



2018-2019

# Mental Health Services Act Program and Expenditure Plan **ANNUAL UPDATE**





WELLNESS • RECOVERY • RESILIENCE

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# MHSA PROGRAM & EXPENDITURE PLAN FY 2018-2019

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## EXECUTIVE SUMMARY

In November of 2004, California voters passed Proposition 63 creating the Mental Health Services Act (MHSA). The Act created an additional one percent tax on any California resident making more than \$1 million dollars. Annually, the tax is added on to every dollar (over \$1 million) the residents make. The revenue is distributed to counties in order to accomplish an enhanced system of care for mental health services. A portion of the MHSA revenue is distributed to agencies at the state level. The passing of Proposition 63 provided the first opportunity in many years to expand county mental health programs for all populations: children, transition-age youth, adults, older adults, families, and especially, the un-served and under-served. It was also designed to provide a wide range of prevention, early intervention, and treatment services, including the necessary infrastructure, technology, and enhancement of the mental health workforce to effectively support the system. There are five fundamental guiding principles outlined in the MHSA regulations:

- 1) Community Collaboration
- 2) Cultural Competency
- 3) Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services
- 4) Access to Underserved Communities
- 5) Creating an Integrated Service Array

In 2005, the Butte County Department of Behavioral Health (BCDBH) began the community collaboration process by involving community members and stakeholders in meetings/focus groups; participating via surveys and workgroups to identify the community needs, develop program/service plans, and recommendations to meet the needs of the community. Every three years an MHSA Program and Expenditure Plan is developed in partnership with community members and stakeholders to:

- Identify community issues related to mental illness resulting from lack of community services and supports, including issues identified during the implementation of the Mental Health Services Act.
- Analyze the mental health needs in the community.
- Identify and re-evaluate priorities and strategies to meet those mental health needs.

In addition, the same community input process is used for Annual Updates which define any changes made to the programs, services, or initiatives each year.

Once the community input process is concluded, the BCDBH Administration Team takes all community feedback into consideration to create the proposed MHSA Three Year Expenditure and Program Plan. The Administration Team is composed of: Director, Assistant Directors, Fiscal Manager, Medical Director, Compliance Officer/Managed Care Plan Manager, Community Services Program Manager/MHSA and Cultural Competence Coordinator.

## Program Components

MHSA consists of five funding components, each of which addresses specific goals for priority populations, key community mental health needs, and age groups that require special attention. The programs developed under these components draw on the expertise and experience of behavioral health and primary health care providers, community-based organizations of all types, school districts, community programs and centers, institutions of higher education, law enforcement/the judicial system, and local government departments and agencies. The five components are:

- 1) Community Services & Supports (CSS)
- 2) Prevention & Early Intervention (PEI)
- 3) Innovation (INN)
- 4) Capital Facilities & Technological Needs (CFTN)
- 5) Workforce Education & Training (WET)

Below is an itemization of each program, service, or initiative and fiscal allocations for Fiscal Year (July 1<sup>st</sup>-June 30<sup>th</sup>) 2018/2019 by each component. Also identified, is the status of each program, service, or initiative and any changes made since the last MHSA Program and Expenditure Plan. If there is no designation next to the program, there were no changes since the 2017-2018 Three Year Plan. If a program is designated as updated since the last plan, details of the modification may be found on page 30.

Note that some programs may have additional revenue streams in their budget. For the purposes of the Executive Summary, this next section is strictly identifying what MHSA funds have been allocated to each component.

## Community Services and Supports

\$8,498,039

<b>Crisis Intensive Services</b>	
Crisis Residential Facility	
Crisis Stabilization Unit	
Crisis Triage Connect	Modified
Mobile Crisis Team	New
Support, Employment, Assistance, Recovery, Consumer Housing	
Working Innovations Network	Modified
Youth Empowerment Support	
Youth Intensive Program (YIP)	Modified
<b>Consumer Education, Employment, &amp; Wellness (CEEW)</b>	
6 <sup>th</sup> Street Drop-In Center	
MHSA Coordinator	

Runaway and Homeless Youth Match

Torres Shelter Peer Partner Program

**Housing**

-Avenida

-Continuum of Care Coordinator

-Homeless Census (Point It Time)

-Housing Authority – BHAP

-Housing Authority – HUD

-Housing Consultant

-Master Lease – Youth

-Transitional Housing

**Vocational Training and Employment**

-Caminar

-Consumer Employment

-DBH Staff

-Department of Rehabilitation Cooperative

-Dreamcatchers

-Jesus Center

**Wellness Centers**

-Iversen Center

-Oroville Wellness and Recovery Center

-The Hub Wellness and Recovery Center

**Integrated Health & Mental Health**

Integrated Health and Mental Health

Modified

**Prevention and Early Intervention**

\$2,323,199

**Live Spot**

Gridley and Oroville Live Spots and Prevention Services

Strengthening Families

New

**Community Prevention & Intervention (CPI)**

African American Family and Cultural Center

North Valley Talk Line

Modified

Passages-Older Adult Suicide Prevention and Education

Promotores

Stonewall- LGBTQ Outreach, Education, Training and Suicide Prevention

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Zoosiab- Hmong Cultural Center

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**Welcoming, Triage & Referral (WTR)**

Welcoming Triage and Referral

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**Mental Health Awareness /Community Education**

Care Enough to Act

Community Education Campaign- Cal MHSA

Community Prevention and Early Intervention Staff

Mental Health Awareness- National Alliance on Mental Illness

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**Innovations**

\$580,800

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BCOE- The Center

In development

Physicians Committed (approved on May 24<sup>th</sup>, 2018)

\$767,900

Trauma Informed System Mapping

In development

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**Capital Improvement/Information Technology**

Funds depleted

Reconciliation from previous projects have determined that these funds have been spent.

**Workforce Education & Training**

\$342,092

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Consumer/Family Member Employment Support and Training

Electronic Learning System Management

Job Specific Training

Training Coordinator

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Our projected allocation for fiscal year 2017-2018 was \$10,268,717. We are on target to meet this and may actually receive a little more than originally anticipated. For fiscal year 2018-2019, our projected allocation is \$11,615,994, which is a \$1,347,277 increase over 2017-2018 projections.

As a public funded agency the department is dedicated to being a responsible steward of public funds. Agencies often have an indirect cost for administrative responsibilities when providing services. The indirect cost is applied to all revenue sources including MHSA. Up to 15% of allocated funds may be allowable for administrative costs.

## Cost per Person

Butte County Behavioral Health identified the average MHPA cost per person, by component category, for Fiscal Year 2016/2017 to be reported in this plan. These figures were taken from the FY16/17 Revenue and Expenditure Report and are still pending approval from DHCS. The number served may be duplicated due to a consumer being enrolled in multiple programs within the category.

CSS - CATEGORY	EXPENDITURE	NUMBER SERVED	COST PER PERSON
Crisis Intensive Services	\$11,389,362	2202	\$5172.28
Consumer Education, Employment, & Wellness (CEEW)	\$2,553,795	2424	\$1053.55
Integrated Health & Mental Health	\$711,846	395	\$1802.14

PEI - CATEGORY	EXPENDITURE	NUMBER SERVED	COST PER PERSON
Live Spot	\$949,301	1162	\$816.95
Community Prevention & Intervention (CPI)	\$1,021,534	2509	\$407.15
Welcoming, Triage & Referral (WTR)	\$2,713,643	2851	\$951.82
Mental Health Awareness /Community Education	\$103,350	585	\$176.67

This annual plan update provides an overview of each program, service, or initiative in a descriptive, narrative format. Some descriptions are longer than others due to the scope of that service. Included with each program description is a detail of outcomes and objectives, followed by the supporting data. This plan describes the community and stakeholder feedback processes executed, and conclusions made from this valued process. The last section of the document will contain the budget forms that are configured by the State of California. These forms include more detail about the additional revenue that supports MHPA funds to meet the overall costs of programs and services.

# BUTTE COUNTY

## Geography

Butte County is comprised of approximately 1,637 square miles and is located on the northeast side of the Sacramento Valley next to the Sierra Mountain foothills and at the base of the Butte Creek Canyon. The Sacramento River borders Butte County to the west and several large creeks such as Butte Creek and Big Chico Creek run through the county to the river. The County has a diverse geography between the large almond orchards, the Llano Seco wetlands preserve, creeks, mesas and foothills, and temperate forests stretching up through Paradise and Magalia into the Sierras.

In terms of population, Butte County is the largest California County north of the Bay Area and the Sacramento Valley. Citing the 2016 American Community Survey, Butte County is home to circa 226,864<sup>1</sup> people and is made up of 5 incorporated cities/towns: Oroville, Chico, Gridley, Paradise, and Biggs.

Chico, the city with the largest population in the county, is home to the famous Bidwell Park which is named after Chico's founder John Bidwell. Bidwell Park is one of the largest municipal parks in the United States; it stretches from downtown Chico to the upper foothills of the Butte Creek Canyon and is home to the One Mile Recreation Area, Bear Hole, Chico Community Observatory, and Bidwell Park Golf Course.

Oroville houses the County government and is home to the beautiful Table Mountain and Lake Oroville, which provides most of the County's agricultural irrigation. Feather Falls (shown below) is one of the many magnificent waterfalls that drain into the County's waterways. Gridley and Biggs are rural hubs in

BIDWELL PARK, CHICO CA



COMING OUT OF THE DARKNESS: EDEN WERSTLER

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<sup>1</sup> <https://censusreporter.org/profiles/05000US06007-butte-county-ca/>

the southern part of the county, and Paradise is a large, forested suburban community reaching up into the mountains.

FEATHER FALLS, NEAR LAKE OROVILLE



PHOTO CREDIT: RAY BOUKNIGHT

Butte County contains a Mediterranean climate which means hot summers and cool, rainy winters. The mild weather provides an excellent opportunity for outdoor enthusiasts and nature lovers to enjoy the outdoors year-round. It also creates an ideal agricultural landscape for growing a diverse range of vegetables, nuts, fruits, and grains. These conditions contribute to agriculture being the number one industry in Butte County, which provides a significant base to the county's economy.

SATURDAY FARMER'S MARKET IN CHICO, CA



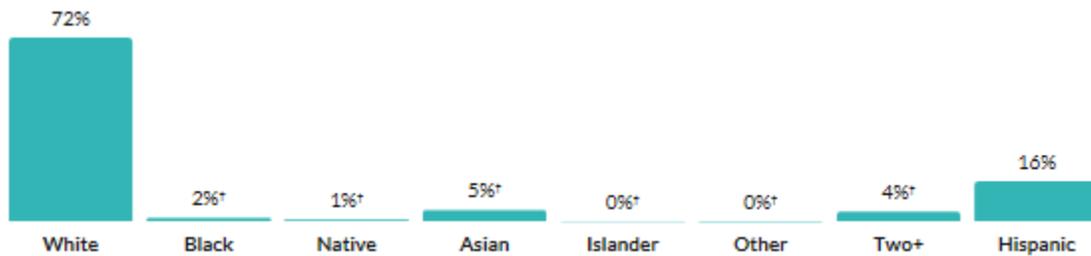
PHOTO CREDIT: DAIN SANDOVAL

Butte County provides a rare combination of rural, natural, and urban beauty that makes it one of the best kept secrets of California.

## Cultural & Economic Diversity

While most of Butte County can be considered homogenous in its racial diversity (see figure below) there are burgeoning ethnic communities and economic opportunities that have characterized Butte County's importance as a cultural and economic hub in Northern California. Large Spanish-speaking and Hmong communities call the County home; the Spanish language meets the criteria for a "Threshold Language" and the Hmong language is just below that designation. We provide many services in both languages and have vital materials translated into both languages as well.

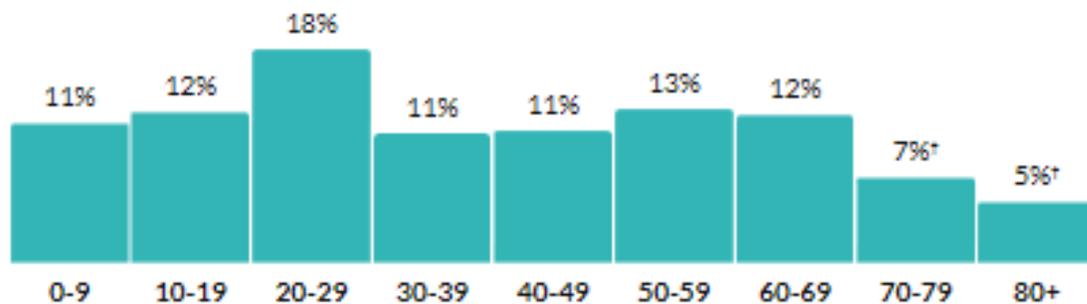
BUTTE COUNTY RACE & ETHNICITY DEMOGRAPHIC (2016 AMERICAN COMMUNITY SURVEY):



*\*Hispanic includes respondents of any race. Other categories are non-Hispanic.*

The percentage of persons below the poverty line in Butte County is 19.9%, which is 1.4 times the rate of California (14.4%). The median household income is \$45,177, about two thirds of the California average<sup>2</sup>. This makes Butte County one of the poorest counties in the state and creates many significant needs for its population.

BUTTE COUNTY POPULATION BY AGE RANGE (2016 AMERICAN COMMUNITY SURVEY):



In comparison to California, Butte County has approximately 3% fewer people under the age of 18 and approximately 4.5% more people over the age of 65. The largest age demographic in Butte County according to the 2016 ACS is 20-29 year olds at 18% with 50-59 years olds coming in at second at 13%.

The California State University, Chico enrolls approximately 16,000 students annually so with so many young individuals in the community much of the cultural and economic activity revolves around the

<sup>2</sup> <https://censusreporter.org/profiles/05000US06007-butte-county-ca/>

university. Chico's downtown is flush with artwork, interesting characters, and a vibrant nightlife. It is also a center for volunteerism which tops all of the universities in the United States in terms of hours volunteered. There is a deep sense of community throughout Butte County and many people are proud to call this county home.

# MHSA COUNTY CERTIFICATION

**County:** Butte

<p><b>Local Mental Health Director</b></p> <p><b>Name:</b> Dorian Kittrell  <b>Telephone:</b> 530-891-2850  <b>E-mail:</b> dkittrell@buttecounty.net</p>	<p><b>Project Lead</b></p> <p><b>Name:</b> Holli Drobny  <b>Telephone:</b> 530-897-3971  <b>E-mail:</b> hdrobny@buttecounty.net</p>
<p><b>Local Mental Health Mailing Address:</b></p> <p style="text-align: center;">Butte County Department of Behavioral Health          Administrative Office          3217 Cohasset Road          Chico, CA 95928</p>	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and non-supplantation requirements.

This Three-Year Program and Expenditure Plan has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on **[to be competed upon submission]**.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

\_\_\_\_\_  
 DORIAN KITTRELL, MFT  
 Mental Health Director/Designee

\_\_\_\_\_  
 Date

**County:** Butte  
**Date:**

# MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION<sup>1</sup>

County/City: Butte

- Three-Year Program and Expenditure Plan
- Annual Update
- Annual Revenue and Expenditure Report

<p><b>Local Mental Health Director</b>  <b>Name:</b> Dorian Kittrell  <b>Telephone:</b> 530-891-2850  <b>E-mail:</b> dkittrell@buttecounty.net</p>	<p><b>County Auditor-Controller/City Financial Officer</b>  <b>Name:</b> Holli Drobny  <b>Telephone:</b> 530-897-3971  <b>E-mail:</b> hdrobny@buttecounty.net</p>
<p><b>Local Mental Health Mailing Address:</b>  <div style="text-align: center;">             Butte County Department of Behavioral Health              Administrative Office              3217 Cohasset Road              Chico, CA 95928           </div> </p>	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for other counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/report is true and correct to the best of my knowledge.

Local Mental Health Director (PRINT)	Signature	Date
<p>“I hereby certify that for the fiscal year ended <b>June 30, 2018</b>, the County/City has maintained an interest-bearing local Mental health Services (MHS) Fund (WIC 5892(f); and that the County’s/City’s financial statements are audited annually by an independent auditor and the most recent audit report is dated <b>December 22, 2017</b> for the fiscal year ended <b>June 30, 2017</b>. I further certify that for the fiscal year ended <b>June 30, 2018</b>, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfer out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund. I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/report is true and correct to the best of my knowledge.”</p>		

County Auditor Controller/City Financial Officer (PRINT)	Signature	Date
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<sup>1</sup>Welfare and Institutions Code Sections 5847(b)(9) and 5899(a) Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (02/14/2013)

## COMMUNITY & STAKEHOLDER ENGAGEMENT

Butte County Behavioral Health began the community and stakeholder engagement process for the MHSA Program and Expenditure Plan in March, 2018. Additionally, an engagement process specifically for the Innovations component was conducted in November 2017. Notifications of Community Input meetings were 1) announced at Behavioral Health staff meetings, community meetings (e.g., Behavioral Health Board), and 2) through email distribution lists to consumers, partnership agencies, community organizations, (e.g., Cultural Competency Committee, Care Enough to Act Committee, Hispanic Resource Council) and a MHSA Community email distribution list. This year the department engaged in utilizing social media to promote Community Input via Facebook events on the Butte County page.

Community Input Meetings were held in March and April of 2018 with two different formats: large public meetings and focus groups. The large public meetings were held at local libraries and community conference rooms. The focus groups were held in warm, friendly settings with translators available for cultural and linguistic considerations. At each meeting the agenda, materials, and presentation contained the same content; translated resources were available as needed. The meetings provided an overview (see Appendix A) of the MHSA history, intent, components, framework, and goals. The meetings described the community planning process, the projected allocation for fiscal year 2018/2019, and an update of any programmatic changes. A total of 98 people signed-in as attending the community meetings (both the large public meetings and focus groups combined).

Each year, MHSA Program and Expenditure Plans and Updates are developed in partnership with community stakeholders to:

- 1) Identify community issues related to mental illness resulting from lack of community services and supports, including issues identified during the implementation of the Mental Health Services Act.
- 2) Analyze the mental health needs in the community.
- 3) Identify and re-evaluate priorities and strategies to meet those mental health needs.

To further encourage and engage community collaboration, BCDBH developed a survey (see Appendix B) to facilitate community participation. The survey was available in English, Spanish, and Hmong, and offered electronically and in paper format. The survey was posted on the Behavioral Health MHSA website during the duration of the community input process and sent electronically to community contacts, MHSA email distribution lists, contracted providers and all BCDBH employees. The MHSA survey was available in paper form at each Community Input Meeting. The survey included currently funded MHSA initiatives so that community members could provide feedback on whether or not the initiatives were meeting the needs of their community. Additionally, the survey asked for feedback on any potential unmet needs, innovative ideas, demographic data, if the programs were effectively engaging cultural populations, the impact of the programs, and access and availability of the programs, services and initiatives. Stakeholder feedback and community input resulted in 190 surveys submitted. The survey period was open from March 29<sup>th</sup>-April 30<sup>th</sup>, 2018.

# COMMUNITY MEETINGS/FOCUS GROUP PARTICIPATION

## Attendance

A total of 98 people signed-in at the community meetings (there were 12 meetings: both large public meetings and focus groups combined). Please see the flyer, in Appendix C, for an example of advertising these meetings. The table below demonstrates who signed-in at each meeting location:

<b>Meetings &amp; Attendance</b>	
African American Family & Cultural Center	4
Chico Library (2 meetings)	28
Gridley Library (1 meeting)	0
Hmong Cultural Center*	12
Iversen Wellness and Recovery Center	19
Oroville Library (2 meetings)	2
Oroville Wellness Center	5
Paradise Library (1 meeting)	2
Promotores (Vista Verde Apt Complex)*	9
Stonewall Alliance	0
The Hub Wellness and Recovery Center	17

*\*Translator utilized*

Each community meeting began with an introduction of BCDBH staff present (MHSA coordinator and MHSA Analyst), followed by a presentation explaining budget details for fiscal year 2018-2019, program details by its funding source, and any changes or updates to the plan. The presentation concluded with a request for verbal and written community feedback.

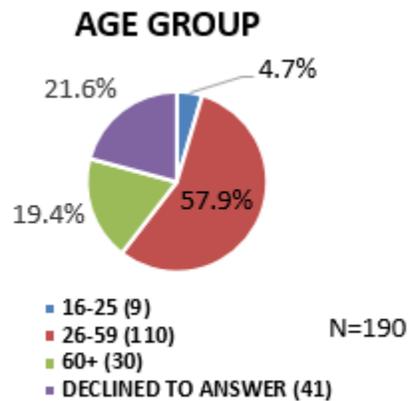
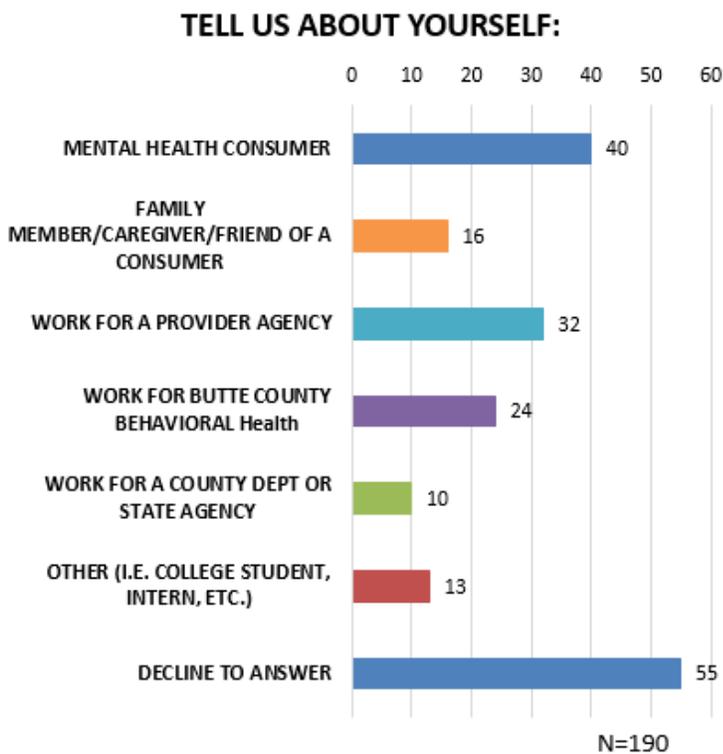
Focus groups began with an introduction of BCDBH staff present (MHSA coordinator, MHSA Analyst) and the translator as needed. These meetings included a round-table discussion of budget details for fiscal year 2018-2019, program details by its funding source, and any changes or updates to the plan. There was food and beverages provided at the focus groups to create a welcoming and casual atmosphere. The intent of the focus groups were to solicit feedback from those enrolled in programs in an atmosphere comfortable to them. The demonstration concluded with a request for verbal and written community feedback.

# SURVEY RESULTS OF COMMUNITY FEEDBACK

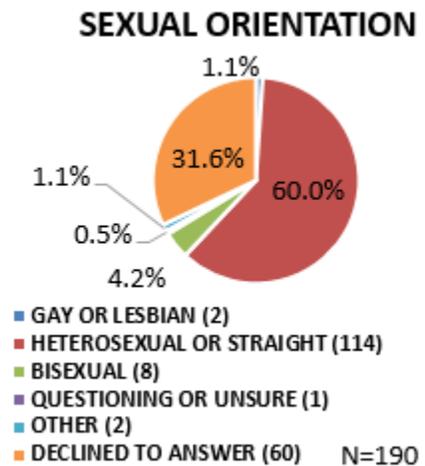
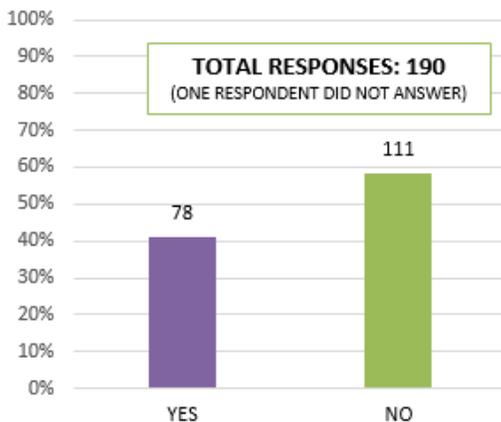
Once the survey period was completed, all other data (e.g., paper surveys) collected via meetings or submitted to Behavioral Health through other avenues (e.g., mailing to/dropping off at Administrative Offices, drop off at program locations), were entered into survey software. The results depicted in the report below were designed by the BCDBH Systems Performance, Research and Evaluations Unit. Overall, there were 190 surveys collected.

## Community Demographic Data

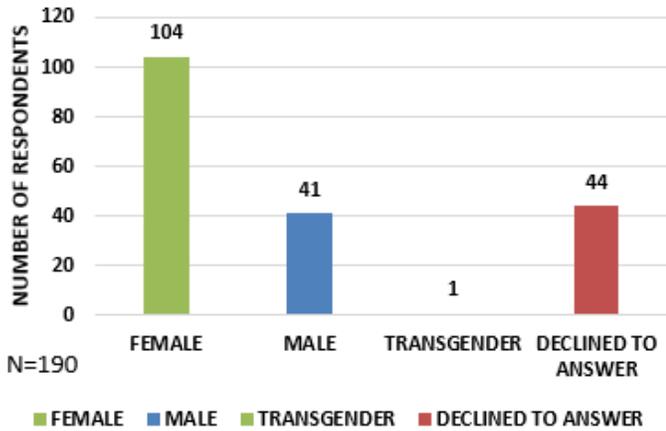
The following figures portray demographic data that the community provided via meeting attendance or online submission. These data are self-reported and voluntary.



