalyst Domestic Violence Services, and perhaps more importantly the Department provides access for community self-help groups. Space is available at the Gridley location well into evening hours to accommodate the working schedule of local residents.

DBH made a major commitment to adapting facilities to the diverse cultural backgrounds of county residents to assure their comfort as they access mental health services. Over the course of two years nearly ten thousand dollars was spent on the acquisition of multicultural art to be placed in all consumer lobbies. Consumer lobbies

currently hold at least one piece of artwork from the Department's Latino, Southeast Asian, African American, and Native American collections. Whenever possible, the purchase of pieces was from local artists in efforts to support their work. Every two years all pieces are brought back into the administrative office of the Department and put on display for all to enjoy and for each site to choose new pieces for their areas. In this fashion the art is rotated providing the greatest exposure to all consumers and staff.

2. Assessment and comparison of the percentages of culturally, ethnically and linguistically diverse direct services providers as compared to the same characteristics of the total population who may need services in the county, and the total population currently served in the county.

DBH recently conducted a study focused on the "dosage" of service that consumers of Latino heritage receive as compared to the dosage of service that Caucasian consumers receive. "Dosage" was defined as the amount of direct service a consumer receives once admitted to the behavioral health system. The study, commonly known as the **Latino Access Study**, was conducted in response to requirements of County Mental Health Plan contracts for fiscal year 2002/03. As referenced in the contract language, DBH chose "to develop an access study that includes Latino and other underserved populations, rather than a study that focuses exclusively on Latino populations". Department administrators recognized the opportunity to not only analyze services to the Latino constituents of Butte County, but to those of African American, Native American, and Hmong consumers as well. One of the assumptions inherent in this study was that the dosage of service received by consumers would conspicuously differ based on ethnicity and language. Preliminary findings suggested that there does not appear to be a significant difference in terms of service dosage based on ethnic and linguistic designation. However, there was a moderate difference with regard to the dosage that was manifested by those consumers who spoke English as compared to those who spoke Spanish. This observation warrants further inspection, and is currently in process through the efforts of the Ethnic Services Coordinator, the Cultural Competence Advisory Team, and the Quality Improvement Committee.

In addition to direct services offered by staff of the Butte County Department of Behavioral Health (BCDBH), the Department contracts with several agencies across the County for the provision of specialty mental health services. The ethnic and language capabilities of both the BCDBH and contract providers staff is listed and analyzed in the BCDBH Cultural Competence Plan as updated in FY2003-2004. The total staff by ethnicity are: 36 African Americans, 73 Latinos, 46 Native Americans, and 43 Asian/Pacific Islanders. Of those, 16 are in Administration/Management, 140 provide direct service, and 42 provide support services.

A service penetration rate analysis is detailed in the BCDBH Cultural Competence Plan. This provides the mental health service rates for Butte County Medi-Cal eligible individuals. The rates by ethnicity are shown in the following chart.

PENETRATION RATES BY ETHNICITY AND MEDI-CAL BENEFICIARY POPULATION

	<u>County Population</u>	<u>Percent Of Population</u>	<u>Medi-Cal %</u>	<u>Medi-Cal Eligibles</u>	<u>Medi-Cal Consumers Served</u>	<u>Medi-Cal Penetration Rates</u>	<u>Staffing * Profile</u>	<u>Staffing %</u>
Latino	20,320	9.3	31%	6,399	123	1.9	62	4.4%
African American	2,886	1.3	54%	1,549	145	9.4	36	2.6%
Native American	3,445	1.6	26%	879	73	8.3	46	3.3%
API	9,944	4.4	40%	3,997	73	2.1	43	3.1%
White	182,155	83	19%	34,937	3,472	9.9	1,190	84.6%
Other**				3,152	485	15.4	29	2.1%
Total	218,750		23%	50,913	4,371	8.6	1,406	15.4%

*Includes DBH and contract staff

**Other represents individuals who do not identify with the ethnic and linguistic categories offered, or if the information is missing

3. Analysis and discussion of the possible barriers our system will encounter in implementing the programs for which funding is requested in this Plan and how we will address and overcome these barriers and challenges.

The most challenging area will be in the area of human resources. Staffing of county programs is always time-consuming due to the required adherence to personnel processes in place for hiring. BCDBH has a long history of funding through grants and other fluctuating sources, creating an ongoing familiarity with the personnel system and proactive methods to predict and respond to the necessary requirements. A good relationship with the Personnel Department assists in meeting this challenge.

To coordinate the start up the MHSA programs, an MHSA Coordinator will be hired. This position has been approved and a qualified person will soon be identified. This full-time coordinator will be in charge of ensuring timely implementation of all MHSA programs and assisting program staff with start-up activities. Over time the department will grow the number of culturally competent providers through outreach to local ethnic communities and stipends supporting educational opportunities in the mental health field.

The challenge in reducing ethnic disparities is present in the fact that, typically, the pool of applicants is not ethnically diverse and proficient in Spanish and Hmong. In all programs it will be difficult to find staff with these qualifications. The existing Cultural Competence Team will be asked to assist in this area, identifying potential candidates for MHSA program positions.

Section VI: Developing Work Plans with Timeframes & Budgets/Staffing

I. Summary Information on Programs to be Developed or Expanded

- 1) *Complete Exhibits 1, 2, 3 showing summary of detailed work plans. (see below)*
- 2) *Show that the requirement to use at least 51% of the total three-year CS&S funding for Full Service Partnerships has been met.*

Two of the three proposed programs will provide Full Service Partnerships for participants. These are: SEARCH South (homeless mentally ill) and LINK (Youth Center and Housing). The total CS&S funding for these two programs for the three years is: \$2,673,712 or 65% of the total \$4,116,787 three-year MHSA CS&S funding.

- 3) *Estimated number of individuals expected to receive services through System Development Funds for each of the three fiscal years and how many of these individuals are expected to have Full Service Partnerships each year.*

All services will be provided with either Full Service Partnership funding or Outreach and Engagement funding.

- 4) *Estimated unduplicated count of individuals expected to be reached through Outreach and Engagement strategies for each of the three fiscal years and how many of those individuals are expected to have Full Service Partnerships each year.*

The 23-hour crisis stabilization program will be funded with Outreach and Engagement funds. Because this program does not exist now, there is no outreach to people who are in need of a short-term crisis stabilization. They are unserved in the county behavioral health system. The main purpose of the program is to reduce the number of people who are placed in the Psychiatric Health Facility and divert those experiencing mental health crisis from hospital emergency rooms.

The program will accommodate six people at one time. If the program is full every day, a total of 2,190 individuals will be served in a calendar year (6 x 365 days). However, some days there will be more than six people served, because the crisis will be alleviated in less than 23 hours. With this in mind, the program may serve over ten people per day, for a total of 3,650 visits per year. About 25% of those are expected to be repeat individuals, making the unduplicated count 2,737 in a year. The age and ethnic percentages are expected to be similar to the county demographic breakdown.

Although some of the people served in the 23-hour crisis stabilization program will be expected to have Full Service Partnerships because they are served in the existing BCDBH ROOF, SEARCH, SMILE, and Youth Compass programs, it is not expected that these will be the primary users of this service.

5) Describe Wraparound programs for children, youth and families that are in place, under development, and/or to be developed.

Youth Services Division of BCDBH has implemented a children's system of care program for over ten years. The goals of these culturally competent services are to keep children at home, in school, clean and sober, and out of trouble. Youth Services provides mental health services to more than 2,000 youth and their families, in collaboration with contract providers and local county agencies. Youth Services has a budget of around \$13 million, which is over one third of the \$35 million BCDBH budget.

Very recently, Youth Services has been successful in being awarded over \$8 million to enhance the existing system of care services. The new program, known as Connecting Circles of Care, will provide a complete system of care through wraparound services for children with severe emotional disturbance and their families, in a family driven, strength based, and culturally competent delivery of evidence-based practices. It is an innovative partnership of a family run organization, Native American tribal organization, and BCDBH. All communities of Butte county will be brought into an effort to develop: 1) early intervention and family strength-based treatments for severely emotionally disturbed youth; 2) Family run organization involvement in planning and process; 3) Meaningful and useful evaluation; 4) Cultural acuity through family involvement and competence training; 5) Family crisis identification and effective wraparound service provision.