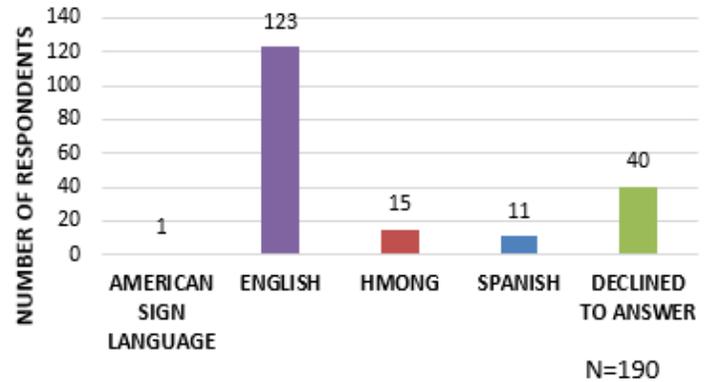
**DID YOU ATTEND AN MHSA COMMUNITY MEETING OR FOCUS-GROUP?**



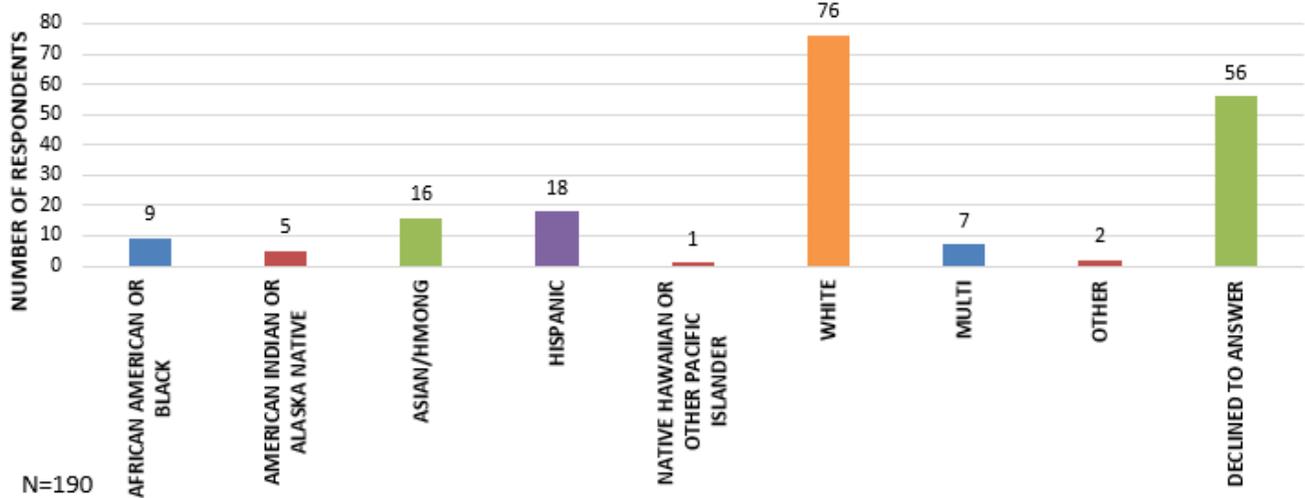
**GENDER**



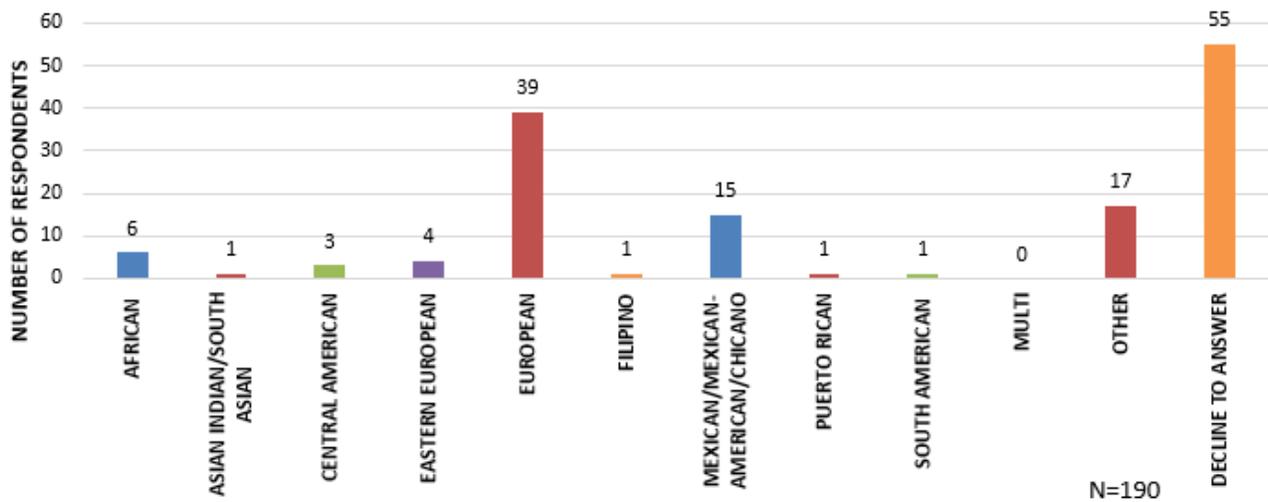
**PRIMARY LANGUAGE**



**RACE**



**ETHNICITY**



WHAT AFFILIATIONS DO YOU IDENTIFY WITH?	NUMBER OF RESPONDENTS*
ADVOCATE	53
COMMUNITY BASED/NON-PROFIT BEHAVIORAL HEALTH SERVICE PROVIDER	44
CLIENT/CONSUMER/RECOVERY COMMUNITY	36
CHILDREN AND FAMILY SERVICES	27
COUNTY BEHAVIORAL HEALTH DEPARTMENT STAFF	25
FAMILY MEMBER OF A BEHAVIORAL HEALTH CONSUMER	25
COMMUNITY SOCIAL SERVICES	20
COMMUNITY BASED ORGANIZATION (NOT MH SERVICE PROVIDER)	17
FOSTER CARE	12
HOMELESS	10
SUBSTANCE USE DISORDER SERVICE PROVIDER	7
SENIOR SERVICES	6
VETERAN SERVICES	6
K-12 EDUCATION PROVIDER	5
HOSPITAL/HEALTH CARE PROVIDER	4
LAW ENFORCEMENT	4
OTHER	7
DECLINED TO ANSWER	20

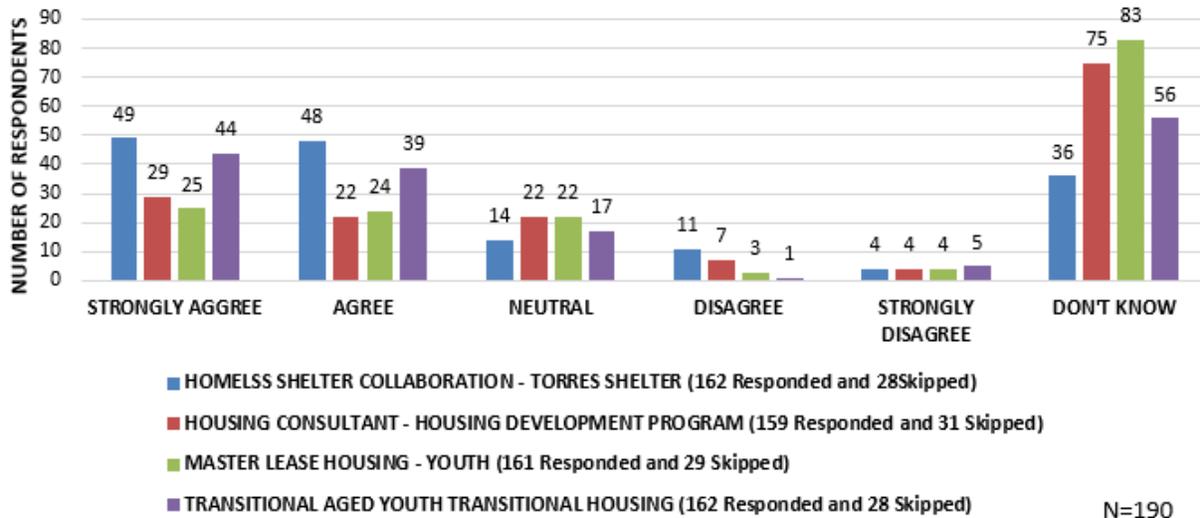
*\*Survey participants could make multiple selections for the Affiliation question.*

### Feedback & Input Report

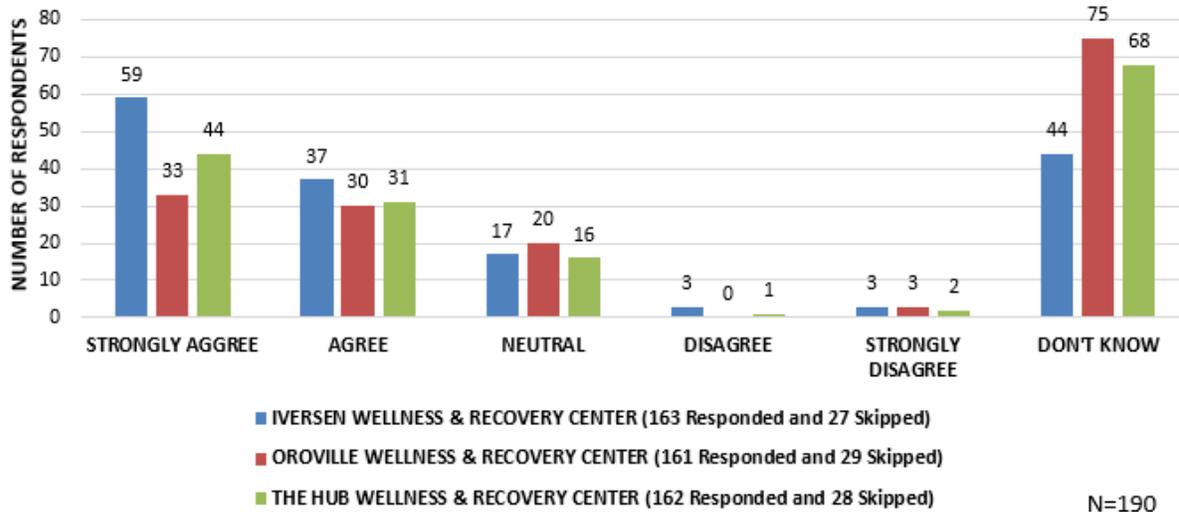
The following report shows the outcomes as entered into Mental Health Services Act (MHSA) Community Meetings and Focus-Groups Community Feedback Survey. For a view of the actual survey, see Appendix B. Please note: comments submitted during the 30-Day Public Comment period are included in the “30-Day Public Comment” Section.

Responses below were from the section “Please rate all programs that you identify as meeting the needs of the community.”

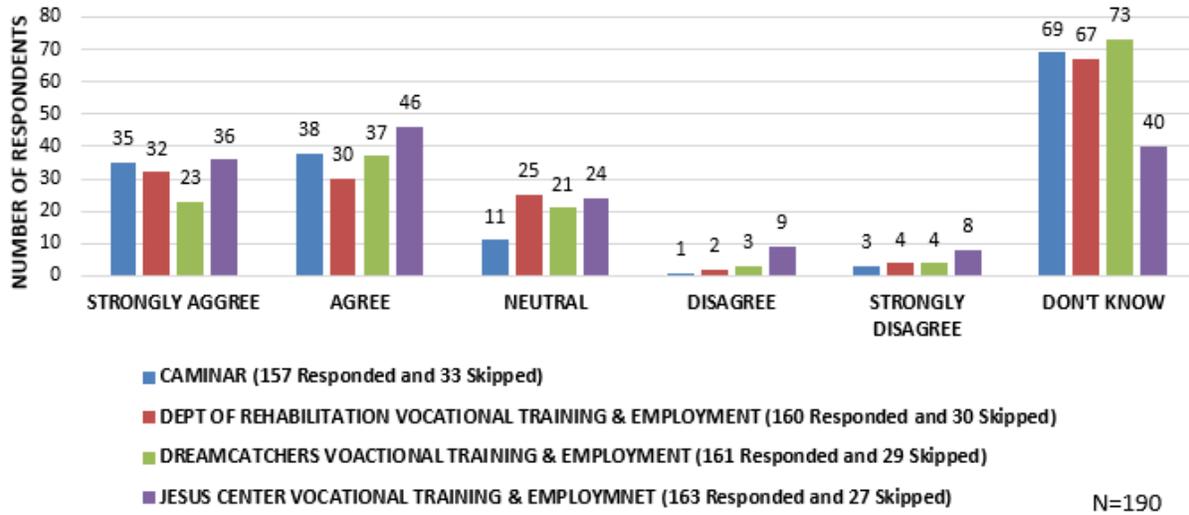
#### CSS - HOMELESS PROGRAMS



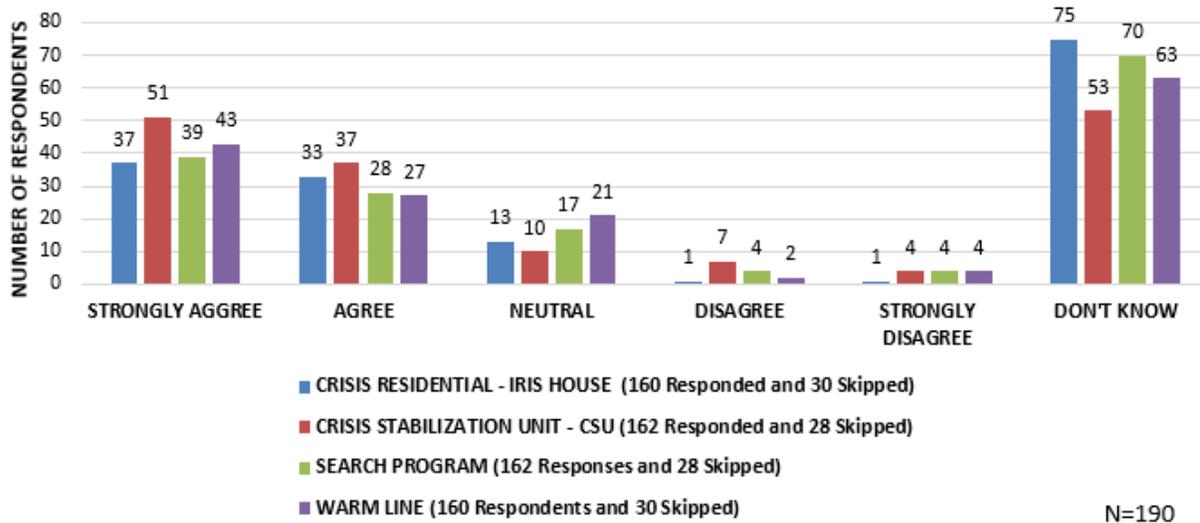
#### CSS - WELLNESS & RECOVERY CENTERS



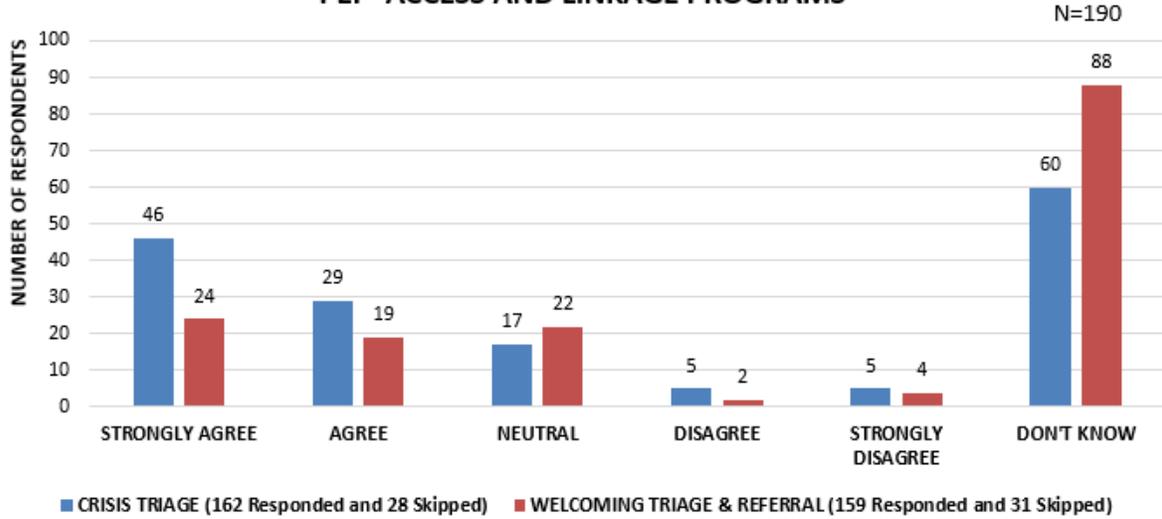
**CSS - VOCATIONAL PROGRAMS**



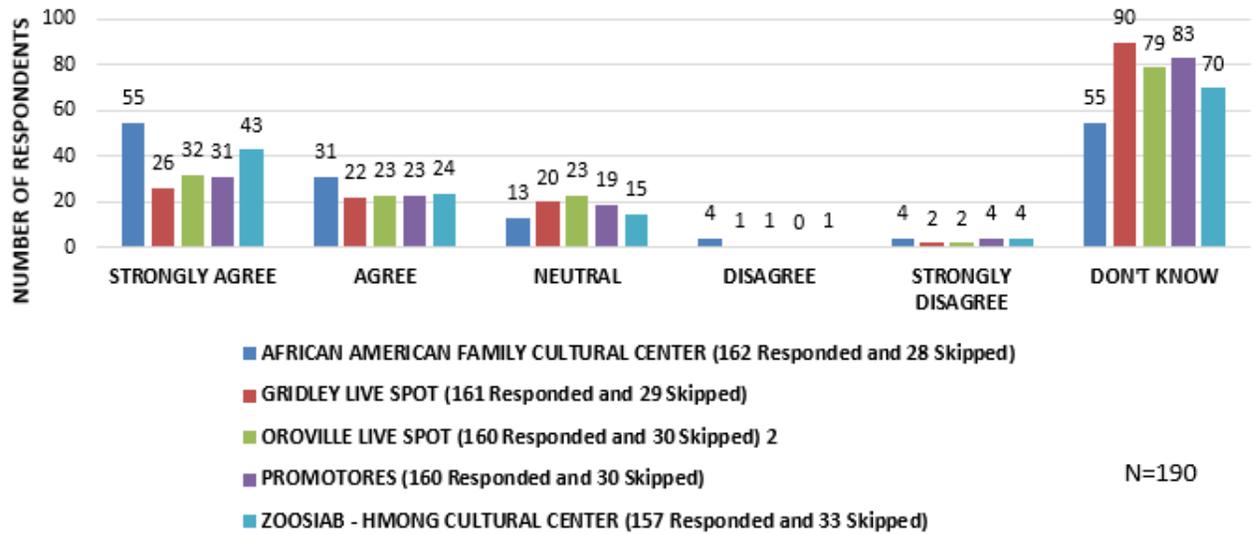
**CSS - CRISIS SERVICES & SUPPORTIVE PROGRAMS**



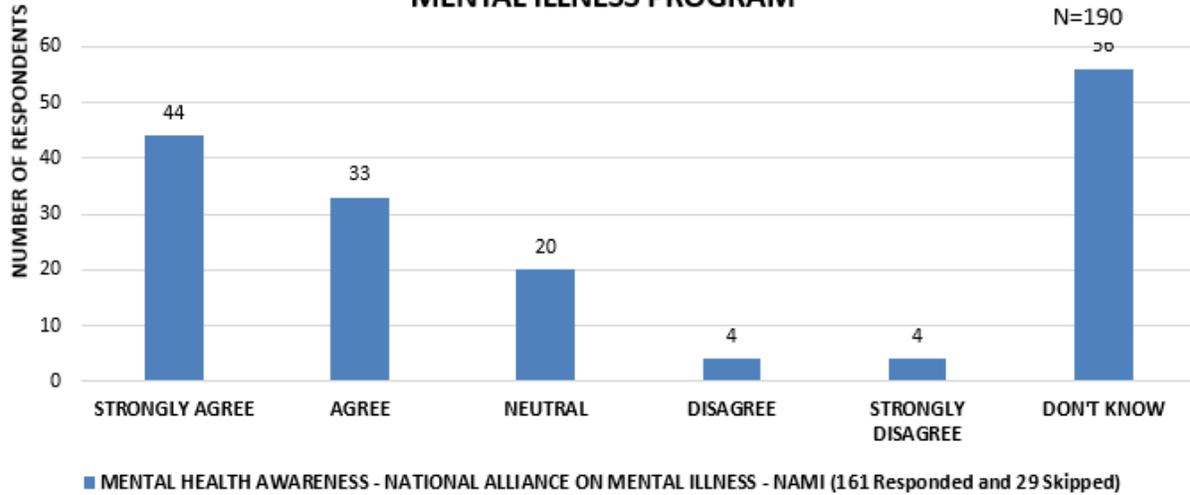
**PEI - ACCESS AND LINKAGE PROGRAMS**



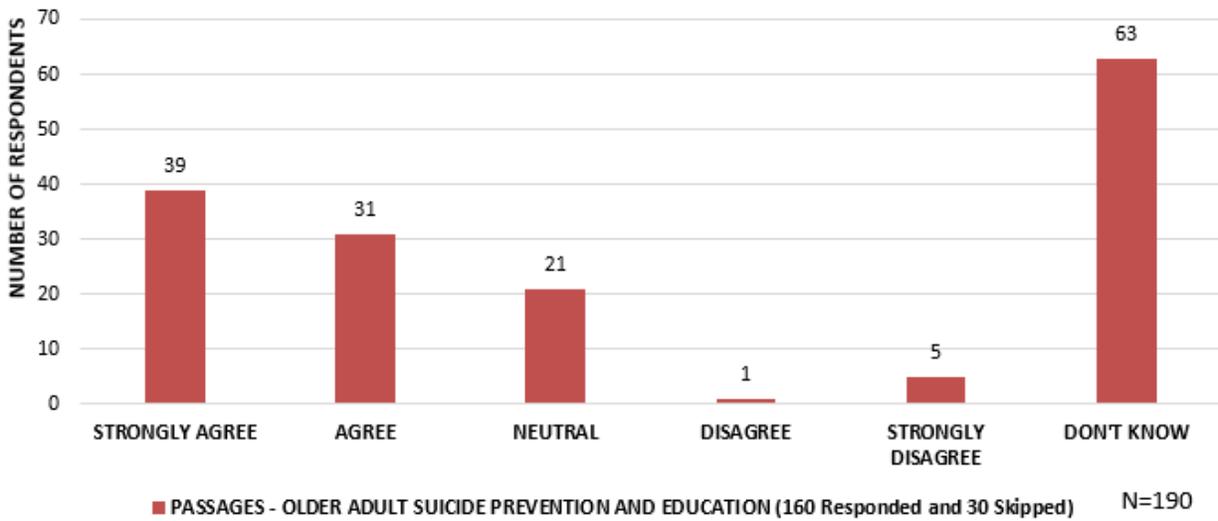
**PEI - PREVENTION PROGRAMS**

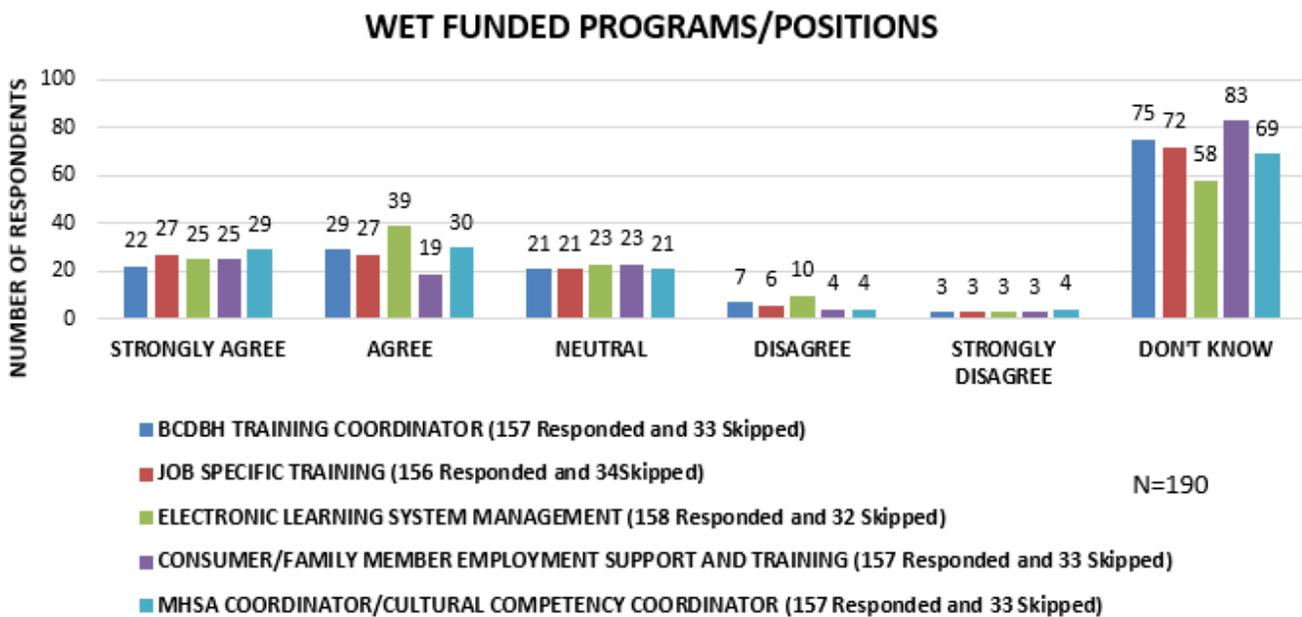
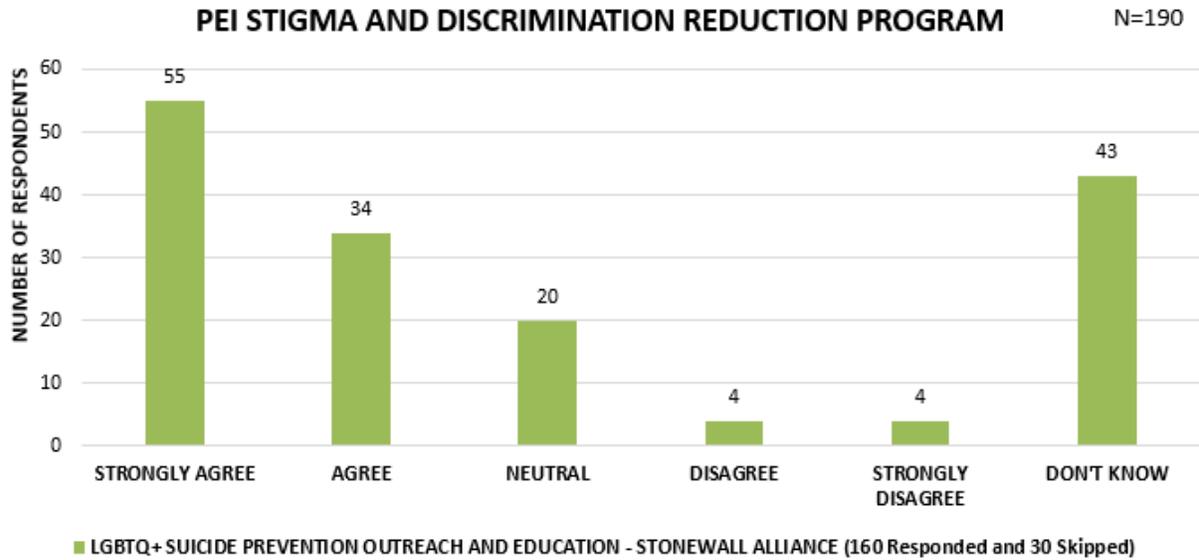


**PEI - OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS PROGRAM**



**PEI - EARLY INTERVENTION PROGRAM**





**BASED ON YOUR KNOWLEDGE OF MHSA FUNDED PROGRAM/SERVICES, PLEASE INDICATE ANY IDEAS THAT NEED IMPROVEMENT OR ANY SUGGESTIONS FOR SPECIFIC PROGRAMS/SERVICES YOU MIGHT HAVE:**

- Peer advocates should have the option of being regular, benefited employees. MHSA gives us a chance, now is time to give us a leg up. I spend over \$1,000 per month for health insurance. I am very grateful for my job (max earnings before taxes are \$1,000), and, I would like to be able to at least cover health insurance.
- Transient housing.
- There is NOT enough outreach going on for persons with mental illness experiencing homelessness. Mobile crisis hours are too limited.
- We need mental health workers staff working swing/weekends at Oroville board and care sites.
- More one on one counseling services. Classes on mindfulness.
- More funding for programs that benefit older adults.
- I would like to see a Latino Cultural Center in Butte County. Also increase transportation services for county services.
- Iris House is too hard to get in to.
- There is a critical need for more outpatient providers for older adults in Butte County, particularly older adults who have Medi-Care as their primary insurance. There is also an overall lack of trained providers to work competently with the older adult population.
- Increase perinatal maternal child mental health.
- Increase community based opportunities for workforce education and training.
- Support expert early childhood mental health supports, prevention and intervention.
- Paradise Youth are totally under represented with any funding in our Butte County Community and there is a critical need for support with multi-generational drug abuse, chronic poverty and total isolation. There was a study done at one point in time by a CSUC intern in the master of Social Work program honor thesis that did a study of suicide rate in the Paradise/Magalia community that surpassed ratio of any other town in Butte County. I am saddened that they do not offer the Prevention Unit in this community that includes mentoring at the Junior Highs and High School Club Liver for alcohol prevention at both Ridgeview and Paradise High in one of our most dire communities.
- More funding for Youth and Cultural specific programs.
- There is no youth programs for the underserved communities, especially for the Hmong youth.
- Incentives for attending Zoosiab groups.
- Access to services remains a huge problem - transportation is lacking.
- Better customer service at clinics. Feel pressured to take medication with constant questioning from doctors. Treated as a child by health providers.
- Interpretation services.
- Better health services and educational groups. Community based group to help community [Oroville] reduce stress as a whole. More interpreting services. Improve mental well-being with the hold of Hmong Cultural Center at Butte County.
- I am a family member of a consumer and a volunteer advocate who spends 3/7 days of the week having been told at least once by a BCBH staff member that the needed services do not exist, or that their hands are tied, or that they will call me back, or that they are also frustrated... and am left to deal with ACTUAL PEOPLE IN ACTUAL CRISIS on my unprofessional own. I live in frustration at the FAILURE OF SERVICE DELIVERY by BCBH.

- Have more in-person interpreters available vs. cyber interpreters. Improve customer services with medical providers.
- All services are doing their best with what they are providing for consumers.
- MHSA funds need to be used for all populations identified in the cultural comp. plan not just some. Specific services for the Native community need to be developed.
- Housing in paradise for adults living with mental illnesses. MHSA funds none.
- [Regarding Innovations project *Physicians Committed*,] \$756,000 is a great deal of money for a 3-year training program. The program states that it will assist physicians in including MH in screening along with physical health, and will assist with referring to resources. A major concern in our community is that it is much easier to identify young children and adolescence in need of services than it is to actually provide effective services. Is a portion of this funding set aside to actually provide services? My suggestion would be to set aside a significant portion of this funding to provide direct MH services to hundreds of kids we already know need support in schools where they are easy to identify and serve. It seems there's a lot more money in the medical field than in MH, so is the medical community contributing like funds in any way?
- There is a tremendous need for a new modernized Psychiatric Health Facility. There is also a tremendous need for a detox facility for the epidemic of addiction problems with alcohol, methamphetamine, and other drugs.

**DO YOU HAVE ANY INPUT ON THE COMMUNITY PLANNING PROCESS, MHSA FUNDING AS A WHOLE, OR ANY OTHER SUGGESTIONS?**

- I would like to see a Peer Advocates certification program so there is a baseline of knowledge amongst this awesome asset. Also, a clear path for advancement for peer advocates.
- Offer night time mobile crisis response. Work on a strong Crisis Intervention Team coordinating with the CPD, Sheriff's office, and BCDBH.
- Thank you for providing community input opportunities
- Reach out to older adults and make more of an effort to include them in your planning.
- Comprehensive data reports would support informed input and community education and information efforts.
- There is a need for more services and service locations for people in the county. Service contracts may help with providing local service sites for people in the rural county.
- I like to see more done to target done on a true recovery model to support not making our client's sick, but making them better, expecting more by supporting Laura's Law & affordable housing opportunities.
- Need to have a culturally and linguistically youth program.
- Treat everyone with respect and care; improve customer service.
- Help build a stronger community relationship so that the MHSA funding can improve as a whole along with the Butte County population. Need the support from both sides.
- Housing is a major issue and it is hard to find affordable housing.
- Help the elders to participate on more activities such as indoor or outdoor events.
- More opportunities for community involvement. Include Chico State and Tribes.
- I would like a full report on the MHSA funding for services in Paradise. I would like to see the resources and funding for the 38,000 people in Paradise and Magalia.
- In the past we were told we had support for Zumba classes at Promotores. I would like Promotores to provide transportation to appointments and also provide translators.
- More information and programs in Spanish.

- I would like to have a therapist or someone to help me.
- Peer advocate involvement in SEARCH programs. Chronically mentally ill need peer support in all aspects of recovery.
- Crisis unit in Paradise, CA, rather than transporting out of our community.
- More peer advocates in MHSA funded programs.
- More opportunities for youth, individuals and families to become empowered through use of peer-led advocacy groups; with a real, tangible place at the table to discuss community resources and ways services can be improved to meet individual, youth, family and community needs.
- I appreciate community meetings, surveys and input! It's important to obtain community feedback to best serve the population.
- Increase mental health supports for those who may have substance abuse issues.
- I would like basic resources such as housing, food, shelter, and socialization to be considered indicators of the health and interdependence of our human systems, and addressed on a comprehensive, macro level. Scapegoating the poor and disenfranchised is eroding social stability, and providers feel overwhelmed by the challenges facing their clients.
- PEI services should focus on youth.
- Outreach to groups that already meet to get their input. Go to them or make an effort to reach out more to them.
- The planning process is not very clear
- Efficiency is a beautiful thing.
- We need healthier buildings to work in, sufficient staff to prevent the increasing amount of burnout due to high caseloads.
- It seems like many projects are now geared towards administrative desires and less on funding for clinical care and this bothers me.
- The community be made more awareness of how to help the homeless.

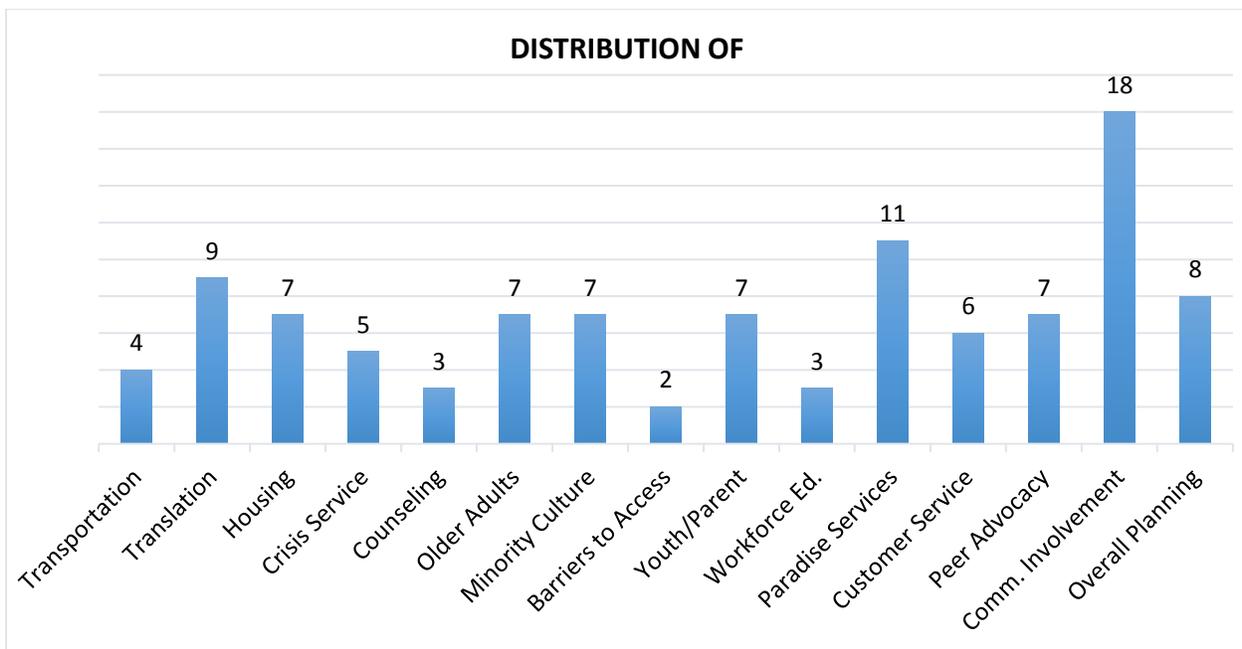
***IF YOU ATTENDED A COMMUNITY MEETING OR FOCUS-GROUP, BASED ON THE FISCAL INFORMATION PROVIDED, PLEASE INDICATE ANY AREAS THAT PRESENT QUESTIONS OR ANY OTHER SUGGESTIONS AND COMMENTS:***

- Great job! Clear and informative.
- More detail and transparency to promote information dissemination, education and understanding. Detailed data about services, demographics and costs support informed feedback also.
- I think focus needs to be in Paradise, as Gridley even has a live spot. I think this community is truly struggling as I see so many addicted parents and how it impacts their children and youth.
- Should have interpreter service ready even if client says they understand English.
- Thanks for helping the community with their mental health services. Hope that the support doesn't stop.
- Don't fully understand what MHSA is and can't help with due to language barriers.
- Why has the county identified populations as priorities but not providing specific services for all those populations?
- Housing for adults and transportation costs for the 38,000 people in Paradise and Magalia.
- I attended MHSA group at Iversen Center it was educational.
- Not a fan of marketing money being spent, would rather see a service.
- The information was very direct and appropriate.
- I would like to know more about the programs and their locations.

- I want to know where I can get mental health care.
- More meetings in Spanish.
- Innovation project: mobile med management for homeless.
- We need increased money put into employment to create a continuum of support for all clients despite level of functioning. Our employment program as designed leaves out a large group; it caters only to moderately mentally ill. We need a "place then train" model.
- Keep The HUB going.
- More technology available to consumers in Paradise, CA and more training for those technologies.
- I would like more information on numbers serviced and outcomes of those served in the various programs.
- The ER newspaper said that all that money we are taking through the 1% of those making \$1 million and more is not being utilized. I'd like more information on that. I would hope that we could be doing more for our mentally ill community if we used the money we had.
- The direction of funding in all areas.
- The focus-groups need to be heard at middle schools or all schools so children can feel like they have someone and somewhere safe to go and to speak with. They also need to at a meeting at the hospitals.
- More activities for people with mental illness.
- Great work!
- Of the questions asked I would estimate that 2/3 were met with ""I don't have that information".
- The Iversen Center is a bright spot in the community right now. We all appreciate it.
- Expand hours/money at 6th Street. Support groups including Spanish. Continue to communicate meeting dates.
- Add the Greater Chico Homeless Task Force and the Butte County Continuum of Care to the email notifications.
- More details on all programs that are MHSA funded and who they serve. 3 Year Plan discussed & explained better.

## Community Comments Summary

This section provides a brief summary of the feedback provided via written comments. The following graph shows the distribution of the frequency of topics mentioned. Below that is a description of the categories that included the highest number of frequency.



### Top Mentions

1. *Community Involvement:*
  - a. Community-based group services to reduce community stress.
  - b. Appreciation for the community input process.
  - c. Enhancing communication with the community; more detailed and comprehensive data reports for MHSA programs and associated costs.
  - d. More opportunities to involve community in programs in order to help each other.
  - e. Increased community involvement with schools and tribes.
2. *Paradise Services:*
  - a. More funding allocated to prevention services for youth.
  - b. Housing for adults with mental illness.
  - c. Increased services in Paradise, including Crisis Unit.
3. *Translation:*
  - a. In-person interpreters available vs. cyber interpreters.
  - b. More services/groups available in Spanish.

Honorable mentions: *Housing, Older Adults, Minority Culture, Youth/Parent, Peer Advocates, Overall Planning, Customer Service.*

## 30-DAY PUBLIC COMMENT PERIOD

This section is utilized to provide an overview of activities included the 30-Day Public Comment period, May 18<sup>th</sup> through June 17<sup>th</sup>, 2018. On May 18<sup>th</sup>, notifications were sent to the community announcing the commencement of 30-Day Public Comment period, with instructions on how to access the plan online and how to provide feedback. Below is the feedback provided from the community during this 30 day period.



### **TOPIC: PROGRAM CHANGES**

- Allocate funds for peer partners and peer counselors.
- What funds can be applied to Mobile Crisis so 5 pm – 12 am is covered?
- Money for psychiatrists' on-sight to help with medication and services at BCDBH direct services.
- Physician Committed questions: how will this be assessed for success? Can the crisis intervention specialists be hired and well-paid around the clock?

### **TOPIC: COMMUNITY NEEDS**

- Extensive crisis intervention training for law enforcement, police & sheriff department.
- Paradise needs housing, a bed facility and trained professional hired and more money.
- Help via funding for C.H.A.T. in their efforts to house the homeless.
- Funding for transitional and permanent housing.
- Wrap-around staff paid to help implement Laura's Law to work with BCDBH consumers who can stop the revolving door of hospitals/jail/street.
- Tiny house construction and maintenance in every Butte County community to create community.
- More Iris House type housing in Paradise, Oroville, and Chico.

## NOTABLE UPDATES & MODIFICATIONS

The purpose of this section is to state any noteworthy updates that have been made to Butte County Mental Health Services Act (MHSA) funded programs, services or initiatives since the previous plan update.

### Integrated Health Care & Mental Health (IHMH)

IHMH will no longer be a stand-alone program, instead it will be a service that BCDBH provides via case management throughout our system of care. At the onset, this program provided mental health clinicians co-located at Federally Qualified Health Centers (also known as primary care facilities) to coordinate integrated health care so that BCDBH consumers would be able to access medical and mental health care at the same site. As the program evolved, the logistics of embedding clinicians into these sites proved challenging. Eventually, the decision was made to continue this program from BCDBH locations; this would provide a designated IHMH clinician at each outpatient clinic.

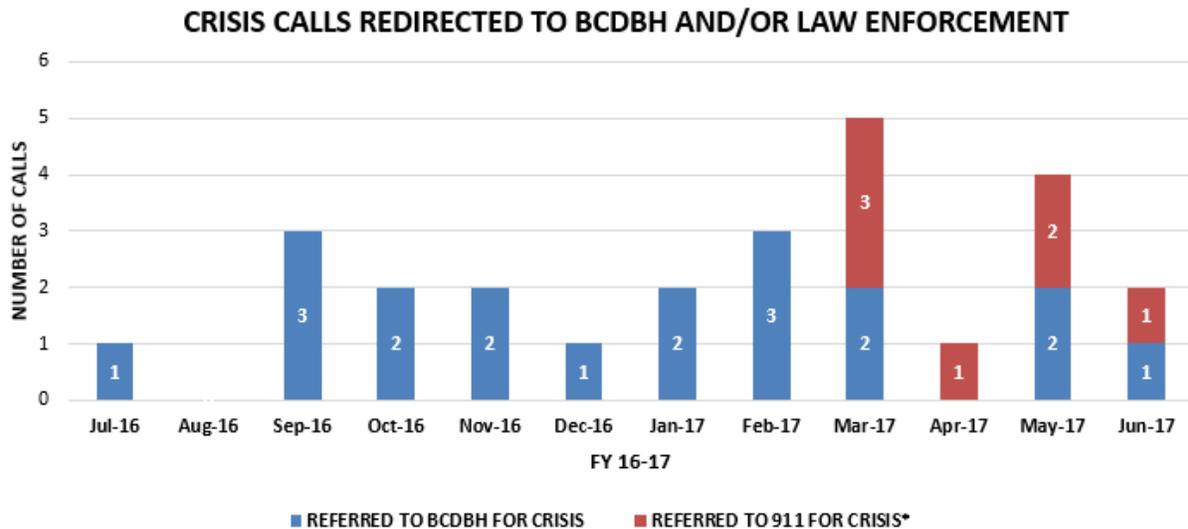
With the passage of the Medicaid Final Rule, integrated healthcare is now a priority for mental health plans and managed care plans. This allowed all BCDBH staff to engage in IHMH activities. Integrating mental health and health care is now a characteristic of the service our agency provides. The allocations designated for IHMH are now being allocated to Full-Service Partnership programs, SEARCH (pg. 42) and YIP (pg. 46).

### Mobile Crisis Team (MCT)

This is a new program to MHSA as of March 2018. This pilot program was born out of the Community Input Process that was initiated during the development of the 2017 Three Year Program and Expenditure Plan. MCT dedicates two full-time counselors to provide on-call assistance to the Chico Police Department for mental health crisis support. This program will be expanding to collaborate with the Butte County Sheriff's Office in FY1819. This expansion is made possible by grant funds awarded from *SB 82 investment in Mental Health Wellness Act of 2013*. For more information on this program, please see page 37.

### North Valley Talk Line (NVTL)

This program is moving from CSS to PEI beginning July 1, 2018. NVTL provides a free, consumer-run, peer support telephone service that offers support and referrals. In the past, this program has been designated in the Crisis Intensive Services Category of CSS. After review of the outcome data (below), it was determined that there are rarely crisis calls or crisis interventions needed for this talk line. The majority of calls pertain to problem solving, develop coping skills and conflict management. For more information on NVTL, see page 38.



*\*REPORTING CALLS TO 911 DID NOT START UNTIL MARCH 2017*

## Strengthening Families (SFP)

This program is expanding through MHSA funding. Strengthening Families (SFP) is a nationally and internationally recognized parenting and family support program. SFP consists of a Challenge Day, 11 sessions, and a graduation night focused on building the parent’s, the teen’s, and the family’s capacity for healthy functional relationships.

## Triage Connect

This program will move from PEI to CSS beginning July 1, 2018. This program was initially funded through the 2014 SB82 award, and has evolved since the conclusion of the grant in FY1617. This program was then adopted by MHSA as an Access and Linkage program, due to the increased personnel at access locations throughout the County. As this program progressed, it has become primarily focused on case management, hospitalization placement and discharge. Below are the notable changes to the program:

### Homeless Team

In the 2017 Three Year Plan, BCDBH stated that, “The department is currently evaluating a better way to allocate resources to local homeless shelters that will incorporate more linkage and case management services.” Since this review, it was determined the Homeless Triage Team now be funded via PATH (Projects for Assistance in Transition from Homelessness), and is no longer an MHSA program.

### Hospital Team

At the onset of this SB82 program, The Hospital Triage team was located at three local emergency departments: Enloe, Oroville, and Feather River. The clinicians are now located at BCDBH Crisis Services, and dedicated to calls from the hospitals.

## Working Innovations Network (WIN)

The WIN team is now embedded in the Triage Connect team. In the 2017 Three Year Plan, the WIN team was described as providing support to the CSU to resolve crises with the goal of linking consumers and their families to local community services. WIN also supports the CSU by answering the crisis phone, providing food for clients, and providing a compassionate, understanding active listening as needed. The WIN team also provides transportation as needed for consumers to and from psychiatric hospitals to ensure a warm hand-off.

## Youth Intensive Program

The Youth Intensive Program (YIP) is a program involving staff from BDCBH and another agency. YIP is a full service partnership program that provides interventions and treatments that have been shown to decrease youth hospitalization, disruptive out-of-home placements, and involvement in the juvenile justice system while improving mental health and daily functioning. To keep a cohesive team with direct communication and access to the clinical records, all positions will be staffed by BCDBH starting July 1<sup>st</sup>, 2018.

# SECTION 1: COMMUNITY SERVICES & SUPPORTS

CS&S

## CRISIS STABILIZATION UNIT (CSU)

<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	General (Non-FSP)	<input type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input checked="" type="checkbox"/>	Children (0-15)		
	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)		
	<input checked="" type="checkbox"/>	Adult (26-59)		
	<input checked="" type="checkbox"/>	Older Adult (60+)		

### PROGRAM DESCRIPTION

The Crisis Stabilization Unit (CSU) offers voluntary mental health crisis services for any adult or youth experiencing acute psychiatric symptoms. The CSU helps resolve crises with the goal of linking consumers and their families to local community services. The purpose of the CSU is to assess the crisis, allowing time for the individual to be away from stimuli that may provoke the crisis. A consumer experiencing a psychiatric crisis can be in the CSU for up to 23 hours. Providers can then assess if the crisis can be resolved to the point that the consumer can reintegrate into the community, or if the crisis dictates a higher level of inpatient care. The CSU operates 24 hours a day, 7 days a week.

Consumers have responded positively to Crisis Stabilization Unit services, which have been shown to be effective in preventing hospitalizations. Overwhelmingly consumers from the CSU are discharged to their home or community living program as opposed to hospitalization.