II. Programs to be Developed or Expanded (must provide information for **each** program)

1) *Complete Exhibit 4 to give summary of program, and funding types, by age group.*

Program Work Plan Name: 23-Hour Crisis Stabilization Program

Estimated Start Date: July 1, 2006

Description of Program: This program will provide stabilizing mental health services for consumers experiencing acute psychiatric symptoms, to determine if hospitalization is necessary, to avoid hospitalization if it is not necessary, and to refer to care services.

Priority Population: Any community member in need of psychiatric crisis services, especially those who receive hospital emergency room services, or who have contact with law enforcement agencies. The program will provide services to older adults, adults, and youth who are in acute mental distress.

Strategies to be used: By providing a calming and stabilizing environment for up to 23 hours, consumers will have the ability to remove themselves from the crisis environment and begin to explore ways to return to a stable condition.

- The Program will be open 24 hours per day 365 days per year, located on Rio Lindo Avenue in the existing Behavioral Health complex in Chico.
- Access to the program will be available to consumers who walk-in, from 8:00 a.m.-midnight; and 24 hours a day to Behavioral Health Case Managers who have received calls for help from existing consumers, to Law Enforcement officers, and to hospital practitioners.
- A mental status evaluation will be conducted by on-site staff to determine if admission to the 23-hour crisis stabilization program is appropriate and safe.
- Medical stabilization services will be provided by the local Butte County hospital Emergency Rooms.
- Staffing will include at least one licensed RN, and one licensed mental health clinician or case manager each shift.
- A comfortable waiting area will be available.
- Children and adults will be separated at all times.
- Consumers needing acute hospitalization will be transferred to the nearby Psychiatric Health Facility or another acute inpatient facility where a bed is available.
- A connection with the consumer's Case Manager, or with an intake appointment in existing programs will be made before consumer leaves the program.
- Family members will be invited to assist in the design of the client's care plan, when appropriate.

Funding Types: Outreach and Engagement, Medi-Cal, Private Insurance, grants.

Age Groups: All ages (Children/Youth, Transition Age Youth, Adults, Older Adults)

2) Detailed description of the proposed program using MHSA funding and how the program advances the goals of the MHSA.

The program is an alternative to psychiatric hospitalization, and to inappropriate use of the hospital emergency rooms. Keeping people at home, in a familiar setting rather than in a hospital is a primary goal. In addition, the program will provide an alternative to putting people in jail when they have a mental health related crisis, which requires law enforcement intervention.

The program will provide short-term respite to families of clients in psychiatric crisis, be a deterrent to removing children from the home, and will reduce out of county placement of youth and children in acute psychiatric hospital beds. At this time, there is no acute psychiatric inpatient facility to treat children in Butte County. Children requiring inpatient psychiatric placement are placed out of county. The closest facility is in Sacramento, over 90 miles away.

The program will accommodate six people at one time, with a staff ratio of at least 1 to 4 consumers. The program will be open to two children and four adults at one time. If the program is full every day, a total of 2,190 individuals will be served in a calendar year (6 x 365 days). However, some days there will be more than six people served because the crisis will be alleviated in less than 23 hours. With this in mind, the program may serve over ten people per day, for a total of 3,650 visits per year. About 25% of those are expected to be repeat individuals, making the unduplicated count 2,737 in a year. The age and ethnic percentages are expected to be similar to the county need estimates (prevalence) and demographic breakdown.

Accessing Program Services: Existing consumers who are served by the SEARCH Program (AB 2034 homeless mentally ill), by the ROOF and SMILE programs (chronic and severe mentally ill adults), and HERE (homeless runaway program for youth), will contact the existing crisis phone line when a crisis occurs, at any time of the day or night. These programs have case managers with the capability of visiting the consumer in his/her home, or wherever they are in the county. If the case manager is not able to relieve the situation, the consumer and case manager may determine that the 23-hour crisis stabilization program is the appropriate referral resource.

In addition, all existing consumers in both Adult and Youth Outpatient, are connected with a case manager or clinician who knows the consumer and whether in-patient hospitalization would be necessary or if the consumer's crisis could be handled at a lower level of care, such as the 23-hour crisis stabilization program.

If the caller is not a known consumer, therefore not assigned a case manager or clinician, between midnight and 8:00 a.m., she/he will be asked to either call "911" for assistance, or to meet a Behavioral Health mobile crisis response staff at the local hospital emergency room in the community. Between 8 a.m. and midnight consumers in need of crisis services can walk into the current Crisis Services program and be

evaluated for level of service need, and if appropriate referred into the 23-hour stabilization program. The crisis phone line is operational 24 hours per day to guide callers through the service access process.

Assessment: An RN, or Clinician will conduct an assessment when a consumer enters the program, using a four-page “Crisis Stabilization Services Intake Assessment” form. General areas included will be: Presenting Problem and Diagnosis, Orientation of Consumer, Vital Signs, Medical History, Mental Health History, Allergies and Current Medications, Initial Mental Status Exam, Substance Use History, and Additional Impressions. The individual’s service history will be viewed on the Behavioral Health electronic data base system.

Treatment: During the 23 hour stabilization period, the consumer can speak with and be observed by health professionals within a calming, safe environment where she/he, can rest and stabilize. The assessment performed will determine the specific treatment needs of the consumer that will be monitored and addressed while served by the 23-hour stabilization program. Conditions evaluated and treated might include: depression and suicidal ideation, mania, self-harm, homicidal ideation, poor adherence to medication regimen, poor outpatient follow-up, and existing mental conditions complicated by substance/alcohol abuse, chronic health problems that exacerbate mental status changes, and threatened or absent housing.

Disposition Planning: The consumer will participate actively in the development of the aftercare plan, which begins upon admittance to the program. The planning will include referral to such areas as:

- Short-term living accommodations
- Connection with an outpatient mental health provider for prompt follow-up
- Substance abuse treatment referrals
- Referral to a medical provider for follow-up care
- Social Services Eligibility Worker for Emergency Financial Support
- Patients’ Rights Advocate
- Re-Connection with family members
- Long-term housing options

3) Housing or employment services to be provided.

Determination of a safe housing location will be made before consumers leave the program. If the person does not have a safe home to return to, existing shelters (Jesus Center, Well, Torres Homeless Shelter, Mission) will be accessed. Motel vouchers will be available for vulnerable consumers in need of stable housing while attending initial clinical and case management services, if they are not able to stay in one of the existing shelters. This will provide a safe place during the period immediately after the 23-hour stabilization service, while the consumer accesses the services identified in her/his care plan.

When a consumer is in need of financial assistance, a case manager within one of the outpatient programs may provide a referral to the existing job program, provided by a contract agency – Caminar, Inc. In partnership with the Butte County Department of Employment and Social Services, an eligibility staff will be contracted to work with program participants, assisting them with benefits eligibility including Medi-Cal, Medicare, CMSP, and General Assistance. Local educational and job training programs are also referrals available to consumers.

4.) Average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

This program does not appear to meet the definition of full service partnership. However, the cost per participant in the program can be determined. The cost per participant will be \$500.00 (based on 2,737 unduplicated participants per year=5,474 for two years, and a total two-year grand total budget of \$2,734,339)

5) How the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. How we will ensure the values of recovery and resiliency are promoted and continually reinforced.

Consumers with active Wellness, Recovery, Action, Plans (WRAP) in place that include the 23-hour crisis stabilization program as a requested option when in crisis, will be admitted to the program when their crisis meets that level of care. Consumers will be encouraged to develop a WRAP plan while participating in all BCDBH programs in order to make decisions about care during crisis. These plans will be included in their charts and a copy will be on-file at the 23-hour crisis stabilization program to ensure ease of access for these consumers to the program.

The 23-hour crisis stabilization program will provide consumers with information that will teach and empower them to participate fully in their treatment and self-sufficiency. The goal of the teaching process will be to give consumers the ability to take charge of their own healing journey. “Peer Specialists” will provide support to consumers while in the 23-hour crisis stabilization program, and will assist with providing hope and a belief in recovery from their illness.