### OUTCOMES

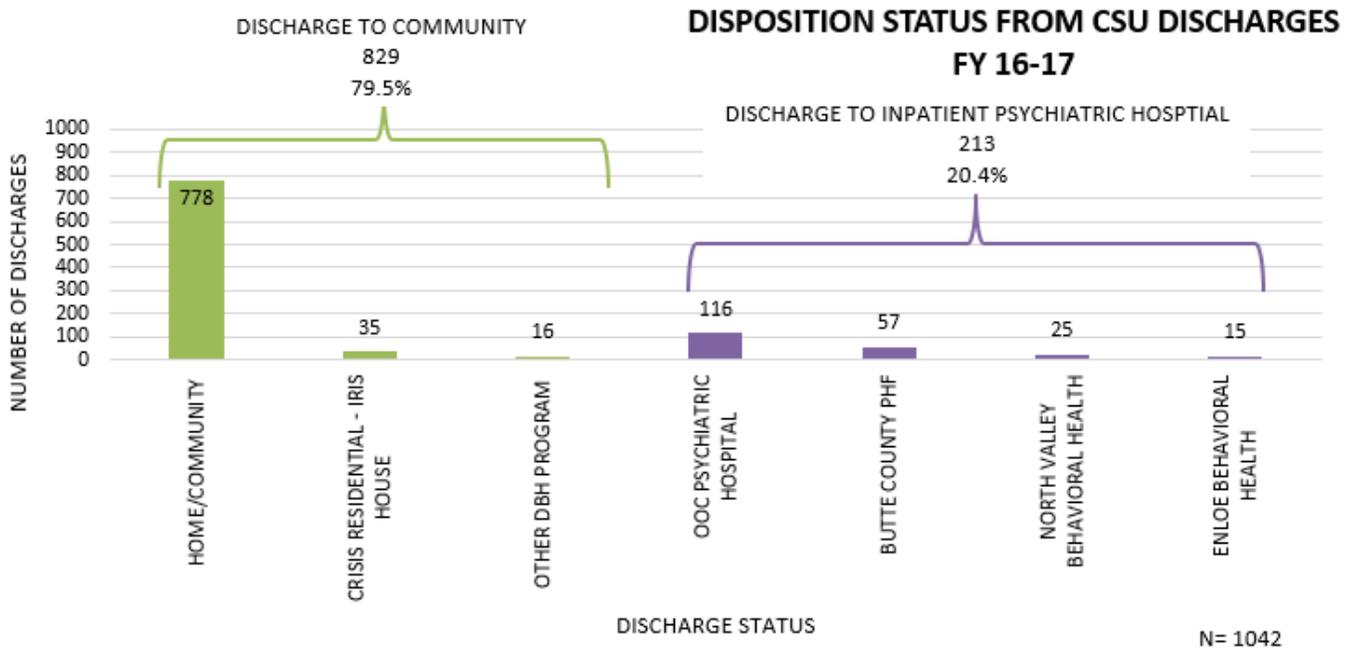
1. Reduce number of hospitalization.
2. Discharge consumers to community resources.
3. Increased usage of CSU.

### MEASUREMENTS

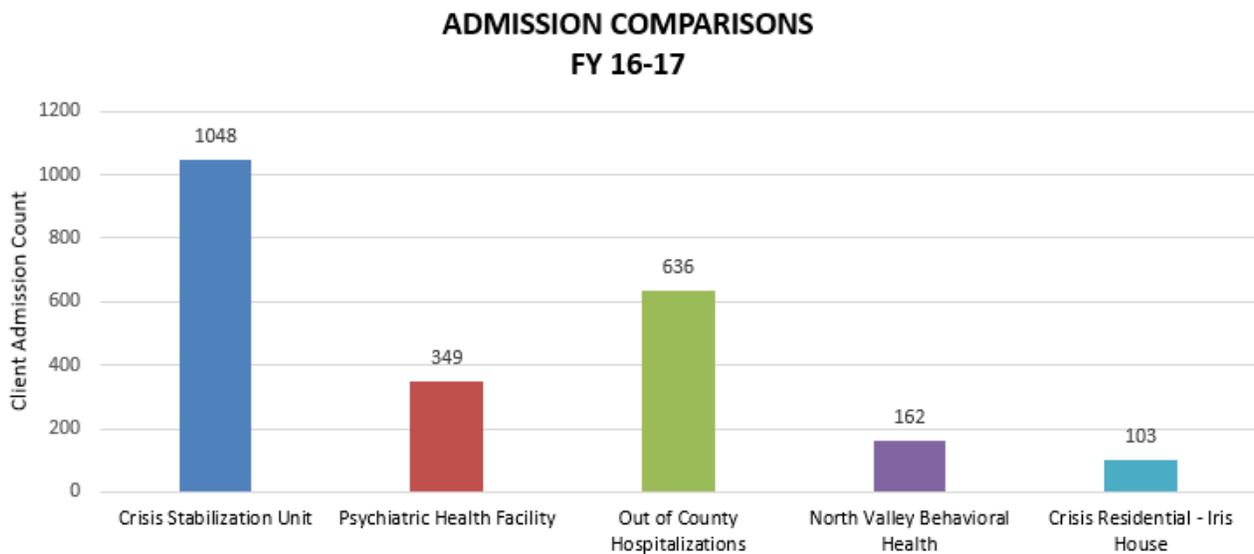
1. Disposition upon discharge from CSU.
2. Discharge consumers to community resources.
3. Increased usage of CSU.

Outcome 1: Reduced number of hospitalizations.

Outcome 2: Discharge consumers to community resources.



Outcome 3: Increase usage of CSU.

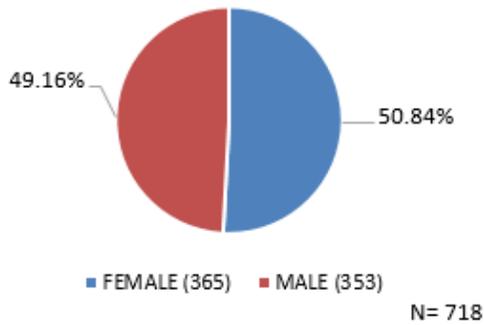


**DEMOGRAPHICS OF DISTINCT CLIENTS SERVED**

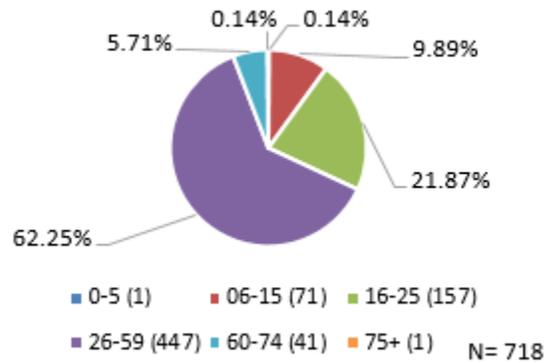
FY 16-17

Number Served: 718

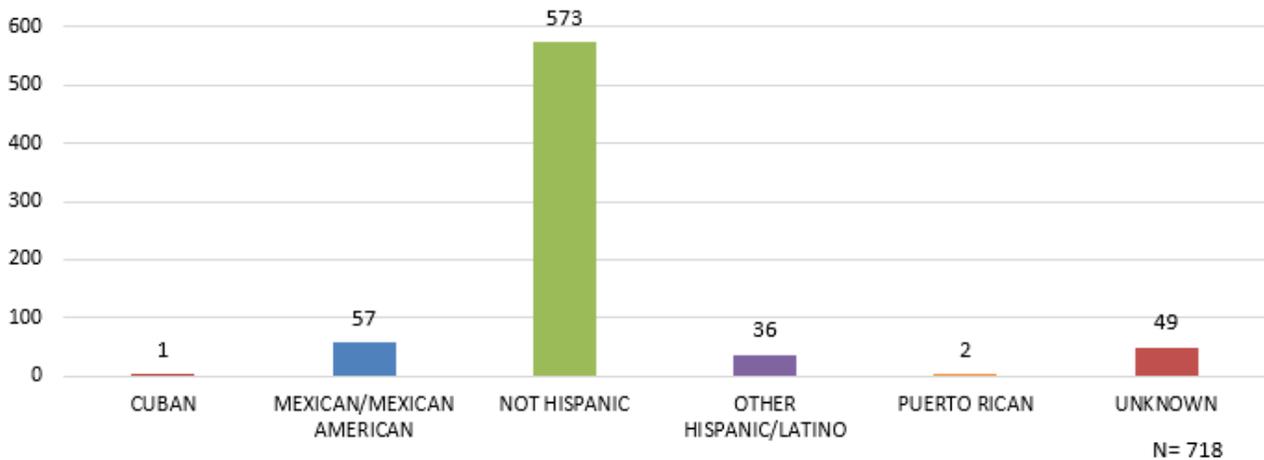
**OPEN CLIENTS BY GENDER**



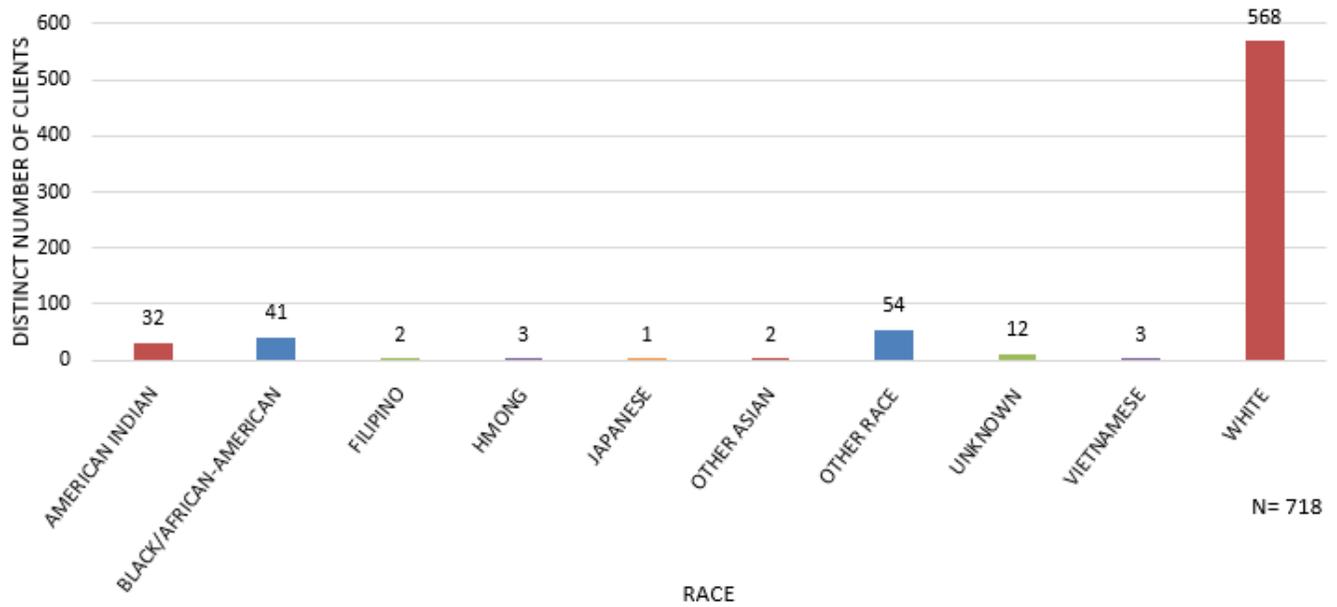
**OPEN CLIENTS BY AGE GROUP**



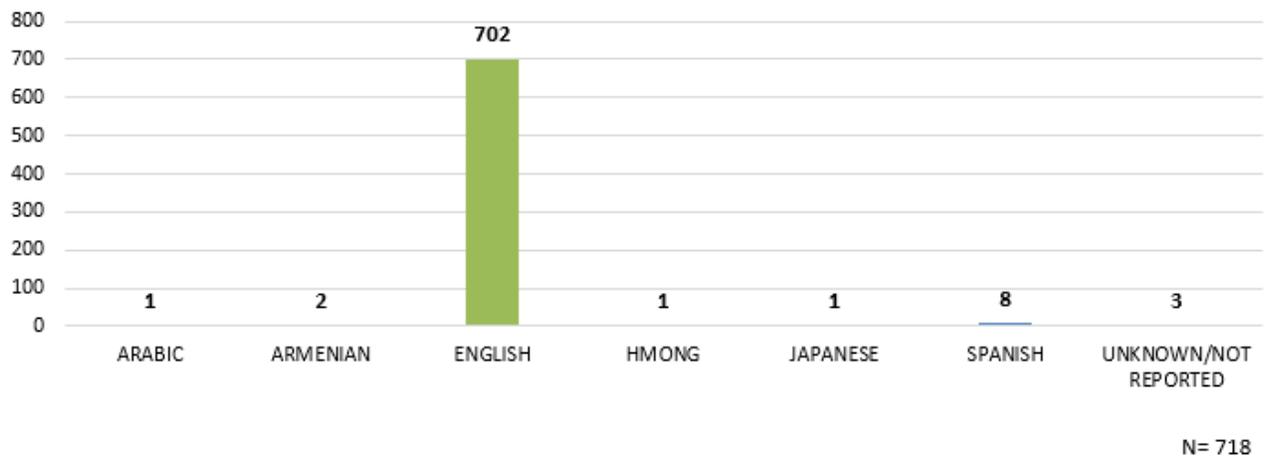
**OPEN CLIENTS BY ETHNICITY**



### DISTINCT COUNT OF RACE



### DISTRIBUTION OF OPEN CLIENTS BY PRIMARY LANGUAGE



<b>STATUS</b>	<input checked="" type="checkbox"/>	New	<input type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	General (Non-FSP)	<input type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input checked="" type="checkbox"/>	Children (0-15)		
	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)		
	<input checked="" type="checkbox"/>	Adult (26-59)		
	<input checked="" type="checkbox"/>	Older Adult (60+)		

#### PROGRAM DESCRIPTION

The Mobile Crisis Team will partner with the law enforcement to provide crisis related outreach and engagement as well as respond to 911 requests regarding possible psychiatric or emotional crises in the community. The Mobile Crisis Team will operate with the goal of reducing the use of involuntary psychiatric hospitalization, when appropriate, by providing consultation, crisis assessment and engagement of the individual in need, seeking alternative treatment resources, when appropriate, including referrals to voluntary psychiatric services as available.

#### OUTCOMES

1. Reduce number of involuntary psychiatric hospitalizations by co-responding with the law enforcement resulting in role-modeling and educating law enforcement about effective ways to de-escalate interactions with people who have a mental illness.
2. Increase number of engagement with people with mental illness in the community to provide resources, support and transportation to services.
3. Decrease usage of 9-1-1 non-emergency users and ER visits.
4. Increase client satisfaction with the services they receive.

#### MEASUREMENTS

1. Police and Sheriff changes in attitudes, knowledge, and/or behavior related to mental illness that are applicable to the specific program:
  - a. Pre/Post Survey every 6 months which will address understanding of mental health resources, general feelings of engaging with people with mental illness and increasing compassion for people with mental illness.
  - b. Number of people on 5150's in hospital emergency rooms decrease.
  - c. Decrease the number of 5150's rescinded in the ER's.
2. Number of community members that receive engagement.
3. Number of community members that receive transportation to services.
4. Use of crisis units post-intervention (9-1-1, ER, etc.). Measurements will be derived from:
  - a. Surveys conducted by Peer Advocates post-intervention.
  - b. *CS Client Tracker* form in electronic health record system.
5. Peer advocate will conduct surveys with clients post-engagement to asses for:
  - a. Satisfaction with services.
  - b. Ability to relate to BCDBH staff.

<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	General (Non-FSP)	<input type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input checked="" type="checkbox"/>	Children (0-15)		
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	<input checked="" type="checkbox"/>	Adult (26-59)		
	<input checked="" type="checkbox"/>	Older Adult (60+)		

**PROGRAM DESCRIPTION**

Since August 2010, the Northern Valley Talk Line (NVTL) has provided a free, consumer-run, peer support telephone service that offers non-emergency, non-crisis support and referrals. The majority of calls pertain to problem solving, help with coping, and conflict management. Callers that are in crisis or that are at risk of harm to themselves or others are referred to crisis services. The Talk Line number is 1 (855) 582-5554 and is open 7 days a week from 4:30 PM to 9:30 PM.

Talk Line’s continued increase in calls and high level of retention of staff are examples of the program’s outstanding supervision and training as well as a dedicated group of staff. Talk Line operators regularly describe how proud they are to give back and how much the program has done for them. Several of the staff have discontinued Social Security Disability Insurance (SSDI) and moved from homelessness to stable housing. Another success was the way in which the Talk Line developed a modified, culturally appropriate line for the Hmong community. Consumers use this line as a part of their recovery plan; by placing regular calls to the program consumers are actively reducing loneliness and isolation.

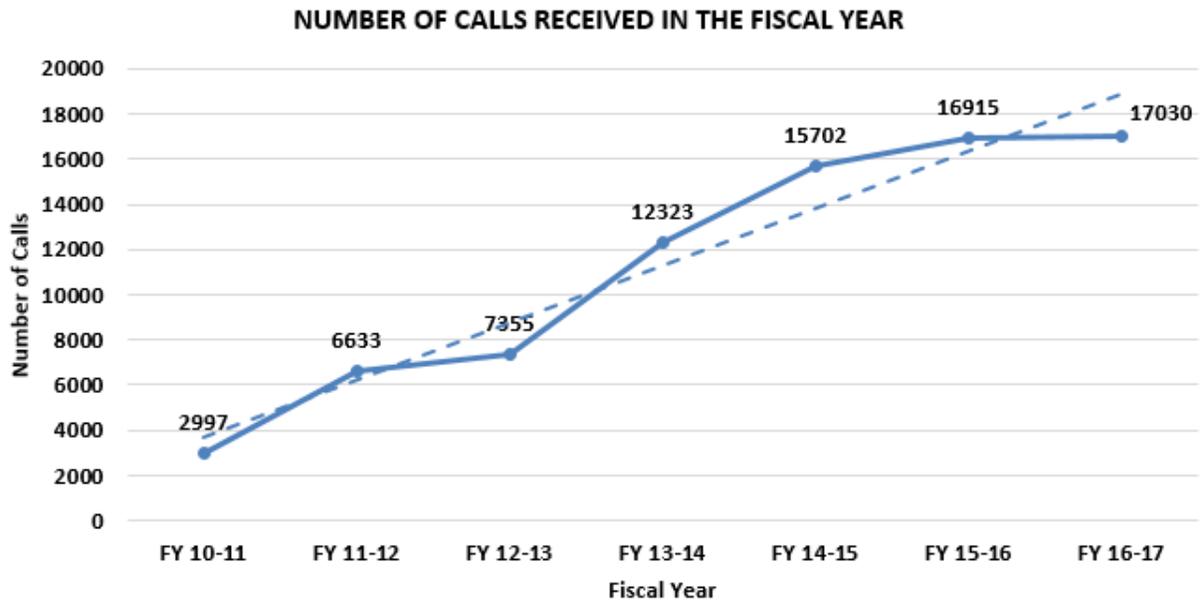
*“I feel as though I’m not alone in the world, I feel validated, excepted, and affirmed. I have wonderful relationships with the Warm Line operators...Gives me clarity, strengthens my spirit/being.”*  
 - Consumer

**OUTCOMES**

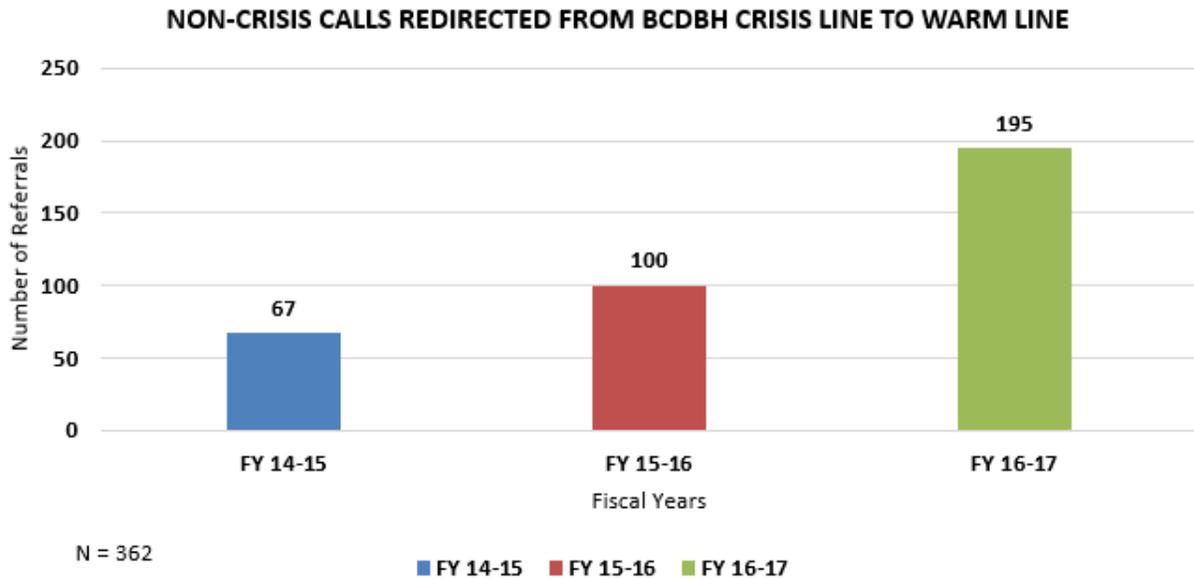
1. Non-crisis calls redirected from BCDBH Crisis Line to Warm Line.
2. Crisis calls redirected to BCDBH and/or law enforcement.
3. Resolves issues to prevent escalation and increase rapport of staff with caller.
4. Increase local community support services.

**MEASUREMENTS**

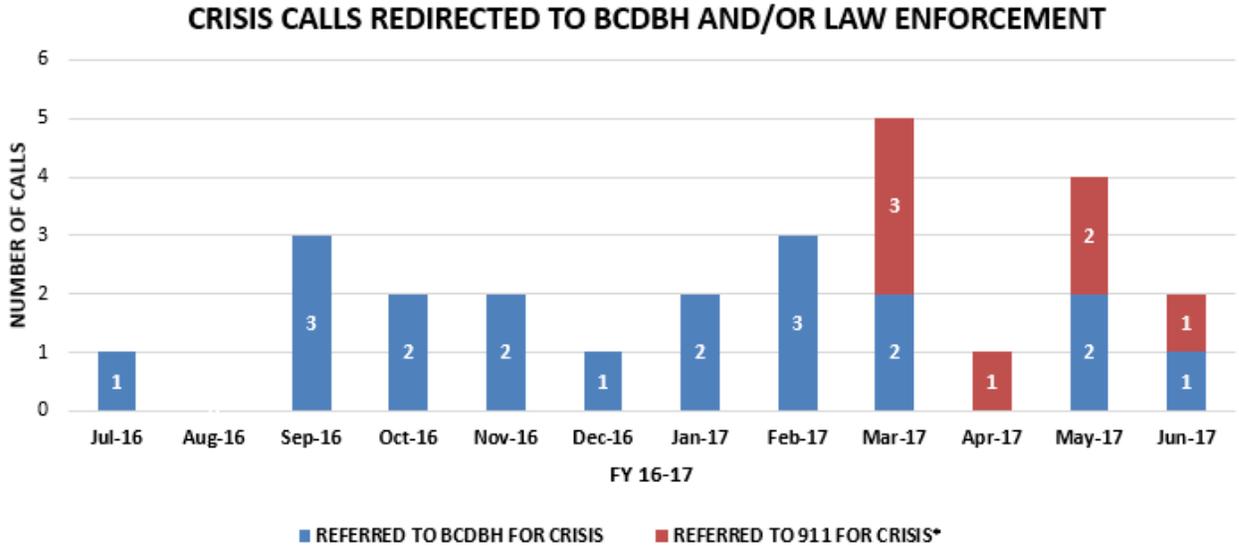
1. Number of calls referred to Warm Line from BCDBH Crisis Line.
2. Number of calls to BCDBH and/or law enforcement.
3. Capture caller satisfaction (end of the call satisfaction survey). Survey questions began January 2017.
4. Number of referrals made to medical, financial, housing or other community services.



Outcome 1: Non-crisis calls redirected from BCDBH Crisis Line to Warm Line.



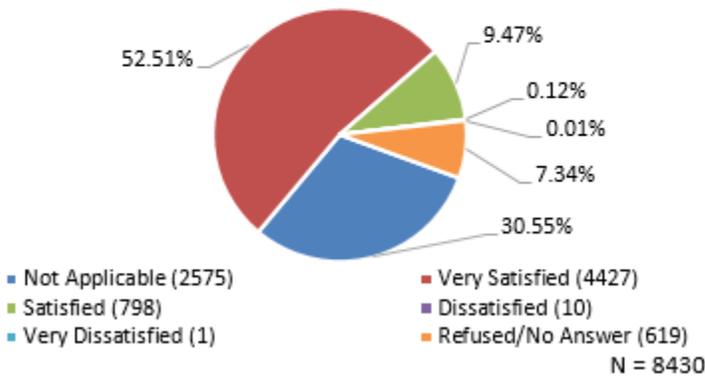
Outcome 2: Crisis calls redirected to BCDBH and/or law enforcement.



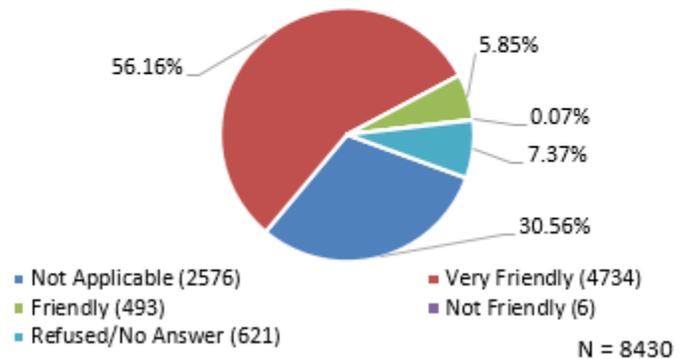
\*REPORTING CALLS TO 911 DID NOT START UNTIL MARCH 2017

Outcome 3: Resolves issues to prevent escalation and increase rapport of staff with caller.