The “whole person” approach will be the basis of the care plan, by including independent living areas such as housing and income, as well as mental health and substance addiction treatment. Rather than treating symptoms only, the participant’s skills, abilities and capacity will be tapped to develop personal growth and recovery.

The exit plan for all participants will be made with the full participation of the consumer, including youth and children, and their families. Staff will be trained in methods for increasing resiliency in children. Children and youth will be referred to the Behavioral Health Prevention programs including Friday Night Live and Club Live, where Youth Development strategies encourage resiliency.

6) If expanding an existing program, description of the existing program and how it will change under this proposal.

The 23-hour stabilization program is a new program.

Currently case managers from the SMILE, ROOF, SEARCH, and HERE program are on-call 24-hours per day for consumers in their programs. The Mobile Crisis Team is on-call 24-hours per day for community members in crisis who are currently not receiving services. Specialty programming for older adults, Senior Connections, is provided in each of the four main cities in Butte County.

7) Description of services and supports clients and/or family members will provide. (Will clients/family actually run the service or are they participating as a part of a service program, team or other entity?)

Family members will be included in the creation of the aftercare plan, either in person or by telephone. If they are not able to participate within the 23 hours, contact with them will be included in follow-up activities, when appropriate, upon release from the program. BCDBH will employ "Peer Specialists" in the program through a contract with Caminar. Peer Specialists are consumers who have completed a 16-week training, and have received certification to provide support and recovery counseling services to individuals throughout the department.

8) Collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explanation of how they will help improve system services and outcomes for individuals.

The key collaborative partners will be the four local hospitals in Chico, Oroville, Gridley and Paradise; and law enforcement agencies-four city police departments, Highway Patrol, the county Sheriff's Department, and Passages Adult Resource Center. Response roles will be clearly determined, and procedures will be mutually agreed upon. Existing mobile response procedures in conjunction with law enforcement and hospitals will be used to respond to crisis events from midnight to 8:00 a.m. A contract with the County Department of Employment and Social Services will provide an eligibility staff to help participants with financial assistance.

9) Discussion of how the program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. How the program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The program will have a translator phone service available 24 hours per day. When a consumer and his/her family speak Spanish or Hmong, a staff member fluent in the

appropriate language will accompany the consumer and case manager to meet with the family members regarding the aftercare plan.

Outreach to all ethnic communities regarding this program will be achieved through Behavioral Health Peer Staff and program staff who have an established, on-going relationship with the Native American, Latino, African American, and Hmong communities. They will emphasize the voluntary nature of the program, and the participation of family members. Consumers who are from these cultures will be encouraged to become Peer Specialists and provide support services to consumers at the 23-hour crisis stabilization program. They will emphasize the voluntary nature of the program, and the participation of family members.

The 23-hour crisis stabilization program will be decorated with artwork from Asian, Native American, African American, and Hispanic American heritages to help all participants feel welcomed.

10) How services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

In this program, staff will include licensed mental health professionals, specialists in co-occurring illnesses, peers and family members hired as staff, and licensed medical staff for physical health evaluation, medication administration and assessment. Family and peer partners hired as staff will assist in outreach and support to families and individuals in crisis. All staff will have on-going training in the best practices of intervention for all the county's populations; including children and youth, transition-age youth, adults, older adults, and ethnic groups to include Latinos, Southeast Asians, Native Americans, and African Americans; and gay, lesbian, bisexual, and transgender (GLBT) people. Outreach to the GLBT community will be conducted through the Stonewall Alliance non-profit organization serving this population.

Male and female counselors will be available to work with consumers, and referral to contracted GLBT specialist counselors will be made based on consumers' needs.

11) How services will be used to meet the service needs for individuals residing out-of-county.

The 23-hour crisis stabilization program is not applicable to this population.

12) If selected strategies are not listed in Section IV, describe how they are transformational; and how they will promote the goals of the MHSA.

The strategy selected is a crisis treatment alternative, designed to avoid placement on the PHF or in jail, as listed in Section IV.

13) Timeline for this work plan, including all critical implementation dates.

Completion Date	Activity
March 1, 2006	Recruit and hire staff
May 1, 2006	Conduct collaborative meetings with law enforcement and hospitals to design procedures and develop MOU's
July 1, 2006	<ul style="list-style-type: none"> • Provide staff training in crisis stabilization, using a recovery model • Create scheduling plan
June 30, 2006	Purchase program supplies and furnishings
July 1, 2006	Open The 23-hour crisis stabilization program
December 1, 2006	Complete local program review and prepare remaneuver plan with collaborative partners

14) Budget Request (23-hour crisis stabilization)

Grand Total (all funding sources)

Year One	Year Two	Year Three	Three-Year Total
\$133,150	\$1,192,613	\$1,408,576	\$2,734,339

MHSA Total Only (Includes Administrative Costs)

Year One	Year Two	Year Three	Three-Year Total
0	\$602,826	\$631,854	\$1,234,680

Budget Narrative:

Staffing: The staffing will include all positions necessary to meet the program goals and provide the 1 staff to four clients ratio on a 24/7 basis. Staff positions will be:

- 1 Supervising Mental Health Clinician
- 5 Mental Health Clinician interns
- 4 Senior staff nurses
- 1 Medical Records Technician
- 2 Mental Health Clinician interns
- 2 Staff nurses

Peer support: 8 part time peer specialists will provide support to clients as they stabilize and make plans for further recovery in the community.

Eligibility support: A .5 FTE Social Worker will be contracted under the Department of Employment and Social Services to dedicate time for clients who are in need of resource eligibility after their crisis has stabilized.

Housing: If clients are in need of housing when they leave the program, their case manager will be able to access the Housing Subsidy to provide rental assistance, deposit, and first and last months' rent.

Food: While clients are in the program, they will be provided with snacks through a contract with a local job program.

Substance abuse treatment: When clients are in need of specialized treatment for substance addiction, contracts with drug and alcohol treatment providers will be provide either residential or out-patient services.

Training: Staff and peer specialists will receive training on gay, lesbian, bisexual, and transgender issues to learn the needs of this population. This training was identified as being needed in the agency.

General program expenses: Operations of the program will require travel, training, and general supplies for staff.

II. Programs to be Developed or Expanded (must provide information for **each** program)

1) *Complete Exhibit 4 to give summary of program, and funding types, by age group.*

Program Work Plan Name: SEARCH South (Support, Employment, Assistance, Recovery, and Consumer Housing Program)

Estimated Start Date: July 1, 2006

Description of Program: This program will expand the highly successful Chico AB2034 program model to the Oroville area where there are currently no services targeting homeless people with mental illness. As the program title states, the program will outreach to homeless mentally ill to provide support, employment, assistance, recovery and housing.

Priority Population: Homeless adults with mental health problems and co-occurring disorders (substance abuse and mental illness) will be the population served in this program.

Strategies to be used: Outreach to homeless people will be conducted by a team made up of paid mental health services consumers and mental health staff. People will voluntarily enter the program becoming “members” of the SEARCH team, and be provided with a care plan to suit their needs. These needs may include medication support, job training and acquisition, substance treatment, housing, transportation, clothing, food, and any other service necessary to help the person stabilize and eventually enter an independent, safe housing environment. In addition, members will be part of a community of peers and professionals that will encourage individuals to seek and meet their own goals.

- Outreach to the existing homeless services, such as the Mission and the Community Action Agency, will be conducted.
- Outreach to the homeless camps in Oroville will be a high priority.
- A Drop-In/Service Center will provide a safe and welcoming area for homeless people to use for services and for a safe place away from the risks of the camps.
- A registered nurse will be available to assess consumers’ health, attend to their minor physical health needs, and provide health education and referrals.
- Pet boarding, veterinary services, and pet food will be available.
- Services will be: outreach, assessment, case management, home visitation, clinical treatment, substance abuse recovery, 24 hour mobile response, job training, medical, and self help/self sufficiency support.

Funding Types: Full Service Partnership

Age Groups: Adults, Older Adults

2) Detailed description of the proposed program using MHSA funding and how the program advances the goals of the MHSA.

In this collaborative initiative, the combined efforts of multi-agency teams will provide a wrap-around continuum of service for the mentally ill and dually diagnosed who will live in independent supported housing. Team members include law enforcement, a job program, local landlords, and existing homeless shelters and food services. Depending on need, service categories available will be: outreach, assessment, case management, home visitation, medical, clinical treatment, substance abuse recovery, 24 hour mobile response, job training, and self help/self sufficiency.

The program, based on the AB2034 program operating in the Chico area, will provide an array of services to homeless mentally ill consumers in the Oroville area, where currently there is no program to serve this population. BCDBH will be the lead agency in the provision of services based on an assessment of consumer needs which is conducted by clinical and social model staff, using a recovery model philosophy and methods. In Chico, BCDBH has successfully operated this program for five years, providing mental health treatment, drug and alcohol programs, residential psychiatric services, medication support, and specialized treatment programs for the homeless mentally ill and mentally ill offenders. Case management provided by BCDBH staff and Peer Specialists will include assistance with:

- Obtaining needed services including medical, dental, optical, mental health, education, vocational
- Accessing community support services such as transportation, libraries, affordable entertainment, AA/NA, and recreation.
- Advocacy regarding health benefits, disability or legal issues
- Managing funds and/or developing budgeting skills
- Developing independent living skills
- Personal hygiene
- Food and clothing
- Development of interpersonal skills
- Medication education, monitoring, and delivery
- Obtaining income or entitlements such as employment, SSI, GA, VA benefits, Medi-Cal, Medicare, Food Stamps

Outreach is a key component of this program. Various locations where homeless people live have been identified as areas to approach.

Consumers in the program will be served on a long-term basis. In the specialized supportive services program, each member will assist in the development of their individualized recovery plan. They will be in contact with staff at least twice each week at the beginning of services, with some people having daily contact until they are stabilized in housing. The SEARCH program is currently tracking and evaluating the existing program in Chico, and is therefore very familiar with the techniques and requirements of the AB2034 evaluation plan. A similar tracking and evaluation process

is anticipated in Oroville, in conjunction with the state evaluation requirements. Generally the program tracks real time employment, housing, criminal activity, and hospitalization (both psychiatric and physical health). Daily staff meetings will be held to assess the effectiveness of weekly contacts with consumers. Consumers and their Personal Service Coordinator will review their goals to determine if they are making progress. Peer Specialists will orient new members to the program and serve as role models, providing a consumer orientation to the program at all times.

Access to all behavioral health and other services is available to clients through home visits by staff and visits to service centers. The City of Oroville has a well-developed bus system that thoroughly accesses every section of the city. Taxi service for disabled people is available. In addition, Oroville has train and long-distance bus service that is available at easily reached departure points. This enables people without cars to visit their families, to access services in all areas of the county, and to travel to jobs outside of the town in which they live. This ability to move around to services is important to this program for people who have no personal transportation available. Low cost bikes will be made available to all members through the existing bike repair program sponsored by the SEARCH Program in Chico.

Three Personal Service Coordinators (PSC's) will be hired on full-time status, dedicated to the identified client population. Each PSC can be assigned up to 12 consumers at a time. Also, two consumer Peer Specialists will be part of the team to do outreach to homeless people, and help with the needs identified by each participant, in conjunction with the PSC's.

3) Housing or employment services to be provided.

Determination of a safe housing location is the primary focus of this program, and will be made as soon as a participant is willing to live in an apartment or motel (temporarily). In Oroville, the Mission is the emergency shelter available to people who can follow the rules of the location. A relationship with local motels will serve the immediate housing needs of homeless mentally ill persons living in Oroville. Motel vouchers will be available for a three-night stay for vulnerable consumers in need of, and desiring, stable housing while engaged with their PSC, if they are not able to stay in the existing shelter. Relationships with landlords have been developed and will continue to provide permanent housing for consumers when they are ready. Funding will be available for the first month's rent, deposit, and on-going rent until the tenant receives established funding to support the lease.

When clients are identified and admitted into the SEARCH South program they will also be assisted with employment and other stable income sources. They may qualify to work in the Apartment Maintenance Program described below, or as a Peer Specialist in the program.

When a consumer is in need of financial assistance, a Personal Service Coordinator will provide a referral to the existing job program, provided by a contract agency-Caminar.

A consumer can also receive help to access General Assistance funds, SSI, and Medi-Cal. Local educational and job training programs are also available to consumers through Butte Community College.

The Apartment Maintenance Program (AMP), developed by BCDBH, has experienced tremendous success and has been critical to the development and maintenance of permanent housing in the community. Work crews of trained and paid consumer staff are dispatched regularly to do maintenance to apartments, some of which have been occupied by BCDBH consumers. This has proven effective in encouraging landlords to continue to rent to BCDBH consumers, thus keeping units available that they might otherwise rent to tenants who do not pose as much of an economic risk. SEARCH South participants will be eligible to work in this program through a contract with a local program that provides jobs and job training to people with disabilities. Social enterprise programs (employment development) may be developed to meet the specific needs of the SEARCH South program members.

4) Average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

Total cost for each Full Service Partnership participant in the SEARCH South program will be \$24,054. (Based on 35 participants in each program year=70 and \$1,683,751 two year program costs. Approximately 150 additional people will receive outreach, assessment, and referral services through this program; these are not Full Service Partnership participants.

FFP (Medi-Cal)	\$0	\$78,745	\$91,896	\$170,641
Total Cost to MHSA	\$0	\$709,651	\$782,981	\$1,492,633

5) How the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. How we will ensure the values of recovery and resiliency are promoted and continually reinforced.

The recovery plan for all participants will be made with the full participation of members. Staff will be trained in the recovery model and the methods that are most beneficial to homeless people having mental illness. The SEARCH South program will provide members with information which will teach and empower them to participate fully in their treatment and recovery. The goal of the teaching process will be to give members the ability to take charge of their own healing journey.

The “whole person” approach will be the basis of the ongoing recovery plan, by including independent living components such as housing and income, as well as mental health and substance addiction treatment. Rather than only treating symptoms, the participant’s skills, abilities and capacity will be tapped to develop personal growth and recovery.

6) If expanding an existing program, description of the existing program and how it will change under this proposal.

This is an expansion of the existing SEARCH program, funded by AB2034 monies. The current program, which serves at least 50 persons per year, is active in the Chico area, serving homeless people who camp along Chico's creeks and in the large Bidwell Park. The SEARCH program in Chico provides a full array of housing, employment and mental health services. This program will not change; it will continue under its existing structure.

The expansion of the program to the Oroville area will operate with the same goals as the Chico program, serving approximately 35 individuals per year.

7) Description of services and supports clients and/or family members will provide. (Will clients/family actually run the service or are they participating as a part of a service program, team or other entity?)

The homeless population often does not have family members who are able or willing to participate in the support of the person being served; or the participants may choose to not involve family members. However, a broad definition of "family member" will be used to determine if there are people who could help in the support of the participants' recovery. At the participants' consent, they will be included in the creation of the ongoing recovery plan, and provide support functions as appropriate.

The program will incorporate two Peer Specialists to work with Personal Service Coordinators and the members, especially during outreach and when on-going support activities are appropriate.

8) Collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explanation of how they will help improve system services and outcomes for individuals.

A network of cooperative landlords has been developed in Oroville; to provide housing when members are ready to accept this type of living environment.

The SEARCH South team will collaborate with the Oroville Homeless Task Force to get input on and identify the challenges of working with the homeless population in the Oroville area. Through this group we will be able to develop relationships with those community leaders, and homeless people who can most assist us in program implementation.

SEARCH South staff will contact local law enforcement in order gain their assistance and expertise in working with the homeless population in Oroville. A good working relationship with law enforcement has already been established by the Department of Behavioral Health currently working in the South County.