#### HOW WOULD YOU RATE YOUR OVERALL SATISFACTION WITH THE CALL?

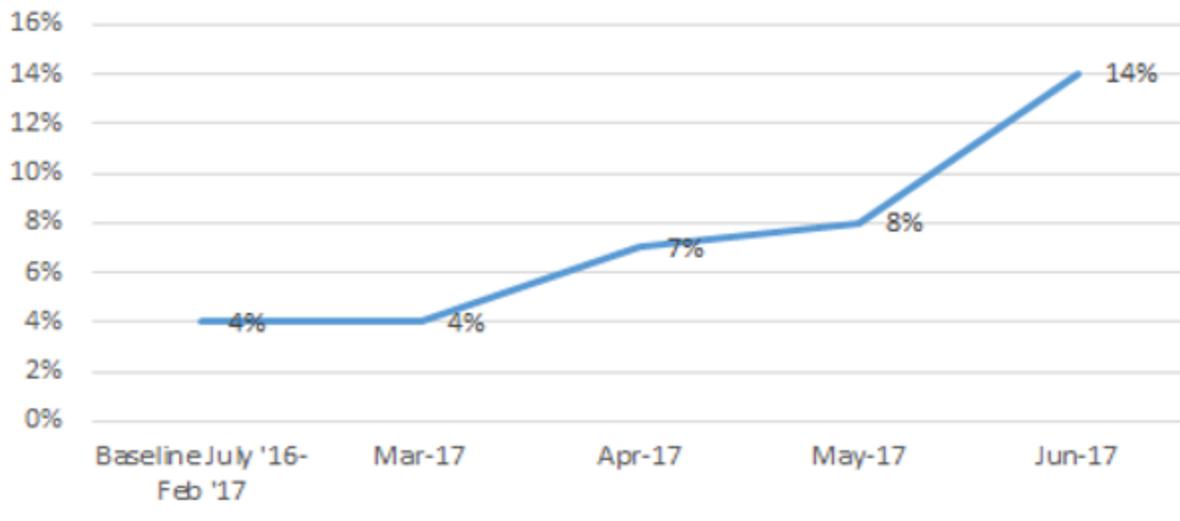


#### HOW WOULD YOU RATE THE FRIENDLINESS OF THE OPERATOR/TALK LINE REPRESENTATIVE?



Outcome 4: Increase local community support services.

### Iversen- Percentage of Members Linked to Community Services



\*Chart Provided by NVCSS

<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input type="checkbox"/>	General (Non-FSP)	<input checked="" type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input type="checkbox"/>	Children (0-15)		
	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)		
	<input checked="" type="checkbox"/>	Adult (26-59)		
	<input checked="" type="checkbox"/>	Older Adult (60+)		

**PROGRAM DESCRIPTION**

The Support, Employment, Assistance, Recovery, Community and Housing (SEARCH) teams use client-centered and strength based recovery philosophies to help individuals with severe and persistent mental illness to reduce impairments from symptoms and achieve the highest level of self-sufficiency while integrating into the community. Butte County Department of Behavioral Health's in-house operated programs, coupled with contracted collaborations with other community-based agencies, have maximized the program's success in providing outreach, support, employment, assistance, recovery, and housing to people who are homeless or at risk of homelessness with mental illness and co-occurring disorders. The goal of SEARCH is to promote consumer self-sustainability in the community, thus reducing further de-compensation and the need for additional services, such as police services and emergency room visits.

The adult outpatient centers in Chico, Paradise and Oroville offer assistance to adults by addressing mental health and substance abuse problems. These consumers receive case-management services as well as have the opportunity for medication services, therapy, and job skill training. Housing, including retention of housing, emergency housing, permanent housing, and employment are key elements of this program. All individuals are assessed on a regular basis to determine if they can graduate to a lower level of care. Depending on clients age, the Milestones of Recovery Scale (MORS) tool or the Child and Adolescent Needs and Strengths (CANS) is used to determine the level of services an individual should receive. Mental health services help consumers to not only have a reduction of mental health symptoms, but achieve employment, housing, and a network of friends.

The SEARCH team also provides supportive services to the residents of the Valley View Apartments. These services are intended to assist the residents in developing self-sufficiency skills (i.e. social skills, housekeeping skills, budgeting skills, symptom management skills, and sober living skills) through its consumer-driven treatment planning and goals setting, as well as Wellness Recovery Action Plans (WRAP). Residents are encouraged to achieve personal growth and maintain his/her wellness and recovery.

## OUTCOME DATA

## SUPPORT, EMPLOYMENT, ASSISTANCE, RECOVERY, COMMUNITY, HOUSING (SEARCH)

### OUTCOMES

1. Increase number of consumers employed.
2. Increase number of consumers housed.
3. Decrease number of consumers hospitalized.

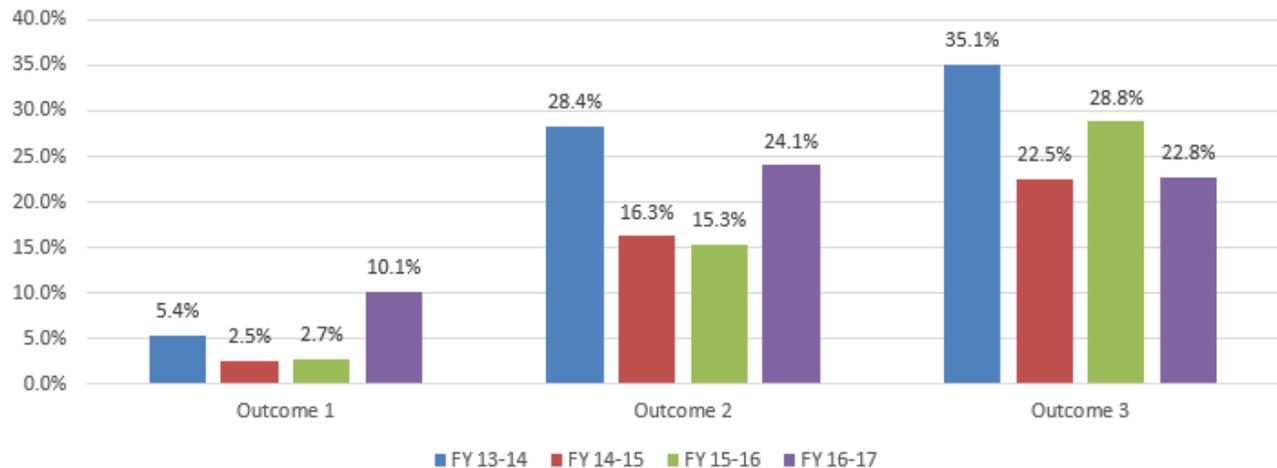
### MEASUREMENTS

1. Distinct number of clients who gained employment at discharge.
2. Distinct number of clients who acquired housing (if homeless at intake).
3. Distinct number of clients who avoided psychiatric hospitalization.

DURING THIS EPISODE THE CLIENT:	FY 13-14	FY 14-15	FY 15-16	FY 16-17
Outcome 1: Gained Employment at Discharge	4	2	3	8
Outcome 2: Acquired Housing (if homeless at intake)	21	13	17	19
Outcome 3: Avoided Psych Hospital (if candidate)	26	18	32	18

\*the above data are captured in the discharge screen in electronic health record

### OUTCOME COMPARISON FOR THE PAST FOUR YEARS



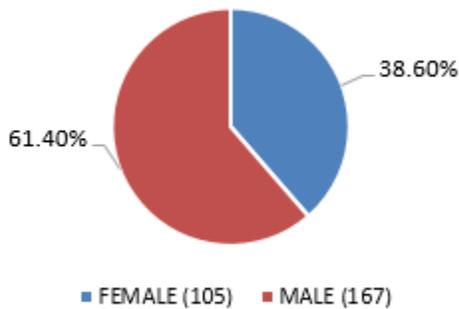
	DISCHARGES	OUTCOME 1: GAINED EMPLOYMENT AT DISCHARGE	OUTCOME 2: ACQUIRED HOUSING (IF HOMELESS AT INTAKE)	OUTCOME 3: AVOIDED PSYCHIATRIC HOSPITAL (IF CANDIDATE)
Chico SEARCH	42	2	7	5
Oroville SEARCH	29	6	10	11
Paradise SEARCH	12	0	2	2
Gridley SEARCH	5	0	0	0

**DEMOGRAPHICS OF DISTINCT CLIENTS SERVED**

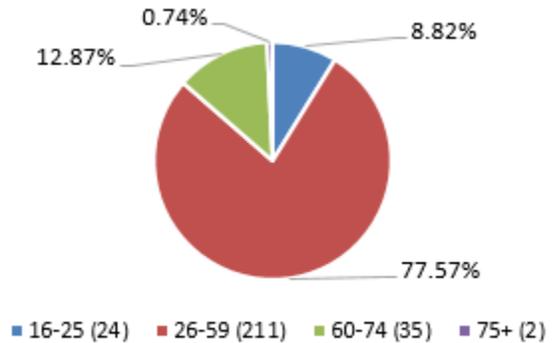
FY 16-17

Number Served: 272

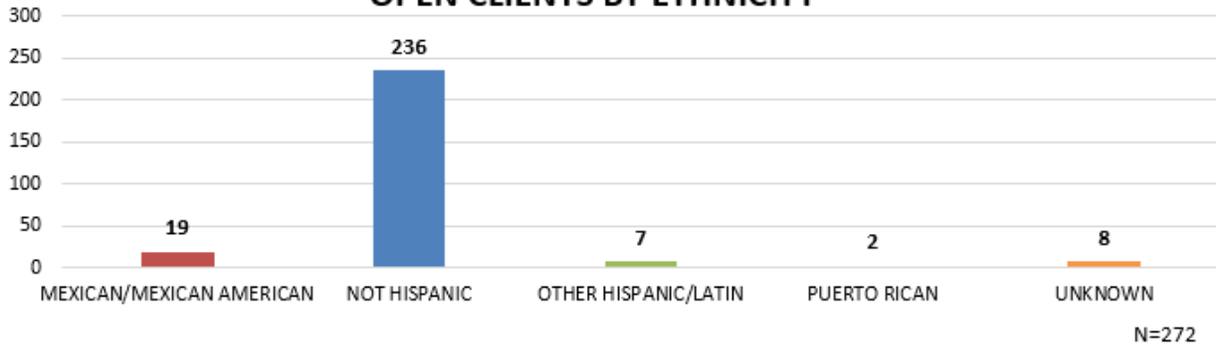
**OPEN CLIENTS BY GENDER**



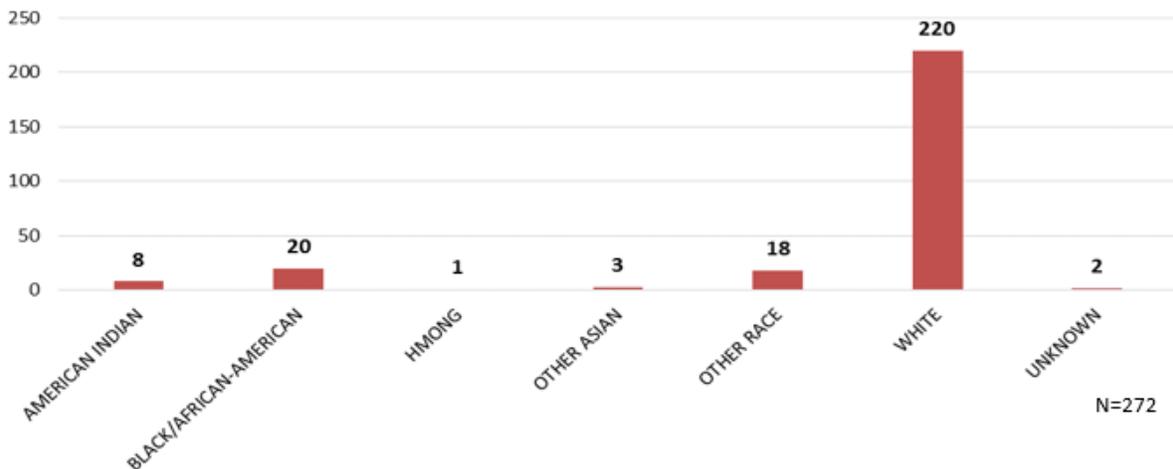
**OPEN CLIENTS BY AGE GROUP**



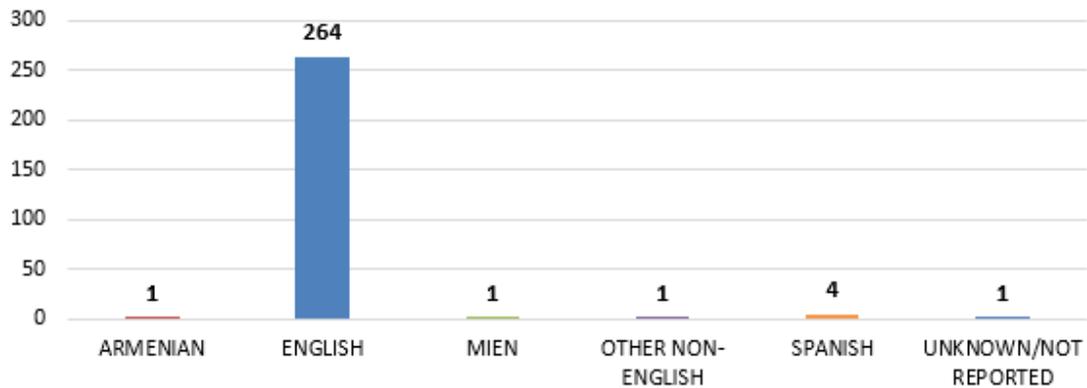
**OPEN CLIENTS BY ETHNICITY**



**DISTRIBUTION OF OPEN CLIENTS BY RACE**



### DISTRIBUTION OF OPEN CLIENTS BY PRIMARY LANGUAGE



#### SEARCH Provides Mental Health Services at the newly opened Valley View Complex

In February 2017, the collaborative housing project between Butte County Behavioral Health and Northern Valley Catholic Social Services was completed. The following month Valley View Apartments began providing permanent supportive housing for Mental Health Services Act (MHSA) eligible adults (18 years and older) with serious mental illness who are homeless or at risk of homelessness. This permanent supportive housing complex offers affordable housing for eligible residents benefitting from mental health services linked through the SEARCH program with housing.



<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input type="checkbox"/>	General (Non-FSP)	<input checked="" type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input checked="" type="checkbox"/>	Children (0-15)		
	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)		
	<input type="checkbox"/>	Adult (26-59)		
	<input type="checkbox"/>	Older Adult (60+)		

**PROGRAM DESCRIPTION**

Youth Intensive Programs are for youth and their families. Services are integrated across agencies and programs to provide coordinated care through an easily accessible process that enables families and youth to be helped by a wrap-around team that addresses their unique needs. The common goal of all Youth Intensive Programs is to provide interventions and treatments that have been shown to decrease youth hospitalization, disruptive out-of-home placements, and involvement in the juvenile justice system while improving mental health and daily functioning. This is the internal program for youth that is the SEARCH counterpart.

**OUTCOMES**

1. Decrease hospitalizations.
2. Reduce out-of-home placements.
3. Improve mental health.

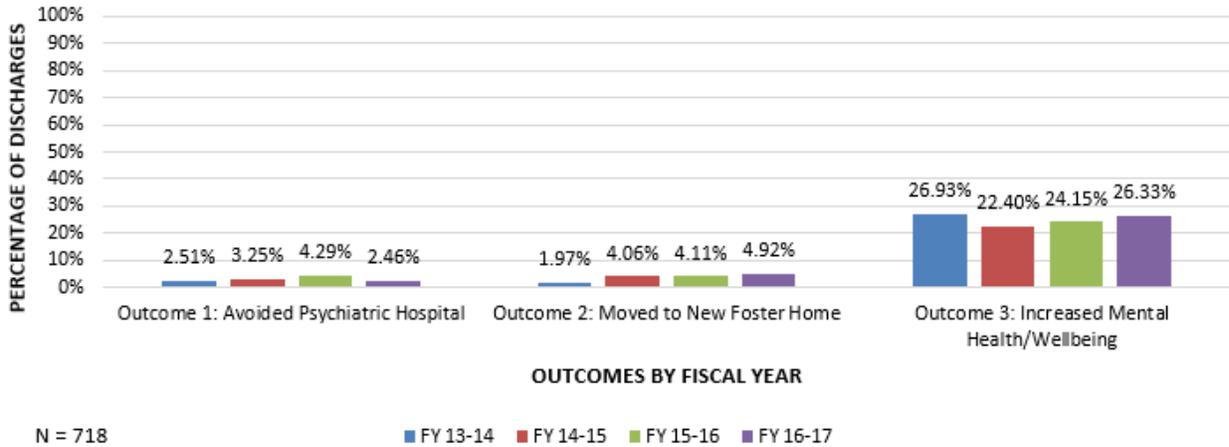
**MEASUREMENTS**

1. Number of individuals who avoided hospitalization.
2. Number of individuals who moved to a new foster home.
3. Number of individuals who were identified as having increased their mental health/wellbeing.

<b>DURING THIS EPISODE THE CLIENT:</b>	<b>FY 13-14</b>	<b>FY 14-15</b>	<b>FY 15-16</b>	<b>FY 16-17</b>
Outcome 1: Avoided Psych Hospital (if candidate)	14	20	24	13
Outcome 2: Moved to New Foster Home	11	25	23	26
Outcome 3: Increased Mental Health/Wellbeing	150	138	135	139
Acquired Housing (if homeless at intake)	9	4	0	4
Completed GED/High School Diploma	13	14	12	8
Gained Employment	20	15	12	26
Gained Living Skills	60	53	61	68
Improved Biological Family Relationship	115	107	102	98
Improved Foster Family Relationship	10	37	36	29
<b>Distinct Count of Clients</b>	<b>557</b>	<b>616</b>	<b>559</b>	<b>528</b>

\*at discharge multiple categories can be selected for each client

**OUTCOME COMPARISON OVER FISCAL YEARS**



**OUTCOME COMPARISON BY SITE**

	DISCHARGES	OUTCOME 1: AVOIDED PSYCHIATRIC HOSPITAL	OUTCOME 2: MOVED TO NEW FOSTER HOME	OUTCOME 3: INCREASED MENTAL HEALTH/WELLBEING
Oroville YIP	285	6	21	76
Chico YIP	202	3	6	44
Paradise YIP	62	0	0	13
Gridley YIP	13	1	1	3

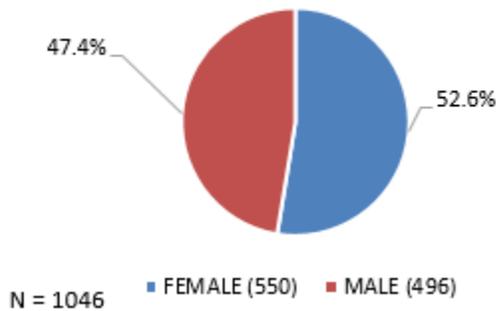
\*the above date is captured in the discharge screen in Avatar.

**DEMOGRAPHICS OF DISTINCT CLIENTS SERVED**

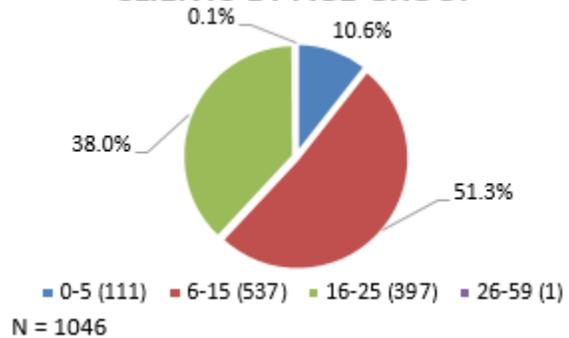
FY 16-17

Number Served: 1046

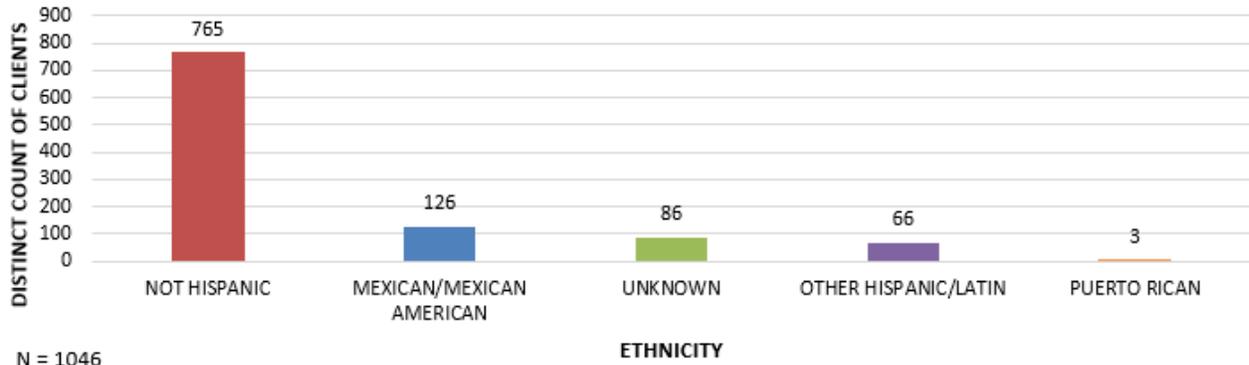
**CLIENTS BY GENDER**



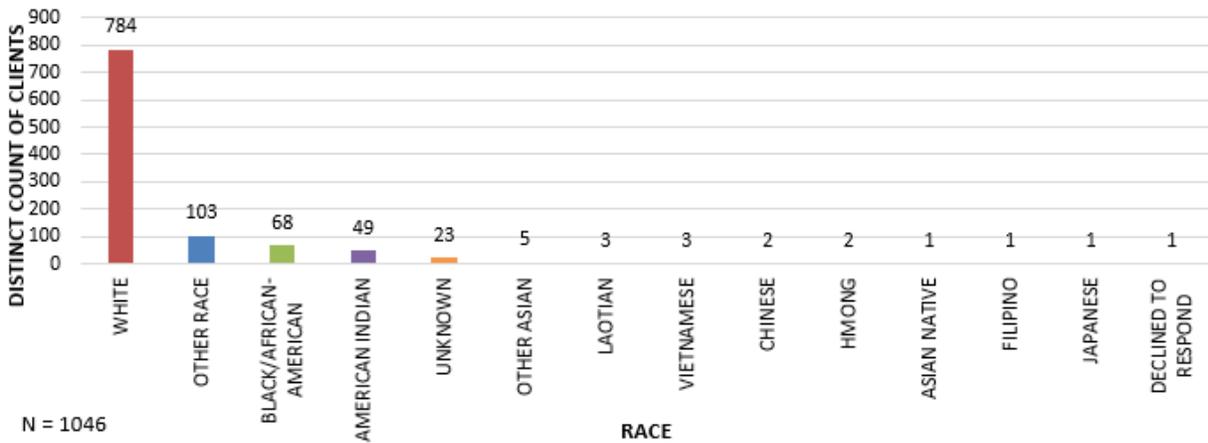
**CLIENTS BY AGE GROUP**



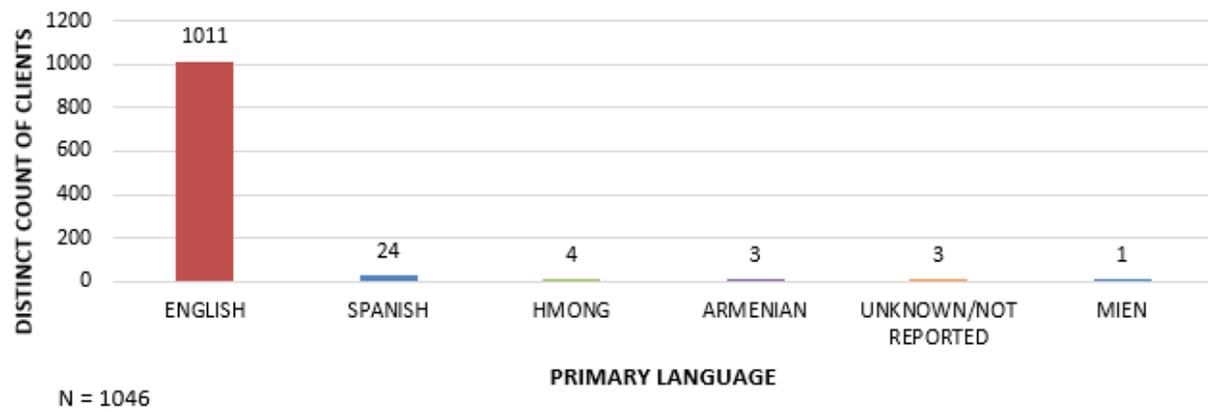
### CLIENTS BY ETHNICITY



### DISTRIBUTION OF CLIENTS BY RACE



### DISTRIBUTION OF CLIENTS BY PRIMARY LANGUAGE



<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input type="checkbox"/>	General (Non-FSP)	<input checked="" type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input checked="" type="checkbox"/>	Children (0-15)		
	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)		
	<input type="checkbox"/>	Adult (26-59)		
	<input type="checkbox"/>	Older Adult (60+)		

**PROGRAM DESCRIPTION**

Youth Intensive Programs (YIP) and Youth Empowerment Services (YES) is a collaborative program involving several agencies and community groups offering culture-based wrap-around services for youth and their families.