Other agencies which are BCDBH partners and the services they will provide are:

- Butte County Department of Employment and Social Services-job training, employment placement
- Legal Services of Northern California-legal assistance
- Del Norte Medical Clinic-medical services
- Butte County Department of Public Health – HIV/AIDS testing, counseling and education
- The Mission–meals, emergency shelter, and spirituality
- Skyway House–substance abuse treatment
- Butte County Veterans Services–general support for veterans
- Department of Rehabilitation–employment services
- Caminar–employment training and job coaching, apartment maintenance program
- Patients’ Rights-advocacy for the mentally ill
- Housing Authority of Butte County–affordable housing
- Private landlords

9) Discussion of how the program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. How the program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

The program will have a translator phone service available 24 hours per day. When a member and his/her family speak Spanish or Hmong, a staff member fluent in the appropriate language will be available to work on the recovery plan with members.

Outreach to all ethnic communities regarding this program will be achieved through Behavioral Health Peer Staff and program staff who have an established, on-going relationship with the Native American, Latino, African American, and Hmong communities. They will emphasize the voluntary nature of the program, and the participation of family members.

The SEARCH South offices and program areas will be decorated with artwork from Asian, Native American, African American, and Hispanic American heritages to help all participants feel welcomed.

10) How services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

In this program, staff will include licensed mental health professionals, specialists in co-occurring illnesses, peers and family members hired as staff, and licensed medical staff for physical health evaluation, medication administration and assessment. Peer partners hired as staff will assist in outreach and support to individuals in crisis. All staff

will have on-going training in the best practices of intervention for all of the program’s populations; including transition-age youth, adults, older adults, and ethnic groups to include Latinos, Southeast Asians, Native Americans, and African American; and gay, lesbian, bisexual, and transgender (GLBT) people. Outreach to the GLBT community will be conducted through the Stonewall Alliance non-profit organization to encourage homeless adults to access this program. The outreach process will be inclusive and encourage access based on program criteria.

The SEARCH program in Chico has served 41 women and 80 men since its inception in 2001. Outreach contact has been made with 213 women and 356 men, showing an engagement rate of around 20% for both women and men. Male and female counselors will be available to work with members, and referral to contracted GLBT specialist counselors will be made based on members’ needs.

11) How services will be used to meet the service needs for individuals residing out-of-county.

The services of the SEARCH South program will be primarily for people who are homeless in the Oroville area. If a person with mental illness, from this area, is without a home, and is living outside the area, she/he will be admitted to the program when she returns to the Oroville area.

12) If selected strategies are not listed in Section IV, describe how they are transformational; and how they will promote the goals of the MHSA.

The strategy selected is a program identical to the AB2034 model, which is a commonly stated example of a transformational MHSA program, as listed in Section IV.

13) Timeline for this work plan, including all critical implementation dates.

Completion Date	Activity
July 1 , 2006	Conduct collaborative meetings: <ul style="list-style-type: none"> • Law enforcement • Private job training agencies to set up job training contracts • Landlords • Motels
July 31, 2006	Purchase program supplies and furnishings
August 1, 2006	Recruit and hire staff
August 15, 2006	Staff training & orientation
August 31, 2006	Establish Member Drop In/Service Center
September 1, 2006	Open SEARCH South Program <ul style="list-style-type: none"> • Homeless outreach • Service provision using a recovery

	model • Housing options
March 1, 2007	Complete local program review and prepare remaneuver plan with collaborative partners

14) Budget Request. (SEARCH South)

Grand Total (all sources)

Year One	Year Two	Year Three	Three Year Total
\$0	\$797,846	\$885,905	\$1,683,751

Total MHSA Funds (Includes Administrative Costs)

Year One	Year Two	Year Three	Three Year Total
\$0	\$709,651	\$782,981	\$1,492,633

Budget Narrative:

Staffing: The staffing will include all positions necessary to outreach to homeless people and to help them make plans for and achieve their recovery. Staff positions will be:

- 1 Program Manager
- 1 Supervisor Behavioral Health Counselor
- 1 Mental Health Clinician
- .5 Staff Nurse
- 2 Mental Health interns
- 1 Medical Records Technician
- 2 Behavioral Health Counselors (Personal Services Coordinators)

Peer support: Part time peer specialists will provide support to clients as they make plans for recovery and access services in the community.

Employment support: A vocational support program will be contracted to help clients find work and to train and support clients in their employment goals.

Housing: Clients will be in need of housing when they leave the parks and river areas. Through the program they will access housing and be provided with assistance using the housing subsidy for rental assistance, deposit, and first and last months' rent. When emergency housing is needed, motel vouchers will be given to clients for immediate safety and shelter.

Standby pay: Staff will be available on a 24/7 basis to meet the needs of clients who may have a crisis, or need to be assisted through a difficult situation at any time of the night or day, including contact with law enforcement.

General program expenses: Operations of the program will require staff travel, training, office rent, and general supplies for staff. Maintenance and fuel for two vehicles used by the program are also budgeted.

Veterinary Care: Homeless people frequently have companion animals that need health care and temporary boarding until their “human” can gain stable housing. A contract with local veterinarians will provide these services.

II. Programs to be Developed or Expanded (must provide information for **each** program)

1) *Complete Exhibit 4 to give summary of program, and funding types, by age group.*

Program Work Plan Name: Youth LINK (Living Insight, New Knowledge)

Estimated Start Date: July 1, 2006

Description of Program: LINK will be a program devoted to serving young people (14-24) who are homeless or at risk of homelessness in Butte County. The program will combine a drop-in center with overnight sheltering and supportive housing to provide services necessary to keep youth safe and help them work toward permanent housing, education, and employment. As the program title states, this program will provide new knowledge to youth to create insight into their living situation. The program will provide safety, support, employment planning, education support, healthy socialization, and emergency and permanent housing.

Priority Population: Adolescent males and females aged 14-24, both foster care youth and non-foster care youth, who are homeless or at risk of being homeless.

Strategies to be used:

This program is a multi-service drop-in center in which youth aged 14-24 can access overnight and daytime shelter, and services to meet their individual needs. Short term help to stay off the streets in a nurturing, supervised refuge will help these young people get back on track, reuniting with their families, stabilizing living situations, returning to school programs, and accessing job training and employment activities. Easily accessed services provided on-site will encourage a high level of trust from the youth and meet their needs on an individual basis by utilizing peers in paid positions to inform homeless youth of service options.

- Outreach to homeless youth will be conducted by a team of adult and youth staff who meet with young people where they gather
- A drop-in center will be designed with youth input to provide a safe and welcoming area for youth who are on the street to use as a safe place away from the risks of the streets, or an unsafe living situation
- Sheltering of an average of 6-10 young people per night will be available
- Chico location to serve youth who run to this small, university-influenced city from all over the county
- Engagement in services in a non-threatening, youth-driven approach
- Formal services dedicated to health, education, housing, and personal goal setting
- Informal activities such as music, yoga, community bicycles, clothing, and food
- Broad collaborative partnership of youth-serving agencies

Funding Types: Full Service Partnership

Age Groups: Youth and TAY, 14-24 years old

2) Detailed description of the proposed program using MHSA funding and how the program advances the goals of the MHSA.

Young people in Butte County face crises such as conflict at home, troubles at school, exposure to domestic violence, physical & sexual abuse, and poor independent living skills that occur in every community, every neighborhood, and every culture. The result is young people running away from home, becoming homeless, and facing dangers for which they are not prepared. Nation-wide statistics generated from federal runaway and homeless youth programs (Basic Center Programs, 1998-99 fiscal year) indicated that over 50% of the youth served presented with symptoms of depression, with 14% having made at least one suicide attempt.

During a twelve-month period (April 2004-March 2005) Butte County Behavioral Health's HERE Program provided counseling services to 235 runaway or homeless youth. We know the actual number of homeless youth in Butte County is much higher because they are often not visible or easy to count. They don't tend to hang out on city streets but instead find refuge in our large natural parks or in our mountain communities where methamphetamine production is plentiful. They often exchange sex for a place to eat and sleep in the college dorms or stay at homes of acquaintances until they are told to move on. Additionally, far too many of these youth leave the county heading to the popular urban centers such as San Francisco, or Hollywood where our rural youth find themselves horribly unprepared for the dangers of urban street life.

These youth need a safe place to go, to avoid the dangers of the street, before they turn to substance abuse, suicide and criminal activity as options to cope with emotional pain, and a lack of basic needs such as food, clothing and shelter. The LINK program will provide for these needs.