YES services provide effective, youth-driven activities in Butte County for diverse consumer youth with a qualified mental health diagnosis. Services are designed and delivered in a culturally effective manner utilizing an intensive, strength-based, consumer guided model of care. YES activities provide a safe and engaging platform for county/provider clinical, Wrap-around staff to address treatment plan objectives. Intervention opportunities include social skills building, life skills, vocational skills, communication skills, problem solving skills, independent living skills, building self-esteem, self-soothing skills, and anger management. Clinical staff will apply rehab treatment plan interventions to support youth during YES recreational activities. Youth will learn appropriate social skills for integrating into the community. YES staff provides an opportunity for clinical staff to address functional social impairments that affect their mental health through Medi-cal billing.

The YES program provides a variety of services including wilderness outings, team building events, seasonal activities, family outings and staff trainings. These activities create opportunities for developing healthy hobbies while supporting the achievement of emotional stability. Family events and outings build on strengths, assets and skills. It supports trust, cooperation, self-worth and family unity. Recreation staff are certified or licensed as required based on activities provided. All staff complete TCI training as well as training to support the needs of program participants.

**OUTCOMES**

1. Manage mental illness symptoms and improve functioning.
2. Reduced conflict with peers, family and in educational setting.
3. Improve self-esteem.\*
4. Effectively communicate with others.
5. Establish support system.
6. Attend and participate in community groups/activities.
7. Gain leadership behaviors, seek mentorship opportunities.\*

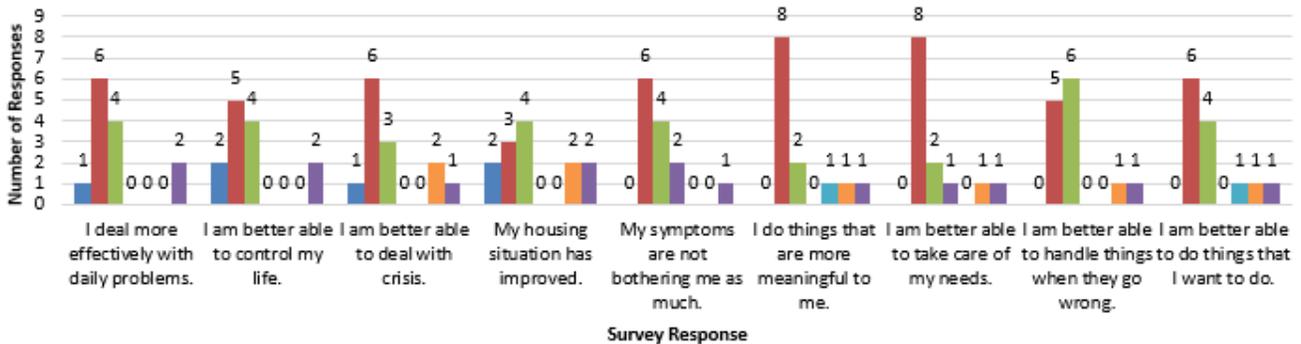
MEASUREMENTS

1. Provide survey results from the Adult, Youth and Family Consumer Perception Survey Results for November 2016 and May 2017.
2. Provide survey results from the Adult, Youth and Family Consumer Perception Survey Results for November 2016 and May 2017.
3. Provide feedback from the YES Self-Esteem Survey\*
4. Provide survey results from the Adult, Youth and Family Consumer Perception Survey Results for November 2016 and May 2017.
5. Provide survey results from the Adult, Youth and Family Consumer Perception Survey Results for November 2016 and May 2017.
6. Provide counts from Outreach Data Collection forms for FY 16-17.
7. Provide feedback from the YES Self-Esteem Survey\*

\*Data was not collected for the FY 16-17

Outcome 1: Manage mental illness symptoms and improve functioning.

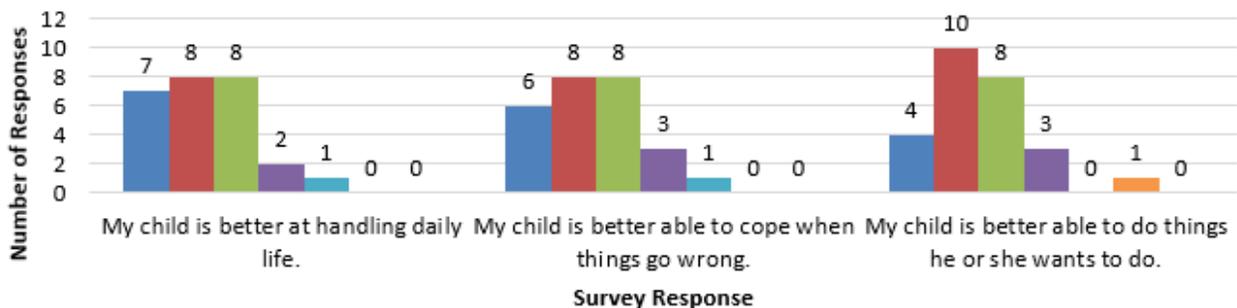
**Manage Mental Illness Symptoms and Improve Functioning  
Adult Consumer Perception Survey Results for Nov 2016 and May 2017**



■ 5 = Strong Agree ■ 4 = Agree ■ 3 = I am Neutral ■ 2 = Disagree ■ 1 = Strongly Disagree ■ 8 = Not Applicable ■ 9 = Missing

N = 13

**Manage Mental Illness Symptoms and Improve Functioning  
Family Consumer Perception Survey Results for Nov 2016 and May 2017**

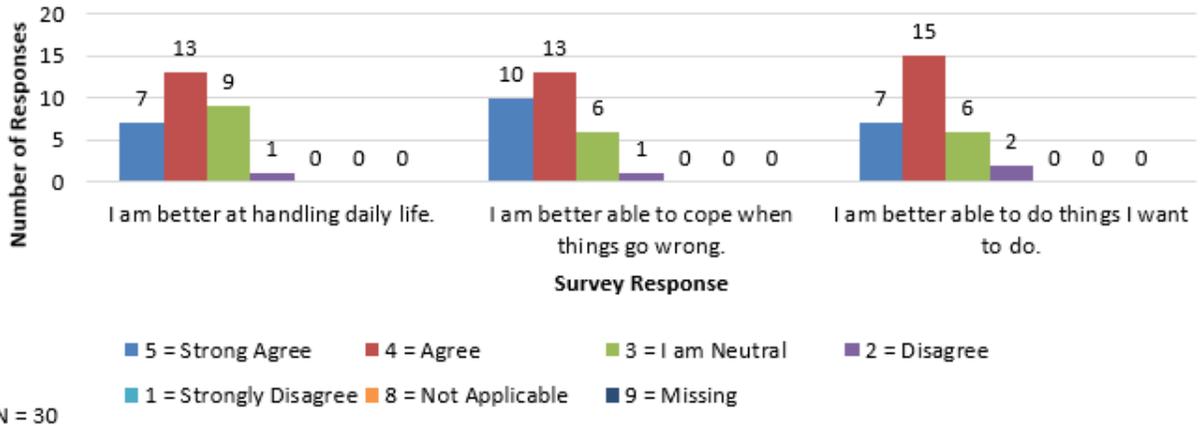


■ 5 = Strong Agree ■ 4 = Agree ■ 3 = I am Neutral ■ 2 = Disagree

■ 1 = Strongly Disagree ■ 8 = Not Applicable ■ 9 = Missing

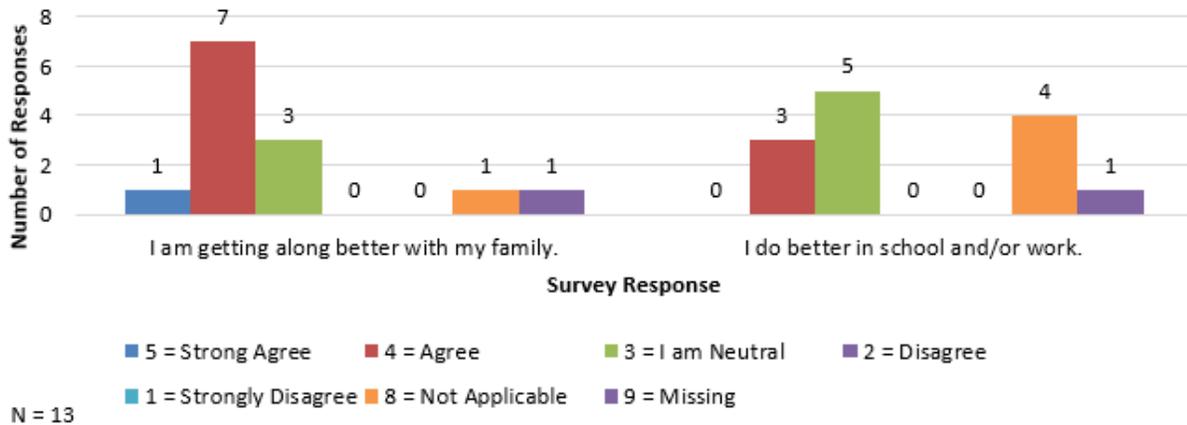
N = 26

**Manage Mental Illness Symptoms and Improve Functioning  
Youth Consumer Perception Survey Results for Nov 2016 and May 2017**

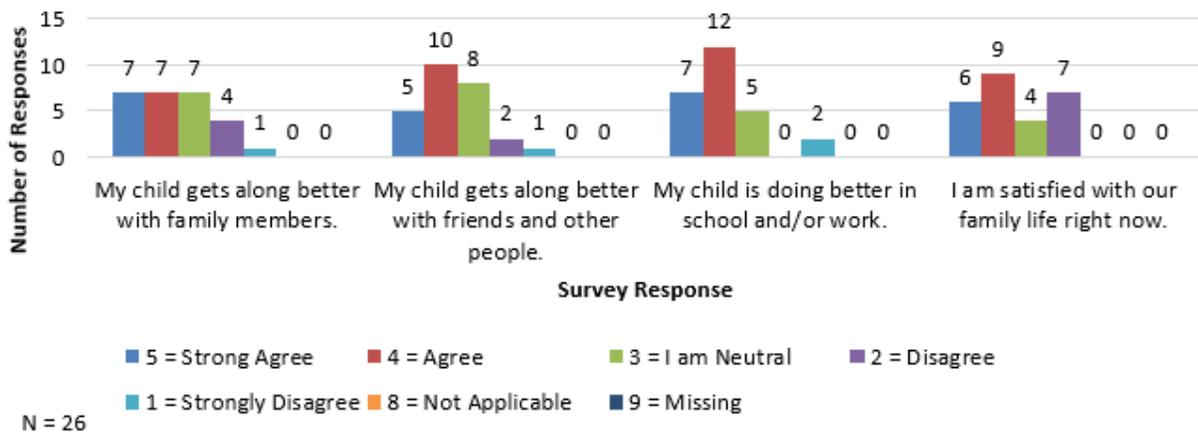


Outcome 2: Reduce conflict with peers, family, and in educational setting.

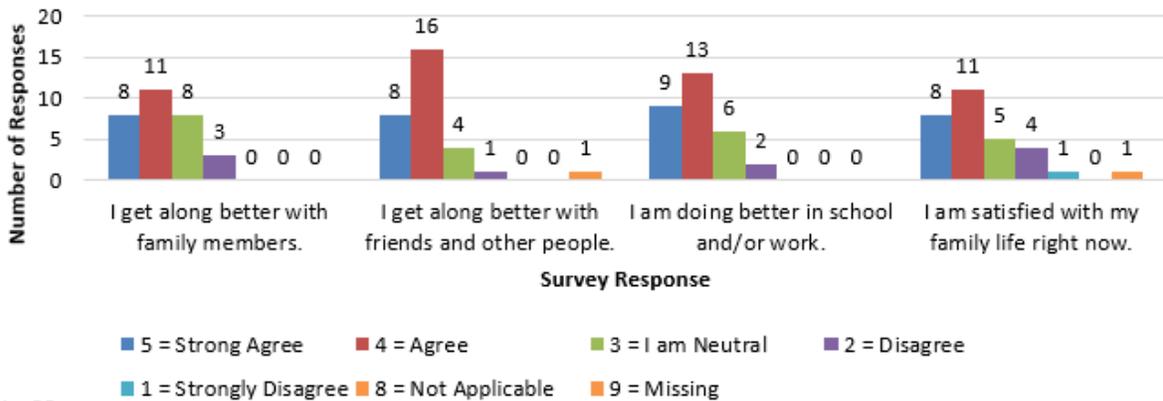
**Reduced Conflict with Peers, Family and in Educational Settings  
Adult Consumer Perception Survey Results for Nov 2016 and May 2017**



**Reduced Conflict with Peers, Family and in Educational Settings  
Family Consumer Perception Survey Results for Nov 2016 and May 2017**

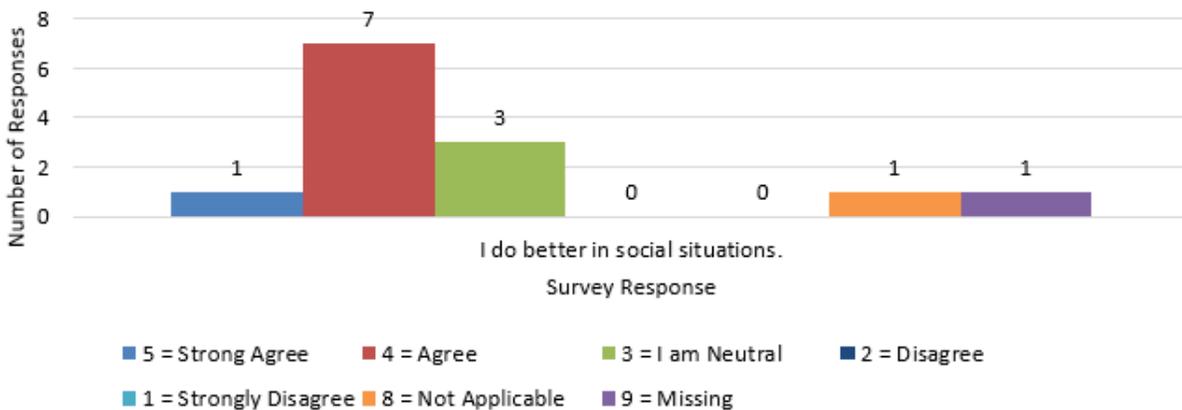


**Reduced Conflict with Peers, Family and in Educational Settings**  
**Youth Consumer Perception Survey Results for Nov 2016 and May 2017**

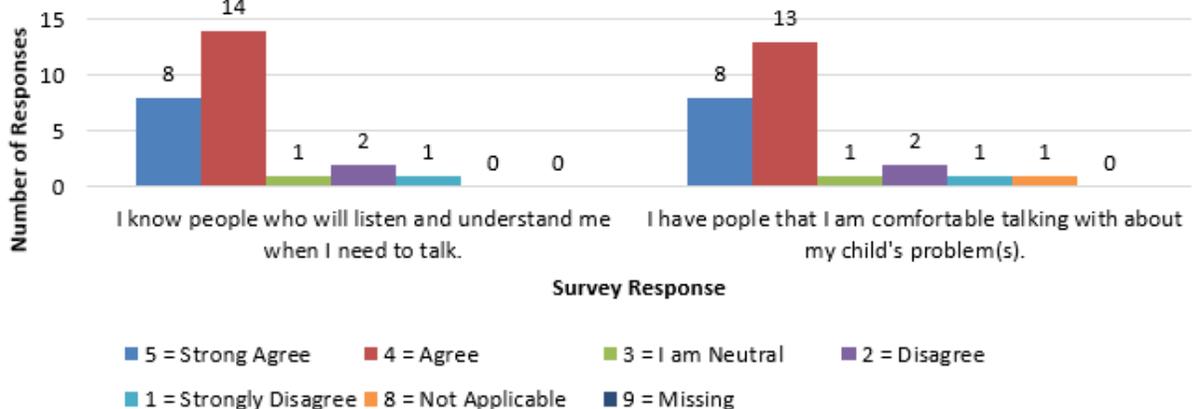


Outcome 4: Effectively communicate with others.

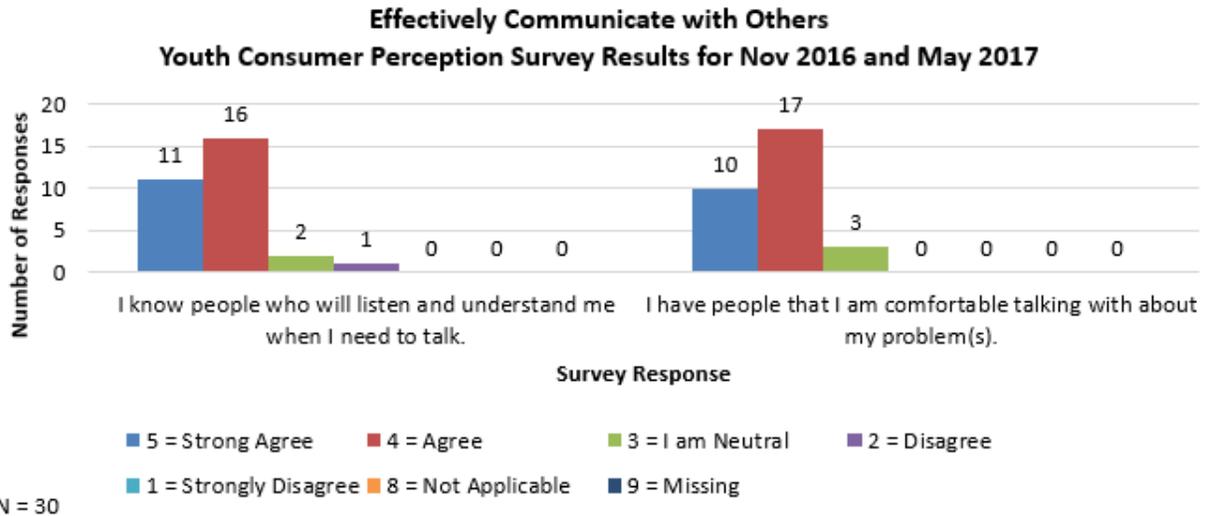
**Effectively Communicate with Others**  
**Adult Consumer Perception Survey Results for Nov 2016 and May 2017**



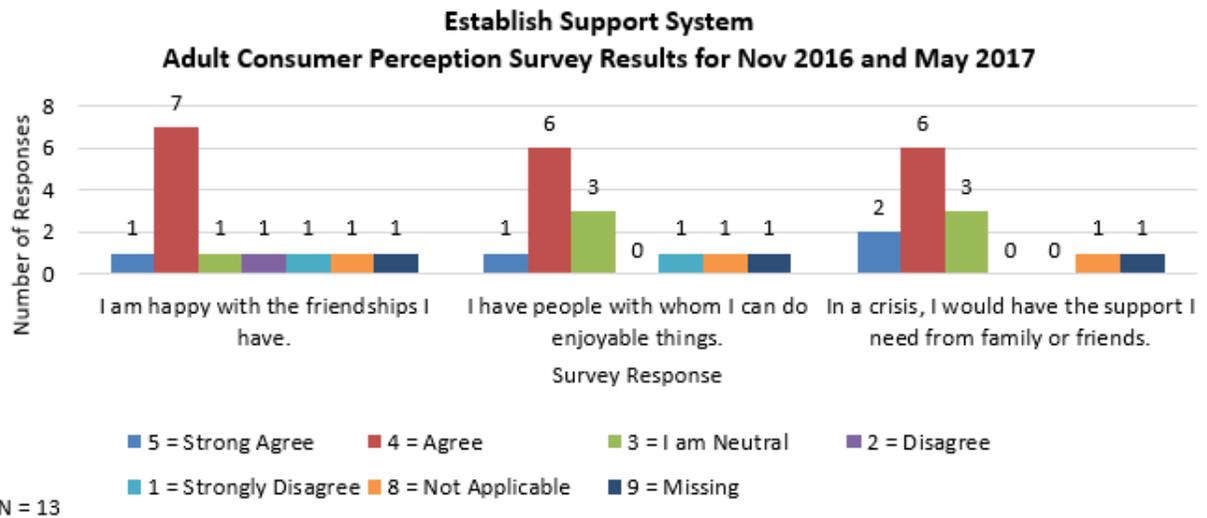
**Effectively Communicate with Others**  
**Family Consumer Perception Survey Results for Nov 2016 and May 2017**



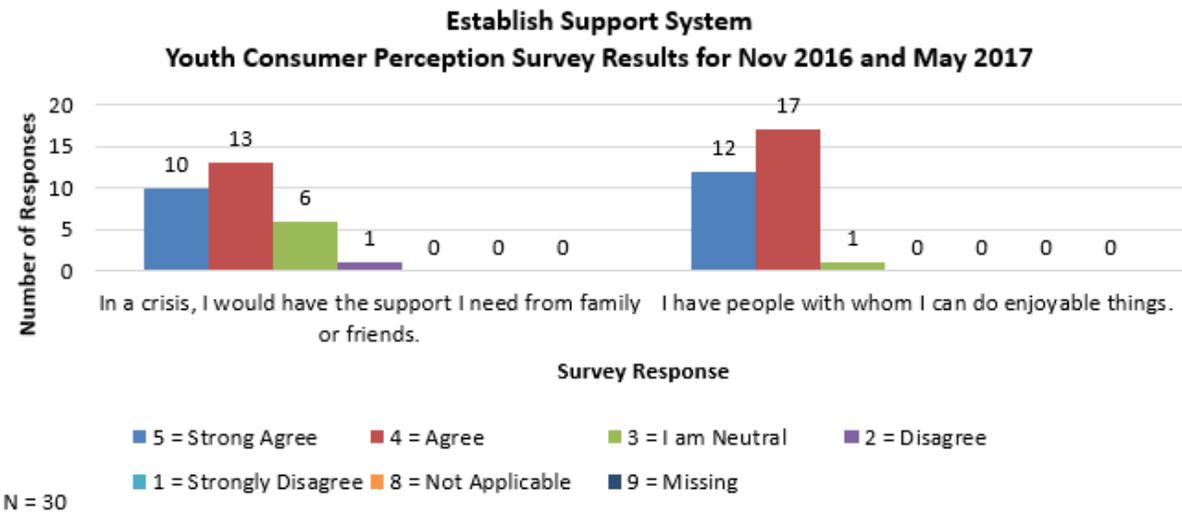
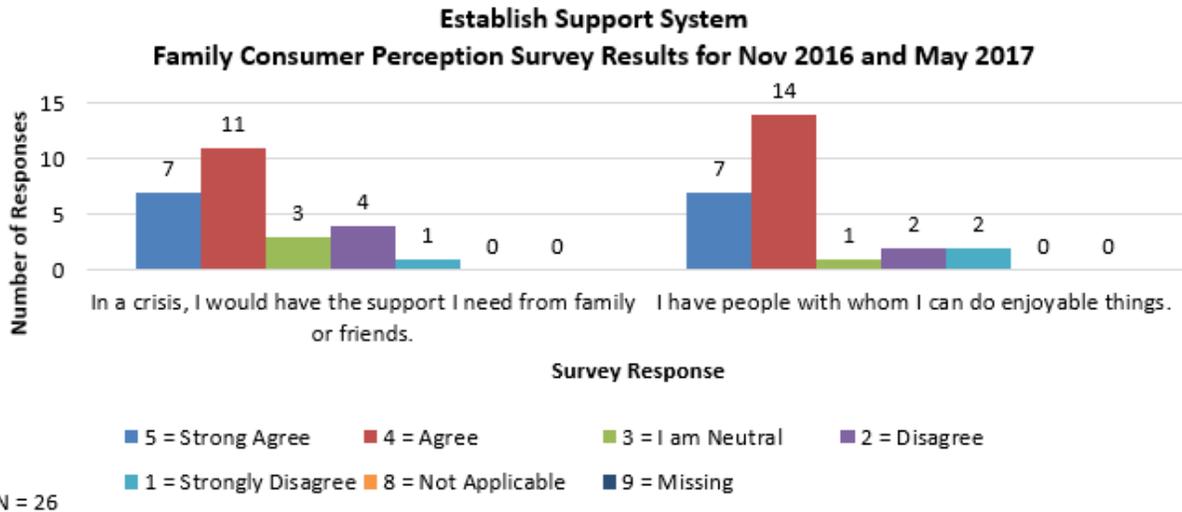
Outcome 4: Effectively communicate with others.



Outcome 5: Establish support system.



Outcome 5: Establish support system.



Outcome 6: Attend and participate in community groups/activities.

GROUP	OCCURENCES COUNT	ATTENDANCE COUNT
Health Education	107	724

EVENTS AND TRAININGS	COUNT
Number of Events or Trainings	43
Estimated Number of Attendees	328

Outcome 6: Attend and participate in community groups/activities.