The Youth sub-committee of the Butte Homeless Task Force has been meeting for over 18 months to determine the best way to serve homeless youth in Butte County. At least ten agencies are currently involved in the planning and are dedicated to providing services in the new youth center, or linking with its referral process.

Number to be Served:

- Drop-in Center will host 10-24 youth per day for a total of over 4,000 visits per year
- Overnight emergency shelter will house 4-6 individual youth aged 14-18 per night. In one year, approximately 1,825 shelter nights will be provided (average of 5 youth sheltered per night)
- Overnight emergency shelter in motels will be provided for approximately two youth aged 18-24 per night. In one year, 730 nights of voucher-paid motels will be provided.

- Permanent supportive housing will be provided for 25 youth aged 18-24

Location:

Chico is the most effective location for the population to be served. Young people who run away or are pushed out of their homes in Oroville and Paradise are frequently found in Chico. Experience shows that outreach efforts in Oroville are not effective because the youth travel to Chico, even though they may be from Oroville. The goal of the program will be to work with youth and their families so they can safely return to their homes, no matter where they are located. For youth over 18 who cannot be housed with family, motel vouchers will be available and supportive permanent housing will be provided. The first challenge is to engage the youth in services; this must be done in Chico, where the youth are found. Youth under 19 will be housed in emergency shelter specifically designed to meet their needs.

Hours of Operation:

Drop-in Center: Noon-9:00 p.m. every day
 Overnight Shelter: 5:00 p.m.-8:00 a.m. every day

Formal services at multi-service drop-in center site:

1. Crisis services including emergency mental health assessment/intervention
2. Case management to address individual needs
 - Anger and stress management
 - Budget management
 - Goal setting and problem solving
 - Medical needs
3. Education- tutoring, school supplies, advocacy, educational options
4. Individual & Family Counseling
5. Public Health services, including HIV/AIDS testing
6. Healthy relationship building and dating violence prevention
7. Drug and alcohol prevention and education, including smoking cessation
8. Employment skills– Job finding and coaching
9. Transportation
10. Emancipation assistance
11. Direct access and transportation to overnight emergency shelter
12. Locating permanent housing

Informal activities and youth resources on site:

1. Youth oriented AA and NA groups	16. Leadership development
2. Activities (recreational)	17. Lockers
3. Art	18. Mail pick-up
4. Basketball	19. Music
5. Clothing	20. Pet boarding referral
6. Community Bicycles	21. Phone

7. Computer access	22. Protection from weather
8. Cultural and ethnic understanding	23. Safe place
9. Dancing	24. Showers
10. Emergency funding	25. TV
11. Food-hot meals, snacks	26. Use of Address
12. Foosball	27. Violence prevention
13. Garden	28. Youth Council
14. Hygienic supplies	29. Yoga/Tai Chi
15. Laundry	

Additionally, access to all Behavioral Health services is available to youth through supportive referral to service centers and activities as determined necessary by the youth. The County of Butte has a well-developed bus system that thoroughly accesses every section of the county. If young people wish to reunite with family out of the area, transportation via bus, plane, or train will be provided after connection has been made with services and family at the destination point.

Even though youth do not always feel welcome at the after school programs in the county, they will be encouraged to participate in these when they are ready. Connection with staff at the programs will be made to introduce the youth to the program and make her/him feel welcome. Three of these locations are The Live Spot after school youth activity center in Oroville, and the Boys and Girls Club in Chico and Paradise. Older youth positive socialization will be encouraged as well. Hours of operation at these programs are typically after school into the early evening. Youth in the LINK program could return to the LINK overnight services for late evening and overnight safety.

To cover the Center program, staffing is planned so that program can operate during the day at the Center, and youth can be sheltered all night every day when needed.

Paid with MHSA funding:

Youth Drop-In Center:

- Program Coordinator/Supervisor: 1 FTE (in Center 8 a.m.-5 p.m.)
 - Evening Coordinator: 1 FTE (in Center 1 p.m.-9 p.m.)
 - Licensed Mental Health Clinician: 1 FTE (flexible schedule to cover Center hours and appointments with youth and families)
 - Housing/Employment Coordinator: 1 FTE (flexible schedule to cover Center hours, appointments with youth and families, and development of housing options)
 - Prevention/Youth Development Specialist: 1 FTE
 - Weekend Program Coordinator: .5 FTE (in Center from Noon- 9 p.m. on weekends)
- In addition, part-time youth staff will be hired to work after school hours and weekends. (5,000 hours per year)
- In-school counselors: 2FTE to help keep youth in school

Sheltering of youth aged 14-18 from 5 p.m.- 8 a.m., seven days per week:

Nighttime Shelter Supervisors: 3 FTE

In-kind contributions from community collaborators:

Catalyst Domestic Violence Services-8 hours per week on site
School Ties (Office of Education) -four hours per week on site
HERE Program (Butte County Behavioral Health)-1 FTE case manager and 1 FTE Outreach Coordinator, and three part time youth for implementation of street outreach
Public Health-Health Educator- four hours per week on site

3) Housing or employment services to be provided.

Providing safe supportive housing for young people is the primary focus of this program.

Emergency housing will be provided via two mechanisms: a supervised house for youth aged 14-17, and monitored motel accommodations for youth aged 18-24. In both cases a two week stay will be the goal, with an extension of two additional weeks when needed.

As soon as a participant is willing to reside in safe permanent housing, a transition will be made. This could include living with family, foster care, and independent living . One year of rental subsidy will be available to program participants during which the youth will be supported to develop an income stream to pay future rent.

The key focus of income development for participants will be education, and creation of employment seeking skills. Young people will be assisted to remain in, or return to school. The active School Ties program will be a strong partner in this effort. The LINK program staff will work with local employers, and youth participants to locate and support jobs. Locally, Butte College and California State University, Chico will be tapped to provide educational opportunities for youth. Supported education will be provided, with particular emphasis on mental health recovery techniques to help students succeed. The Department of Rehabilitation will be a partner in helping youth with mental health challenges find and maintain employment.

4) Average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

The program will provide different levels of service for participants, depending on need. The levels and numbers to be served are:

- Drop-in Center will host 10-24 youth per day for a total of over 4,000 visits per year

- Overnight emergency shelter will house 4-6 individual youth aged 14-18 per night. In one year, approximately 1,825 shelter nights will be provided (average of 5 youth sheltered per night)
- Overnight emergency shelter in motels will be provided for approximately two youth aged 18-24 per night. In one year, 730 nights of voucher-paid motels will be provided.
- Permanent supportive housing will be provided for 25 youth aged 18-24

During the first program year a total of 375 homeless youth will receive Full Service Partnership services. During year two a total of 525 will be served. The average cost of services is \$1,880 per youth (based on 900 youth in two years, and a total two year program budget of \$1,691,857)

LINK Program

	Year One	Year Two	Year Three	Three Year Total
FFP (Medi-Cal)	\$0	\$163,020	\$190,320	\$353,340
Admin UR	\$0	\$ 19,562	\$ 22,838	\$ 42,401
EPSDT	\$0	\$ 68,291	\$109,624	\$177,915
MHSA	\$0	\$581,798	\$536,403	\$1,118,201

5) How the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. How we will ensure the values of recovery and resiliency are promoted and continually reinforced.

The goal setting process for all participants will be made with the full participation of the youth involved. Staff will be trained in methods for increasing resiliency in young people. Youth Development concepts will be ever-present in services provided. Youth will be referred to the Behavioral Health Prevention programs including Friday Night Live and Club Live, and to The Live Spot after school youth activity center in Oroville, where Youth Development strategies encourage resiliency.

The development of protective factors will be emphasized, including external assets of: caring relations, high expectations, and meaningful participation in school, home, community and with peers. Internal assets to be stressed will be: cooperation, empathy, problem-solving, self-efficacy, self-awareness, and developing goals and aspirations.

The LINK program will provide youth with information which will teach and empower them to participate fully in their treatment and recovery. The goal of the teaching process will be to give youth the ability to take charge of his/her own healing and healthy life journey.