YES FAMILY EVENTS		FY 16-17
Event	# of Attendees	
Table Mountain Day	19	
BBQ in the Park	49	
Christmas Tree Cutting Day	41	
Family Raft Day	20	
Challenge Course Day (fall & spring)	40	
<b>Total YES Family Event Participants</b>	<b>169</b>	

**YES GROUPS FY 16-17**

The YES program held over 127 groups total between both the Oroville and Chico locations. The following are sample activities you could expect to take place during group: Book Family Farms, Oroville Fish Hatchery, Upper Bidwell Park, Kirshner's Animal Sanctuary, Riverbend Park, Butte Creek Ecological Preserve, Friends of Bidwell Park volunteer days, Lime Saddle Campground, Butte Meadows, YFC Challenge Course, Lundberg Family Farms, and the Sacramento River.

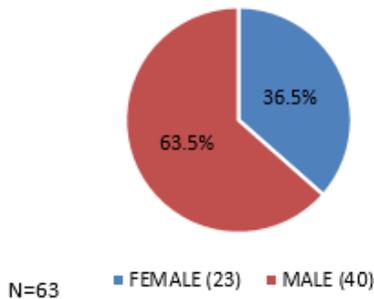
YES EMPLOYMENT & COMMUNITY SERVICE/VOLUNTEER HOURS		FY 16-17
Number of Youth that acquired employment while participating in the YES program	6	

**YES: DEMOGRAPHICS OF DISTINCT COUNT SERVED**

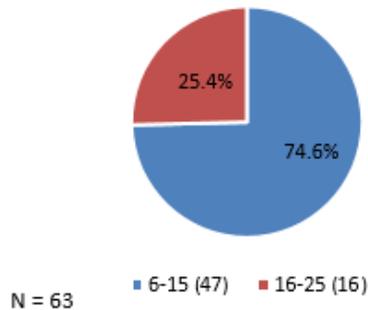
FY 16-17

Number Served: 63

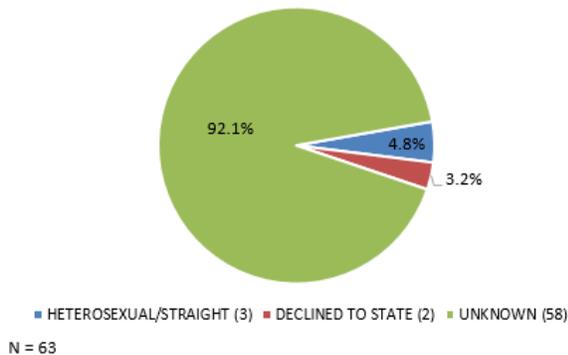
**DISTINCT COUNT BY GENDER**



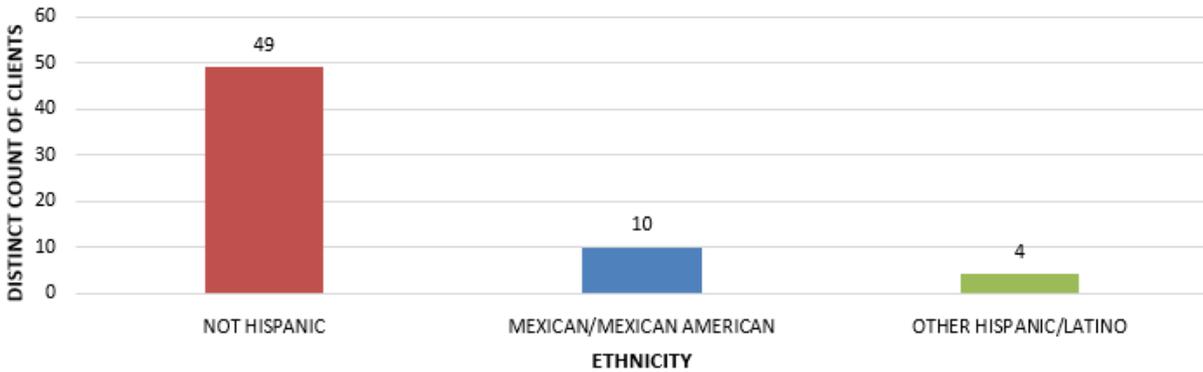
**DISTINCT COUNT BY AGE GROUP**



**CLIENTS BY SEXUAL ORIENTATION**

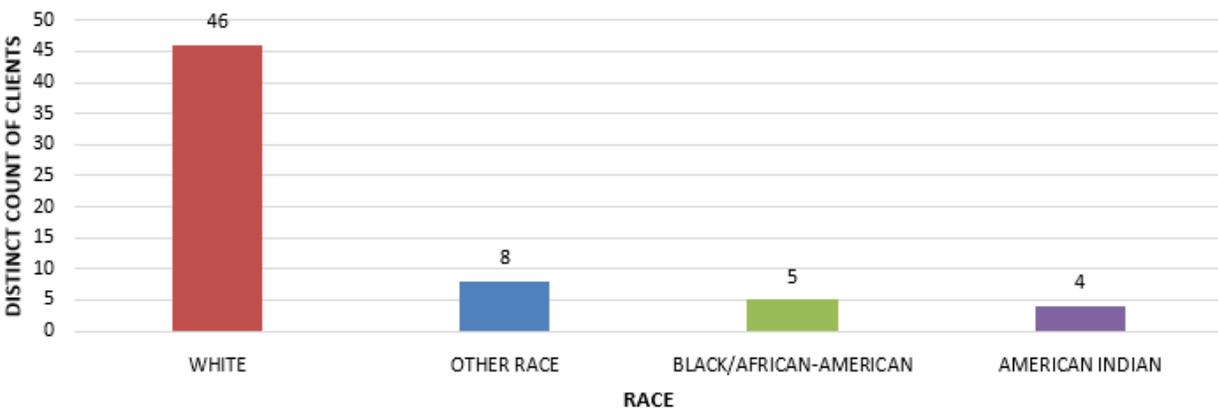


**DISTINCT COUNT BY ETHNICITY**



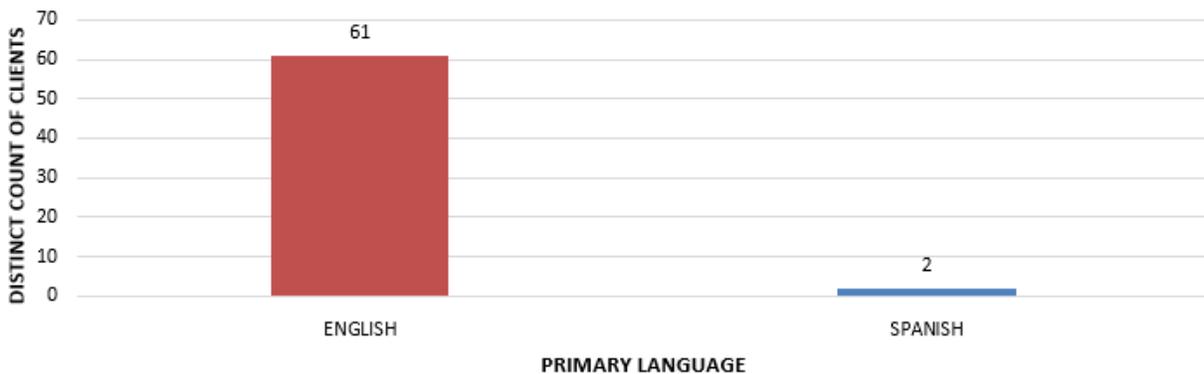
N = 63

**DISTINCT COUNT OF RACE**



N = 63

**DISTINCT COUNT BY PRIMARY LANGUAGE**



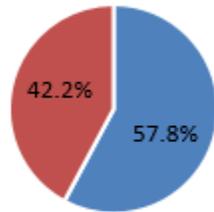
N = 63

**YIP: DEMOGRAPHICS OF DISTINCT COUNT SERVED**

FY 16-17

Number Served: 102

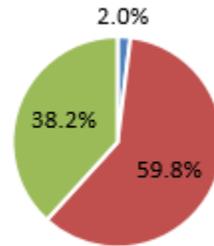
**DISTINCT COUNT BY GENDER**



■ FEMALE (59) ■ MALE (43)

N = 102

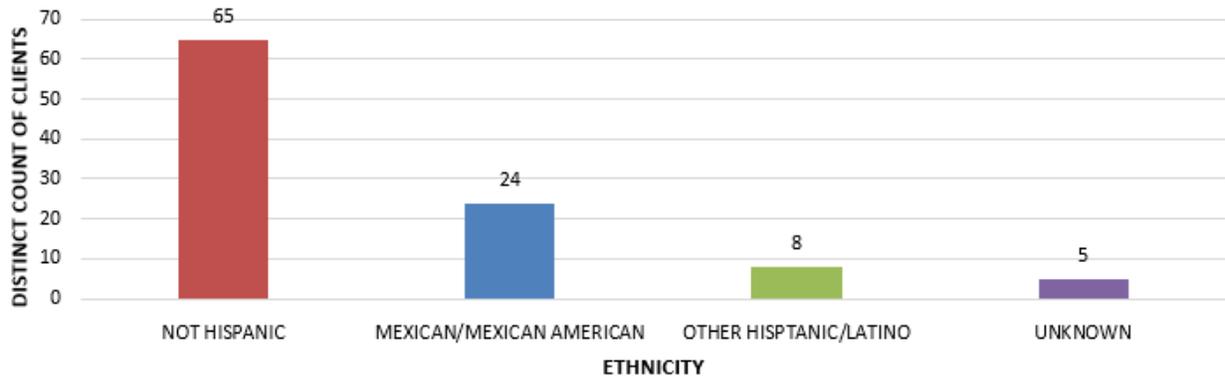
**DISTINCT COUNT BY AGE GROUP**



■ 0-5 (2) ■ 6-15 (61) ■ 16-25 (39)

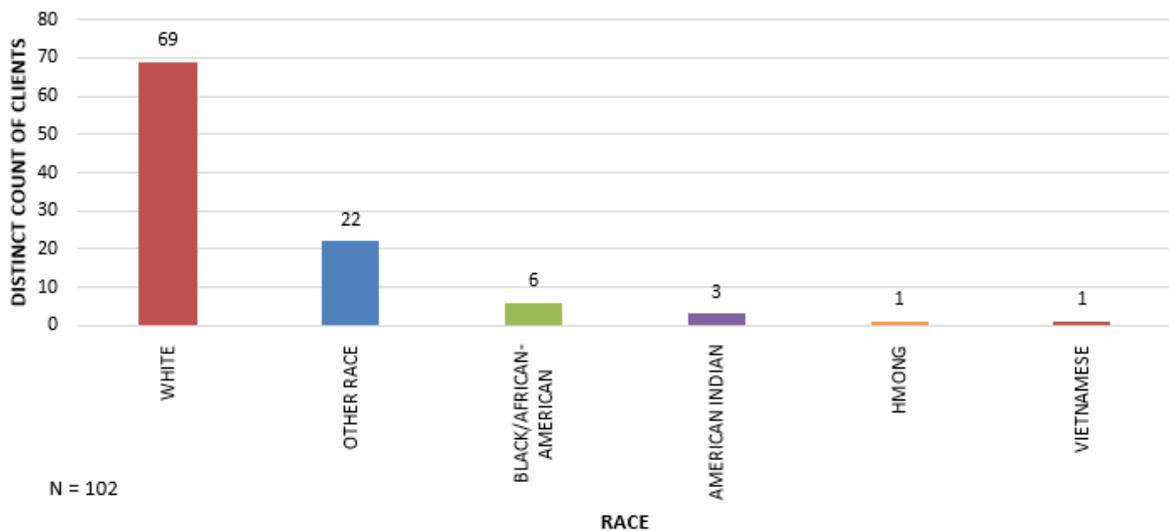
N = 102

**DISTINCT COUNT BY ETHNICITY**



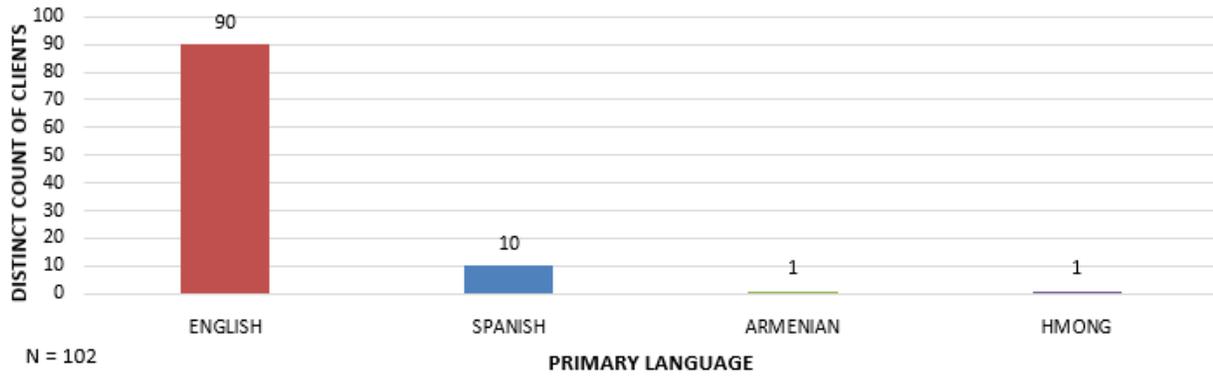
N = 102

**DISTINCT COUNT OF RACE**

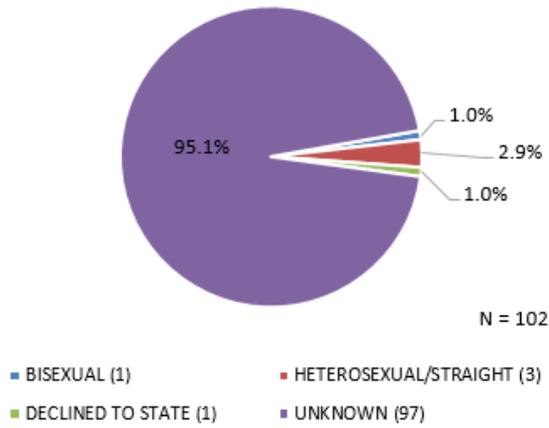


N = 102

**DISTINCT COUNT BY PRIMARY LANGUAGE**



**SEXUAL ORIENTATION**



<b>STATUS</b>	<input checked="" type="checkbox"/>	New	<input type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	General (Non-FSP)	<input type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input type="checkbox"/>	Children (0-15)		
	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)		
	<input checked="" type="checkbox"/>	Adult (26-59)		
	<input checked="" type="checkbox"/>	Older Adult (60+)		

**PROGRAM DESCRIPTION**

The Crisis Residential Program is a homelike, temporary (up to 30 days), safe, and therapeutic environment where adult (18 and older) community members struggling with a mental health crisis can receive 24 hour support and services. This is a voluntary program for persons who are assessed and referred by Behavioral Health staff when it is determined that a residential alternative to hospitalization is within the best interest of the individual. Individuals in the program must agree to program rules that support their recovery and ensure a comfortable and safe environment. At the core of the program are individualized care plans that support a successful transition back into the community. A key component is having professional and licensed staff with experience and specialized training. The program team is on site 24 hours a day and 7 days a week.

The 10-bed, drug and alcohol-free home includes laundry facilities, a kitchen, multiple community gathering spaces, and a fenced-in backyard. The home was acquired by Behavioral Health through Senate Bill 82 grant funding which was awarded in the spring of 2014. These grant funds (\$867,425) financed the purchase/renovation of the house and three months of start-up costs.

Services are individualized and follow a social rehabilitation model that integrates aspects of emergency psychiatric care, psychological rehabilitation, milieu therapy, and coordinated case management and social work interventions. Services include: Crisis Intervention, Psychopharmacologic Medication Evaluation and Management, Health Monitoring and Medical Service Referrals, Community/Peer Support Groups, Health and Wellness Education and Training, Resident Advocacy, Community Socialization, Therapeutic Community, Planned Activities, Daily Living Skills, Coordinated Case Management, and Discharge Planning.

*“Thank you all so much. I really needed a place like this to get on my two feet again.”*  
 - Consumer

OUTCOMES

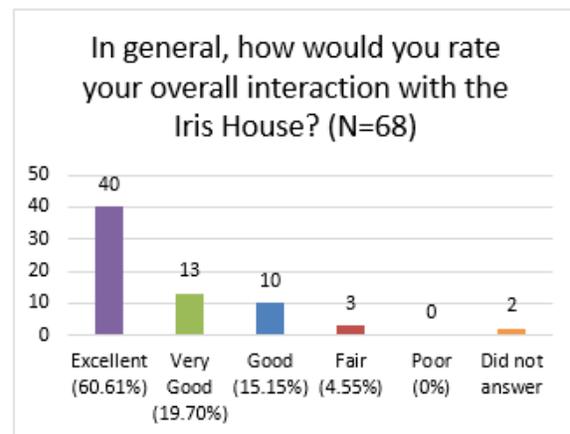
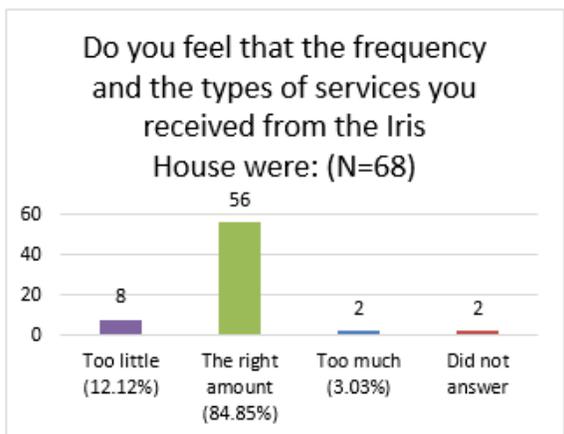
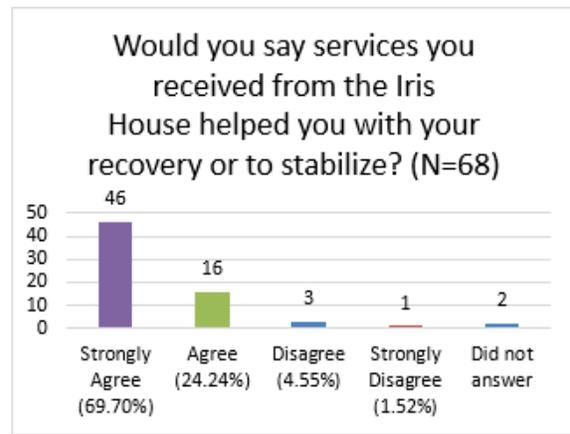
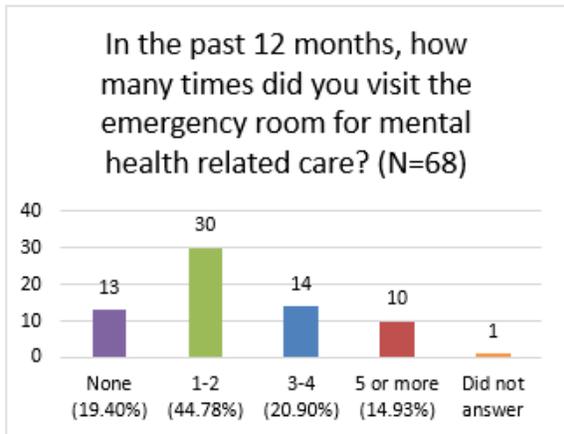
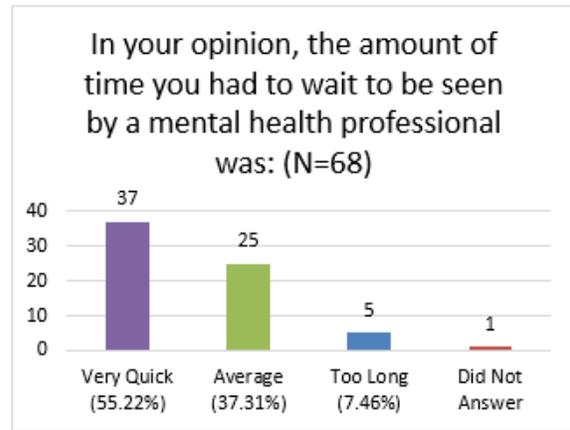
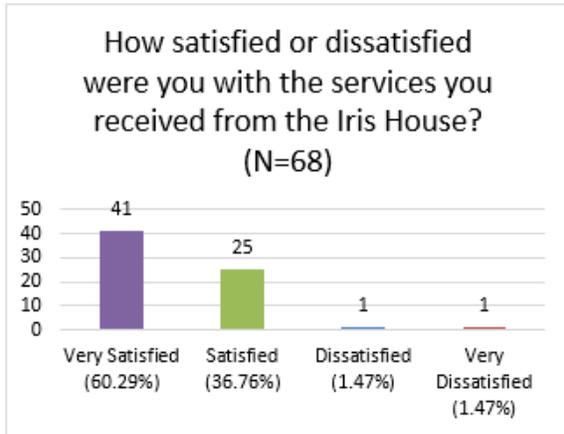
1. Increase number of individual served.
2. Decrease length of time of decision made after receiving referral and admission after receiving referral.
3. Decrease number of consumers who are admitted to BCDBH Crisis Services 15-days and 30-days post-discharge.
4. Increase consumer satisfaction with services.

MEASUREMENTS

1. Number of distinct consumers admitted to Iris House.
2. Timeliness of:
  - a. Referral received by Willow Glenn to decision made
  - b. Referral received by Willow Glenn to admission of consumer
3. Number of consumers who are admitted to Crisis Services (gathered from CS Tracker in Avatar) 15 and 30 days post-discharge from Iris House.

MEASUREMENTS	FY 16-17
OUTCOME 1: Number of distinct consumers admitted to Iris House	103
OUTCOME 2: Referral received by Willow Glenn to decision made by Willow Glenn (average)	2 hours and 59 minutes
OUTCOME 2: Referral received by Willow Glenn to admission of consumer (average)	9 hours and 15 minutes
OUTCOME 3: Number of Iris House discharges that resulted in a subsequent admission to Crisis Services within 15 days	38
OUTCOME 3: Number of Iris House discharges that resulted in a subsequent admission to Crisis Services between 16 and 30 days	11
OUTCOME 3: Total number of Iris House discharges that resulted in a subsequent admission to Crisis Services within 30 days	49 (Total Discharges: 113; Recidivism Rate: 43.36%)

5. Consumer responses to survey questions for FY 16-17.



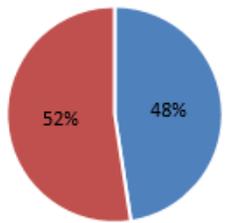
\*Surveys are voluntary and collected via online survey software.