The “whole person” approach will be the basis of the work in the program, by including new knowledge about independent living topics such as housing, education, and employment, as well as mental health and substance addiction treatment. Using a

strength-based philosophy, participants' skills, abilities and capacity will be tapped to develop personal growth and resiliency.

6) If expanding an existing program, description of the existing program and how it will change under this proposal.

This is an enhancement to the existing HERE (Homeless, Emergency, Runaway Effort) program, which has provided street outreach and counseling to runaway youth for over 15 years. Funded by a federal Runaway, Homeless Youth grant, the program can provide four beds at one time in a foster family home, family reunification, and mental health treatment services, while working with the youth to keep them in school and find them a permanent home. The program's effectiveness is limited due to young people's unwillingness to enter a licensed foster care home for temporary shelter and by youth's hesitancy to enter county services through doors that are perceived as being unsafe, controlling and non-youth oriented.

The LINK program will at last provide a welcoming, youth-friendly location for HERE services (counseling and case management) to continue. In addition, other youth-serving programs will join together to provide all services needed to keep young people safe and stabilize their housing. The safety of being off the streets for all youth will be a great addition to the HERE program which does not have a location outside county counseling offices, in which to welcome street youth. The two four beds currently located in a foster family home will be made available at the LINK emergency housing center where young people will not only have a protected place to sleep, but also a full array of services to help them stay off the street and return to school.

7) Description of services and supports clients and/or family members will provide. (Will clients/family actually run the service or are they participating as a part of a service program, team or other entity?)

Often the reason that young people must resort to street life is to run from an unsafe or threatening family home. Nationally about half of all women and children who are homeless are fleeing domestic violence. (US Conference of Mayors, 2004) When a youth is ready to include family members in the creation of goals and plans, this connection will be made. A broad definition of "family member" will be used to determine if there are people who could help in the support of the youths' goals and plans. Family counseling will be available as a key service of the program, when it is appropriate to the situation. Telephone or mail contact with family will be encouraged as one method to initiate connection.

The program will be staffed by adults and 6.5 part-time youth staff. These will be formerly homeless youth, when they are ready for this work.

8) Collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal

organizations. Explanation of how they will help improve system services and outcomes for individuals.

Current Partners in the Homeless Youth Task Group include:

- Butte County Department of Behavioral Health-HERE Program and Young Adult Program
- Butte County Office of Education-School Ties Program
- Butte County Public Health
- CATALYST Domestic Violence Services
- City of Chico
- Community Collaborative for Youth
- Juvenile Justice and Delinquency Prevention Commission
- Northern Valley Catholic Social Services –Teen Parent Program
- Youth For Change

These partners have developed the LINK program plan, and many are committed to providing their existing youth services at the center.

Commitments made include the following current and potential in-kind contributions:

- Current Planning – Members of the Runaway and Homeless Youth Task Force with consultant services provided by Butte County Behavioral Health
- Current Outreach Services – Butte County Behavioral Health / HERE Program (RHYA Grant) and CATALYST / SERV utilizing youth in paid positions.
- CATALYST / SERV Center youth services
- Potential Future Site Acquisition – City of Chico
- Mental Health Crisis Services, Case Management, Family Intervention – Butte County Behavioral Health / HERE Program (RHYA Basic Center Grant)
- On-Site Tutoring & Educational Advocacy – Butte County Office of Education / School Ties Program

9) Discussion of how the program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. How the program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Even though homeless youth come from diverse backgrounds, they share many common experiences and therefore have a unique culture with a shared way of life, common values, beliefs, dress and lingo, and ways of interacting with each other and with adults. Cultural competence in serving homeless youth means working with a knowledge and validation of their values and beliefs, with the goal of creating mutual respect and understanding between the service staff and the youth who are served. In this program, staff will acknowledge the experience of homeless youth in a nonjudgmental way to reduce the distrust of adults that young people have developed due to past conflicting relationships with adults.

The program will have a translator phone service available 24 hours per day, through a contract provided by BCDBH. When a youth and his/her family speak Spanish or Hmong, a staff member fluent in the appropriate language will be available to work on the goals of the youth, with his/her family.

Outreach to all ethnic communities regarding this program will be achieved through Behavioral Health Peer Staff and program staff who have an established, on-going relationship with the Native American, Latino, African American, and Hmong communities. They will emphasize the voluntary nature of the program, and the participation of family members. Youth outreach staff will look like youth who make up the county's population.

The LINK Center will be decorated with artwork from Asian, Native American, African American, and Hispanic American heritages to help all participants feel welcomed.

10) How services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

A staff member of each gender will be available to work with young people, depending on their specific needs based on gender. Staff will receive training from the local Stonewall Alliance organization to gain sensitivity to sexual orientation and the needs of gay, lesbian, bi-sexual and transgender youth. Groups for GLBT youth will be part of ongoing activities at the LINK Center.

11) How services will be used to meet the service needs for individuals residing out-of-county.

The services of the LINK program will be primarily for young people who are homeless in Butte County. If a youth from this area is without a home, and is living outside the area, she/he will be admitted to the program when she returns to the Butte area. Connections with youth serving agencies in surrounding counties will make the services known for homeless youth wishing to return to Butte County.

If young people wish to reunite with family out of the area, transportation via bus or train will be provided after connection has been made with services and family at the destination point.

12) If selected strategies are not listed in Section IV, describe how they are transformational; and how they will promote the goals of the MHSA.

The program selected contains multiple transformational strategies listed in Section IV.

13) Timeline for this work plan, including all critical implementation dates.

Completion Date	Activity
April 1, 2006	RFP out for Community Agency to Implement Program
June 1, 2006	Select Agency to Implement Program
June 30, 2006	Create collaborative agreements re: ways of work, with existing partners
July 1, 2006	Purchase program supplies and furnishings
August 1, 2006	Staff recruitment and hiring
August 15, 2006	Site procurement and site preparation
August 31, 2006	Provide staff training in homeless outreach, and service provision using resiliency concepts
September 1, 2006	Open LINK Program
December 1, 2006	Complete local program review and prepare remaneuver plan with collaborative partners

14) Budget Request (LINK Program)

Grand Total (all sources)

Year One	Year Two	Year Three	Three Year Total
\$0	\$832,671	\$859,186	\$1,691,857

Total MHSA Funds (Includes Administrative Costs)

Year One	Year Two	Year Three	Three Year Total
\$0	\$581,798	\$536,403	\$1,118,201

Budget Narrative:

Staffing: The staffing will include all positions necessary to outreach to and provide program services to homeless youth and to help them make plans for and achieve their goals. Staff positions will be:

- 1 Supervisor Behavioral Health Counselor
- 1 Mental Health Clinician
- 1 Health Education Specialist (Prevention and Youth Development Specialist)
- 1 Behavioral Health Counselor (Day Time Coordinator)
- 1 Behavioral Health Counselor (Housing and Employment Coordinator)
- .5 Behavioral Health Counselor (Weekend Program Coordinator)
- 3 Mental Health Workers (Night Time Shelter Staff)

2 School-based counselors to help keep youth in school
1 Office Assistant

Youth Staff to support the center (approx. 5,400 hours per year)

Rent and maintenance for the youth center and the night time shelter.

Housing: When youth aged 18-24 leave the temporary shelter they will need assistance to acquire and pay rent on housing until they can develop their own revenue to pay this cost. Through the program they will access housing and be provided with assistance using the housing subsidy for rental assistance, deposit, and first and last months' rent. When emergency housing is needed, motel vouchers will be given to this aged youth for immediate safety and shelter.

Standby pay: Staff will be available on a 24/7 basis to meet the needs of clients who may have a crisis, or need to be assisted through a difficult situation at any time of the night or day, including contact with law enforcement.

General program expenses: Operations of the program will require staff travel, training, office rent, phone, water, and general supplies for staff and program operations.

Food for youth in the Center and the Shelter will be provided.

Transportation assistance for youth to get to jobs, appointments, and school will be available in the form of bus and taxi vouchers.

Veterinary Care: Homeless youth frequently have companion animals that need health care and temporary boarding until their "human" can gain stable housing. A contract with local veterinarians will provide these services.

II. Programs to be Developed or Expanded (must provide information for **each** program)

1) *Complete Exhibit 4 to give summary of program, and funding types, by age group.*

Program Work Plan Name: MHSA Consumer Education and Training Office

Estimated Start Date: July 1, 2006

Description of Program: This program will focus on the goal of embedding the Recovery Model into all mental health work of the Butte County Department of Behavioral Health.

Priority Population: Consumers, family members, staff and community partners.

Strategies to be used: The program will be a focal point for the education of new and existing consumers, their family members, clinical staff, and contract providers in implementation and coordination of the Recovery/Resiliency Model. The program will impact all aspects of the systems of care in which the Department of Behavioral Health is engaged. It will provide an active consumer voice and participation in the development of training curriculum and in-service programs for all staff, providers and consumers. The Office will employ consumers from every age group for which training is offered. Consumers from this Office will be engaged in the existing Quality Assurance program currently implemented by the Department.

In collaboration with the MHSA Coordinator, consumer and family representatives will assist in the prioritization of training needs, design and development of consumer-relevant and oriented trainings. A component of this on-going collaboration will be the development of consumer roles and employment opportunities in various program areas.

Consumer members will be involved in selecting contract organizations to provide training for consumers and staff.

Consumers will be involved with Administration, Program Managers and Supervisors in the development of consumer-sensitive services. Consumers from this Office will provide active liaison with the Behavioral Health Board and the local NAMI chapter. A role of the Office will be to conduct outreach to consumers and family members served by contracted service providers.

The Office will coordinate peer-directed activities for consumers.

Funding Types: Outreach and Engagement

Age Groups: All groups-Children and Youth, Transitional Aged Youth, Adults, and Older Adults

2) Detailed description of the proposed program using MHSA funding and how the program advances the goals of the MHSA.

This program will be housed with the MHSA Coordinator and staff. Co-location of the MHSA Coordinator and the Consumers' Office will encourage joint planning, development and oversight of MHSA funded services and activities.

The staffing will include:

FY2006-2007: 1 FTE Consumer Liaison
Extra help staff as needed for program and projects

FY2007-2008: 2 FTE Consumer Liaisons or
1 FTE Consumer Liaison with Extra Help staff as needed for
program and projects

The Office will share the clerical support with the MHSA Coordinator.

The program will be a focal point for the education of new and existing consumers, their family members, clinical staff, and contract providers in implementation and coordination of the Recovery/Resiliency Model. The program will impact all aspects of the systems of care in which the Department of Behavioral Health is engaged. It will provide an active consumer voice and participation in the development of training curriculum and in-service programs for all staff, providers and consumers. The Office will employ consumers from every age group for which training is offered. Consumers from this Office will be engaged in the existing Quality Assurance program currently implemented by the Department.

In collaboration with the MHSA Coordinator, consumer and family representatives will assist in the prioritization of training needs, design and development of consumer-relevant and oriented trainings. A component of this on-going collaboration will be the development of consumer roles and employment opportunities in various program areas.

Consumer members will be involved in selecting contract organizations to provide training for consumers and staff.

Consumers will be involved with Administration, Program Managers and Supervisors in the development of consumer-sensitive services. Consumers from this Office will provide active liaison with the Behavioral Health Board and the local NAMI chapter. A role of the Office will be to conduct outreach to consumers and family members served by contracted service providers.

The Office will coordinate such activities as:

- "Stomp Out Stigma" campaign

- Expand the role and functions of the Drop-In Center
- Peer support specialist trainings
- Peer team coaching
- Development of a call-in center
- Medication support advocacy
- Consumer “Frequently Asked Questions” Web page
- Expansion of Peer Pals Program
- Trainings on consumer advocacy
- Development of commercial arts and crafts training with local Community College
- Development of a healing way that reflects local communities and cultures’ paths to wellness

3) Housing or employment services to be provided.

The consumers employed will initially become involved in the four projects to be funded by CS&S MHSA monies. By institutionalizing the Recovery Model into every aspect of the Department, more consumers will benefit from better-designed services, more suitable housing, and more satisfying employment.

4) Average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

This is not a Full Service Partnership program.

5) How the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. How we will ensure the values of recovery and resiliency are promoted and continually reinforced.

This is the essence and core mission of this component of the CS&S programs proposed. It is wholly about creating an infrastructure within the organization that will guarantee the implementation of the Recovery Model across the entire service delivery system. It will employ consumers in the role of developing the vision of what Recovery Model should encompass for the Department and its service providers.

This program will encourage consumers to be involved in the design of activities that will address wellness, support recovery and resilience; and design a set of integrated service experiences for clients and their families. Through this Office clients and families are able in appropriate ways to participate in the development of training activities, and primary clinical services in which the Department can enter into partnerships with clients, their families, and our community, to provide whatever it takes to enable consumers to attain their treatment goals.

6) If expanding an existing program, description of the existing program and how it will change under this proposal.

This is a new program.

7) Description of services and supports clients and/or family members will provide. (Will clients/family actually run the service or are they participating as a part of a service program, team or other entity?)

In collaboration with the MHSA Coordinator, consumer and family representatives will assist in the prioritization of training needs, design and development of consumer-relevant and oriented trainings. A component of this on-going collaboration will be the development of consumer roles and employment opportunities in various program areas.

Consumer members will be involved in selecting contract organizations to provide training for consumers and staff.

Consumers will be involved with Administration, Program Managers and Supervisors in the development of consumer-sensitive services. Consumers from this Office will provide active liaison with the Behavioral Health Board and the local NAMI chapter. A role of the Office will be to conduct outreach to consumers and family members served by contracted service providers.

The Office will coordinate such activities as the “Stomp Out Stigma” campaign, expand the role and functions of the Drop-In Center.

8) Collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explanation of how they will help improve system services and outcomes for individuals.

This concept came out of a planning process with the members of the current Mental Health Board, and in particular, a special work group of the Board that joined with members of the Quality Improvement Committee to recommend creation of this Office.

This program will encourage consumers to be involved in the design of activities that will address wellness, support recovery and resilience; and design a set of integrated service experiences for clients and their families. Through this Office clients and families are able in appropriate ways to participate in the development of training activities, and primary clinical services in which the Department can enter into partnerships with clients, their families, and our community, to provide whatever it takes to enable consumers to attain their treatment goals.

9) Discussion of how the program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. How the program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Continuous efforts will be made to enlist consumers from across the County in the activities of this Consumer Education and Training Office. This effort will include outreach to members of the four tribal communities, Spanish-speaking population, Hmong and other Asian community members, and African Americans who are residents of Butte County.

10) How services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Consumer employees and participants will be involved in developing an appropriate and sensitive response to sexual orientation in unserved and underserved populations, and their unique needs. The gender specific issues of men and women will be a priority concern in planning and development of activities sponsored by this group.

11) How services will be used to meet the service needs for individuals residing out-of-county.

This program is specifically designed to meet the needs of Butte County residents who are service recipients.

12) If selected strategies are not listed in Section IV, describe how they are transformational; and how they will promote the goals of the MHSA.

These strategies are listed.

13) Timeline for this work plan, including all critical implementation dates.

Completion Date	Activity
September 1, 2006	Recruitment and hiring of consumer staff
October 1, 2006	Orientation and training of staff
October 15, 2006	Set up office
December 1, 2006	Meet w/ consumers to ID key issues to be addressed
January 1, 2007	Develop consumer outreach plan
February 15, 2007	Collaborate w/ MHSA Coordinator to ID staff & provider training needs for first year
April 15, 2007	Initiate training in which consumers are co-trainers

14) Budget Request. (Consumer Program)

Total MHSA Funds (no other funding sources) (Includes Administrative Costs)

Year One	Year Two	Year Three	Three Year Total
\$0	\$105,349	\$165,924	\$ 271,273

Budget Narrative:

The program will be staffed primarily by consumers-2 Consumer Liaisons will outreach to consumers and community members to carry out the recovery-oriented goals of the education and training program. Other part time staff time will be available for consumers on a more short-term basis. As training is one of the major goals of the program, funding for this purpose will be available to train consumers, staff, community members, and family.