**DEMOGRAPHICS OF DISTINCT CLIENTS SERVED**

**FY 16-17**

*Number Served: 103*

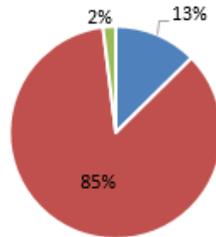
**OPEN CLIENTS BY GENDER**



■ FEMALE (49) ■ MALE (54)

N=103

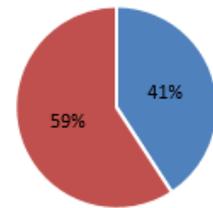
**OPEN CLIENTS BY AGE GROUP**



■ 18-25 (13) ■ 26-64 (88) ■ 65+ (2)

N=103

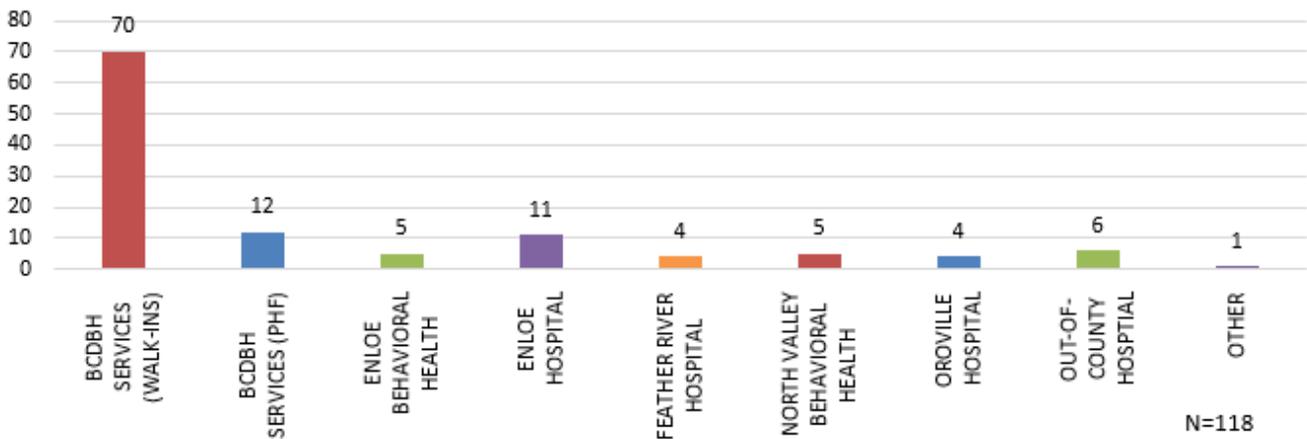
**LIVING STATUS AT ADMISSION**



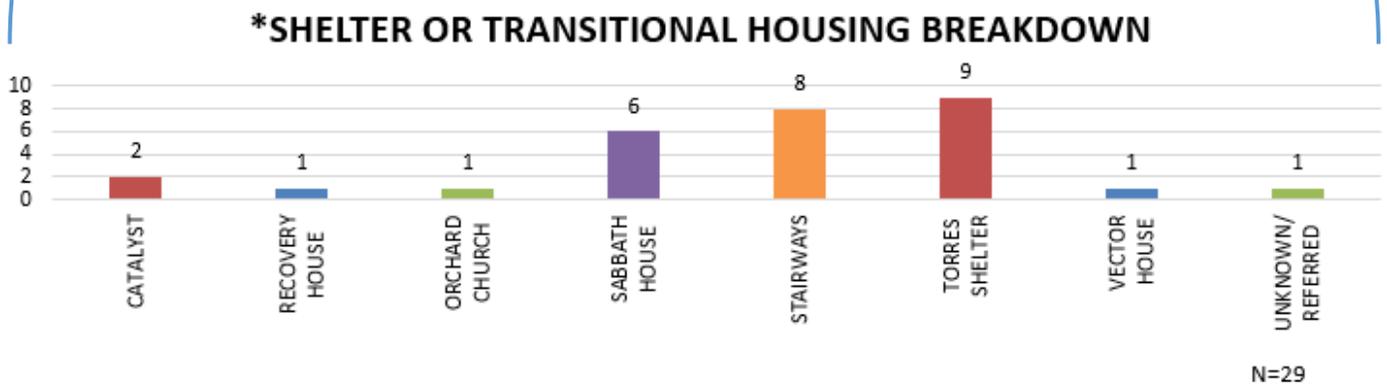
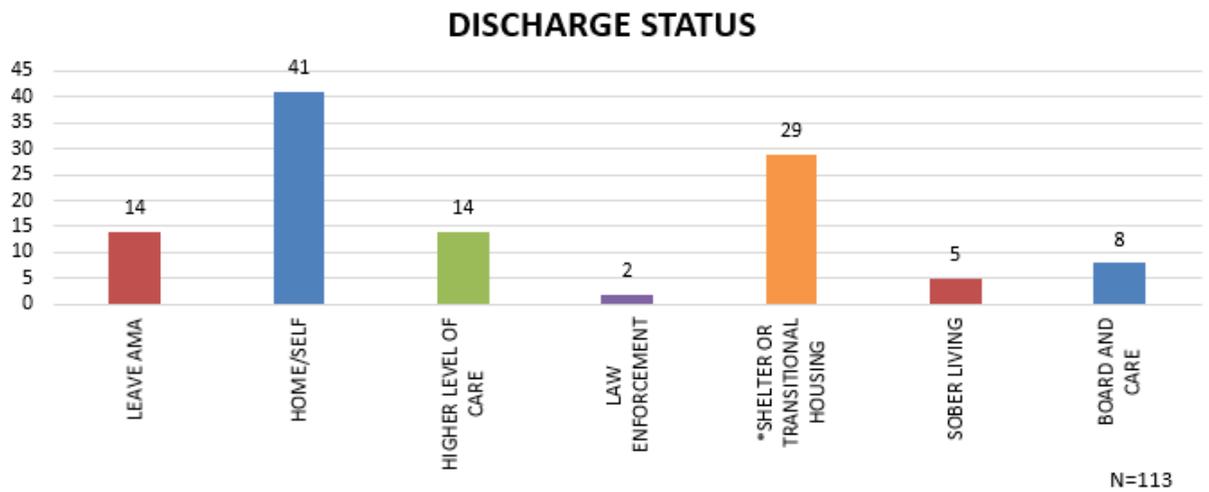
■ NOT HOMELESS (42) ■ HOMELESS (61)

N=103

**POINT OF CONTACT PRIOR TO ADMISSION**



N=118



<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	General (Non-FSP)	<input type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input type="checkbox"/>	Children (0-15)		
	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)		
	<input type="checkbox"/>	Adult (26-59)		
	<input type="checkbox"/>	Older Adult (60+)		

**PROGRAM DESCRIPTION**

The Master Lease Housing program for youth aims to meet the permanent housing needs of those Transitional Age Youth (TAY - between the ages of 16-25). Master Lease Programs afford an opportunity to help consumers on their journey to recovery and self-sufficiency by helping them to secure a safe place to live. Consumers sometimes have difficulty finding safe affordable housing due to poor rental histories, including evictions, poor credit and insufficient financial resources.

Through the Master Lease Programs contracted providers secure lease agreements with local property owners and sublet the units to consumers. Support is provided to assist consumers in maintaining their housing while achieving a level of self-sufficiency. Tenants work towards the goal of securing a lease of their own.

**OUTCOMES**

1. Reduce homelessness.
2. Increase length of stay in housing.

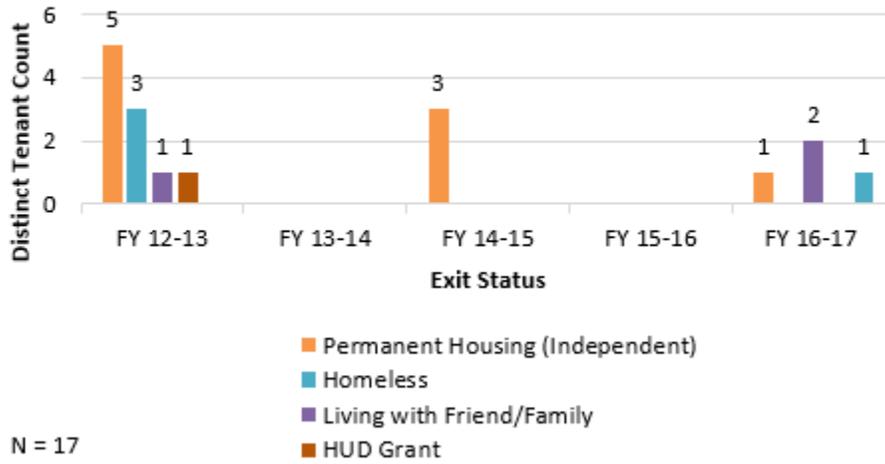
**MEASUREMENTS**

1. Distinct count of clients housed and their living status at discharge.
2. Length of tenant’s stay.

Outcome 1: Reduce homelessness.

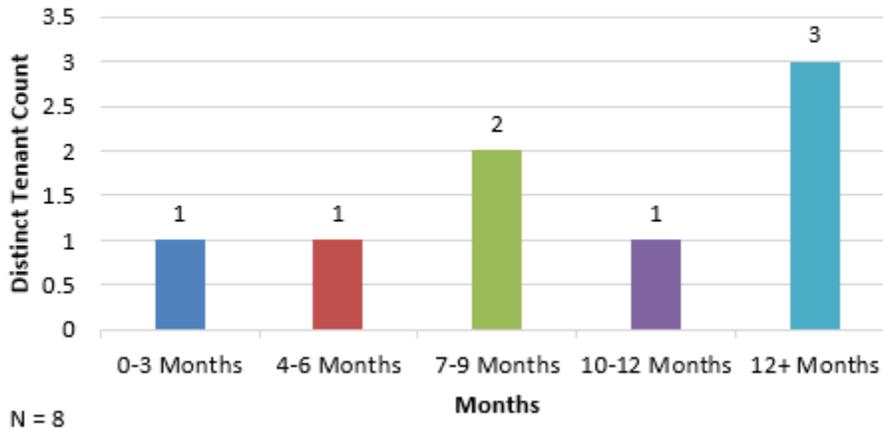
NUMBER OF TENANTS IN TAY MASTER LEASE	FY 12-13	FY 13-14	FY 14-15	FY 15-16	FY 16-17
Distinct Tenant Count	11	4	10	11	8
New Tenants (Included in Distinct Count)	5	2	6	5	4

**STATUS ON EXIT OF TAY MASTER LEASE HOUSING**



Outcome 2: Increase length of stay in housing.

**Length of Stay for TAY Master Lease Housing FY 16-17**



Tenant Demographics	Age	Gender			Primary Language	Cultural Groups			Race / Ethnicity			Distinct Tenant Count
	16-25	Female	Male	Transgender	English	Foster Care	LGBTQ	Other	American Indian or Alaska Native	Multi	White	
TAY Master Lease	8	1	6	1	8	1	1	8	1	2	5	8

\*Multiple selections can be made in this section.

<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	General (Non-FSP)	<input type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input type="checkbox"/>	Children (0-15)		
	<input type="checkbox"/>	Transitional Age Youth (16-25)		
	<input checked="" type="checkbox"/>	Adult (26-59)		
	<input checked="" type="checkbox"/>	Older Adult (60+)		

**PROGRAM DESCRIPTION**

The Support, Employment, Assistance, Recovery, Consumer Housing (SEARCH) program developed a collaborative relationship with Caminar, Inc., to provide residents of the county permanent housing with case management services and support at the Avenida Apartment complex in Chico. Caminar’s Avenida Apartments offers affordable, supportive and attractive housing for people with disabilities who have experienced homelessness.

Featuring fourteen housing units, Avenida Apartments are designed for people with a disability who have experienced homelessness. The complex has a community room for groups and recreational gatherings, laundry, maintained landscaped areas and a community garden. Avenida Apartments has a full time live-in property manager in addition to case management and support services provided by Butte County Department of Behavioral Health. Employment opportunities are also onsite to assist residents in their recovery process to become productive members of the community.

By encompassing a vocational training approach, providing employment opportunities onsite (including our social enterprise bike shop facility, along with grounds maintenance and janitorial services vocational opportunities), Avenida Apartments truly promotes independent living and self-sufficiency to its residents. The model fits perfectly with the Caminar Butte County Region’s goal of building community and enhancing lives for people with disabilities.

**OUTCOMES**

1. Reduce homelessness.
2. Increase length of stay in housing.

**MEASUREMENTS**

1. Capture number of tenants.
2. Capture number of years in housing program.

Outcome 1: Reduce homelessness.

NUMBER OF TENANTS IN AVENIDA	FY 13-14	FY 14-15	FY 15-16	FY 16-17
Distinct Tenant Count	15	20	14	17
New Tenants (Included in Distinct Count)	0	9	1	4

**DEMOGRAPHICS FOR AVENIDA TENANTS**

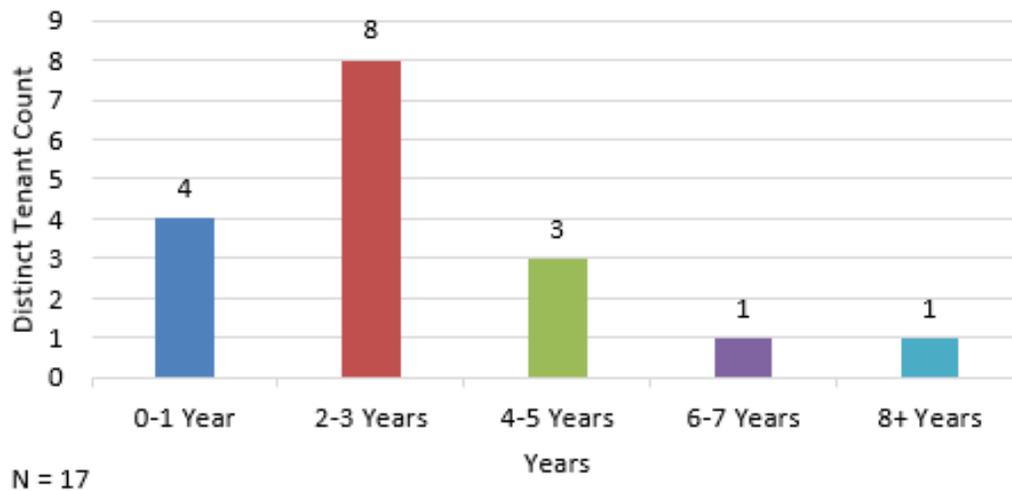
**FY 16-17**

Tenant Demographics	Age			Gender		Primary Language	Cultural Groups		Race / Ethnicity			Distinct Tenant Count
	16-25	26-59	60+	Female	Male	English	Veteran	Unknown	African American	Hispanic or Latino	White	
<b>FY 16-17</b>	1	12	4	8	9	17	2	15	3	4	10	<b>17</b>

Outcome 2: Increase length of stay in housing.

**LENGTH OF STAY FOR AVENIDA TENANTS**

**FY 16-17**



<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	General (Non-FSP)	<input type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input type="checkbox"/>	Children (0-15)		
	<input type="checkbox"/>	Transitional Age Youth (16-25)		
	<input checked="" type="checkbox"/>	Adult (26-59)		
	<input type="checkbox"/>	Older Adult (60+)		

**PROGRAM DESCRIPTION**

Behavioral Health is awarded funds from the United States Department of Housing and Urban Development. These funds do not cover all the expenses for local housing projects implemented through the Housing Authority. MHSAs provide the match to support these housing services.

<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	General (Non-FSP)	<input type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input type="checkbox"/>	Children (0-15)		
	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)		
	<input type="checkbox"/>	Adult (26-59)		
	<input type="checkbox"/>	Older Adult (60+)		

**PROGRAM DESCRIPTION**

Transitional housing provides an opportunity to help consumers on their journey to recovery and self-sufficiency by helping them to secure a safe place to live. Consumers sometimes have difficulty finding safe affordable housing due to poor rental histories, including evictions, poor credit and insufficient financial resources.

Contracted providers secure lease agreements with local property owners and sublet the units to consumers. Ongoing support is provided to assist consumers in maintaining their housing while achieving a level of self-sufficiency. Tenants work towards the goal of securing a lease of their own.

This program provides short-term (6 months to 1 year), temporary transitional housing for transition age youth ages 18-25 with serious mental illness (SMI) who are homeless or at-risk of homelessness and who have no other options for housing. Youth work with a case manager to secure permanent and safe housing and are counseled on independent living skills, education and employment.

During this time, consumers also work with a case manager to secure permanent and safe housing on their own. This case management includes: counseling on independent living skills, education, and employment.

**OUTCOMES**

1. Reduce homelessness.
2. Increase length of stay in housing.
3. Transition tenants to permanent housing.

**MEASUREMENTS**

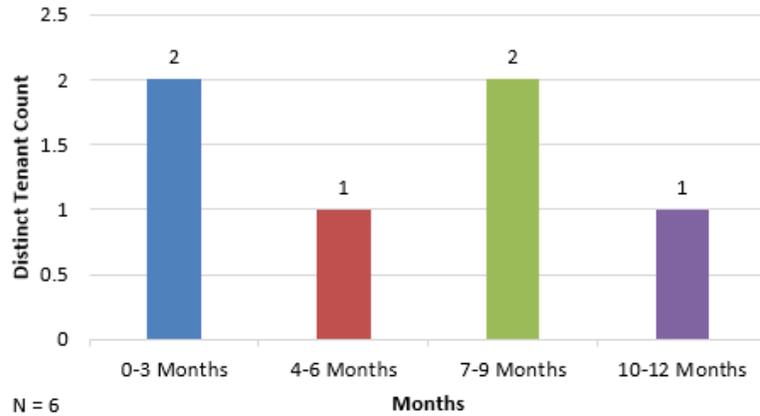
1. Distinct count of clients housed.
2. Length of tenant’s stay.
3. Client’s living status at discharge.

Outcome 1: Reduce homelessness.

<b>NUMBER OF TENANTS IN TAY TRANSITIONAL HOUSING</b>	<b>FY 12-13</b>	<b>FY 13-14</b>	<b>FY 14-15</b>	<b>FY 15-16</b>	<b>FY 16-17</b>
Distinct Tenant Count	9	10	6	9	6
New Tenants (Included in Distinct Count)	2	6	3	6	3

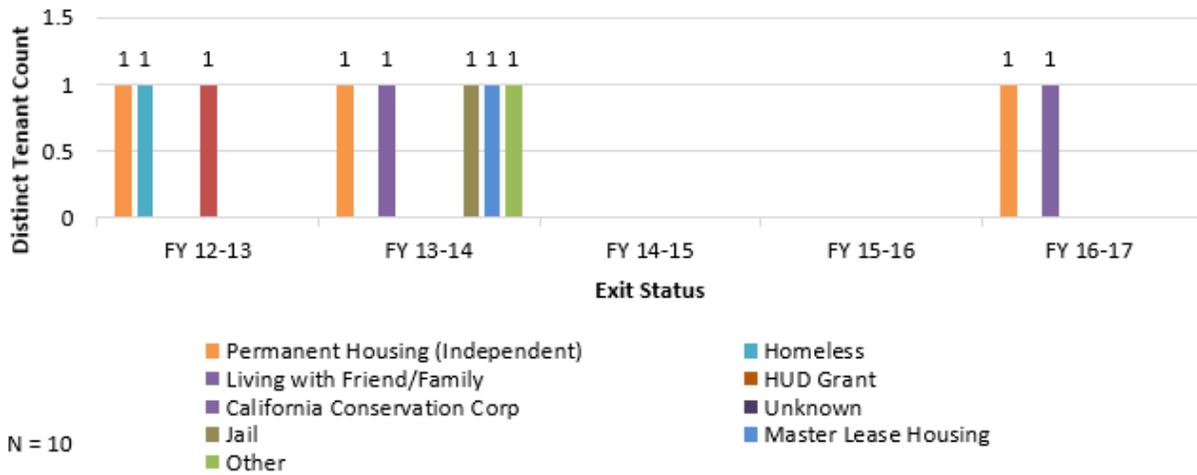
Outcome 2: Increase length of stay in housing.

**LENGTH OF STAY FOR TAY TRANSITIONAL HOUSING FY 16-17**



Outcome 3: Transition tenants to permanent housing.

**STATUS ON EXIT OF TAY TRANSITIONAL HOUSING**



Tenant Demographics	Age	Gender		Primary Language	Cultural Groups			Race / Ethnicity		Distinct Tenant Count
	16-25	Female	Male	English	Foster Care	LGBTQ	Other	Multi	White	
<b>FY 16-17</b>	6	2	4	6	3	1	6	1	5	<b>6</b>

\*Note: tenants can select multiple categories in any demographic group (i.e. Cultural Groups).

STATUS	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
EMPHASIS	<input checked="" type="checkbox"/>	General (Non-FSP)	<input type="checkbox"/>	Full-Service Partnership (FSP)
AGE GROUP	<input checked="" type="checkbox"/>	Children (0-15)		
	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)		
	<input checked="" type="checkbox"/>	Adult (26-59)		
	<input checked="" type="checkbox"/>	Older Adult (60+)		

#### PROGRAM DESCRIPTION

The Countywide Continuum of Care (CoC) assists local governments and community-based organizations in addressing the needs of homeless men and women. A substantial part of the CoC's activities has been in identifying gaps in services to underserved and unserved homeless persons. The CoC Council, comprised of homeless services agencies and other groups, assists in preparation of federal Department of Housing and Urban Development's (HUD's) annual homeless assistance grant applications and reports.

The CoC Coordinator supports grant-writing, facilitation of the Point-in-Time Homeless Survey, organizational development and planning, communication between the agency and nonprofits, and addressing the 10-year strategy to end homelessness.

The Continuum of Care works to identify the County's homeless populations, facilitate the coordinated provision of services to the homeless, identify gaps in services, and seek additional resources in addressing unmet needs and insufficient services. Documentation of homelessness, in part through the annual Butte County Point-In-Time Homeless Census and Survey, has helped to galvanize community support about meeting the needs of the homeless. The Butte County 2011 Homeless Census found that one-quarter (25.5%) of 1,557 adult survey respondents reported that they have a mental illness.

#### OUTCOMES

1. Provide up-to-date data for providers and Continuum of Care collaborative partners

The [2017 Homeless Point in Time Census & Survey Report](http://www.buttehomelesscoc.com) can be found at the Butte County Homeless Continuum of Care website, located at <http://www.buttehomelesscoc.com>.

<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	General (Non-FSP)	<input type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input type="checkbox"/>	Children (0-15)		
	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)		
	<input checked="" type="checkbox"/>	Adult (26-59)		
	<input checked="" type="checkbox"/>	Older Adult (60+)		

**PROGRAM DESCRIPTION**

The housing consultant provides support to the Department of Behavioral Health in identifying housing projects and securing project partners for housing initiatives. The consultant provides important expertise in matters of housing, project development, and monitoring state and federal policy around the issues of tenancy, housing, and housing development.

**OUTCOMES**

1. Secure housing projects and partners to provide transitional and permanent housing for consumers

<b>STATUS</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/> General (Non-FSP)	<input type="checkbox"/> Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input type="checkbox"/> Children (0-15)	
	<input checked="" type="checkbox"/> Transitional Age Youth (16-25)	
	<input checked="" type="checkbox"/> Adult (26-59)	
	<input type="checkbox"/> Older Adult (60+)	

**PROGRAM DESCRIPTION**

Connection to the California Department of Rehabilitation (DOR) provides job training and community-based employment. Butte County has a cooperative (co-op) relationship with the DOR. This arrangement allows for Butte County to receive matching funds from the Federal government. One result of this relationship is that DOR assigns a counselor to work with BCDBH consumers. This DOR counselor has specialized training and experience, and understands the unique needs of BCDBH consumers. Consumers who qualify for DOR services may receive in-depth vocational assessments, financial assistance and job-related education.

**OUTCOMES**

1. Open 60 new cases.
2. Develop 50 new Individualized Plans for Employment (IPE).
3. Close 28 cases successfully.

**MEASUREMENTS**

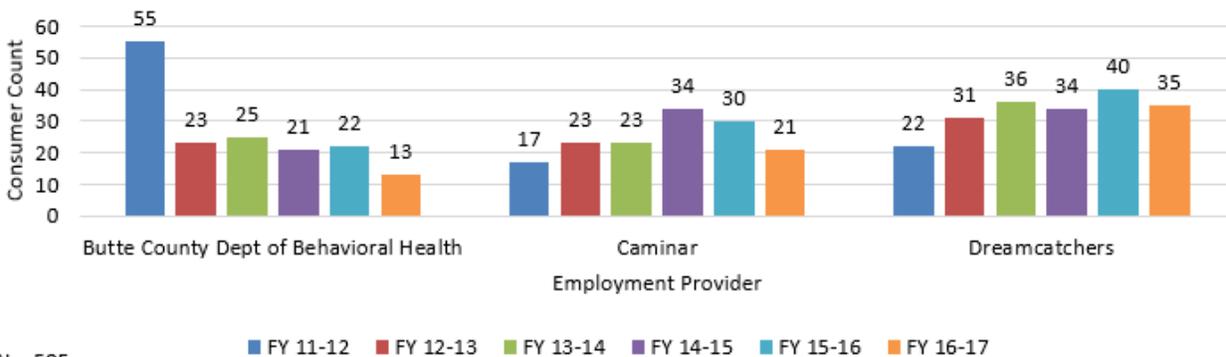
1. Capture number of new cases.
2. Capture number of Individualized Plans for Employment (IPE).
3. Capture number of cases closed successfully.

**TOTAL NUMBER SERVED BY FISCAL YEAR**

	<b>FY 11-12</b>	<b>FY 12-13</b>	<b>FY 13-14</b>	<b>FY 14-15</b>	<b>FY 15-16</b>	<b>FY 16-17</b>
<b>Total Served</b>	218	142	141	157	163	142

Outcome 1: Open 60 new cases.

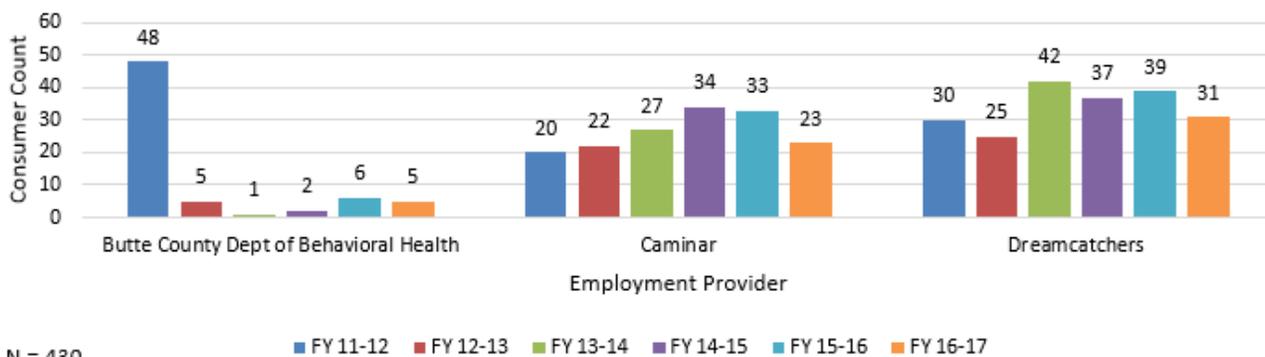
**NEW APPLICANTS**



	FY 11-12	FY 12-13	FY 13-14	FY 14-15	FY 15-16	FY 16-17
<b>Total New Applicants</b>	94	77	84	89	92	69

Outcome 2: Develop 50 new Individualized Plans for Employment (IPE).

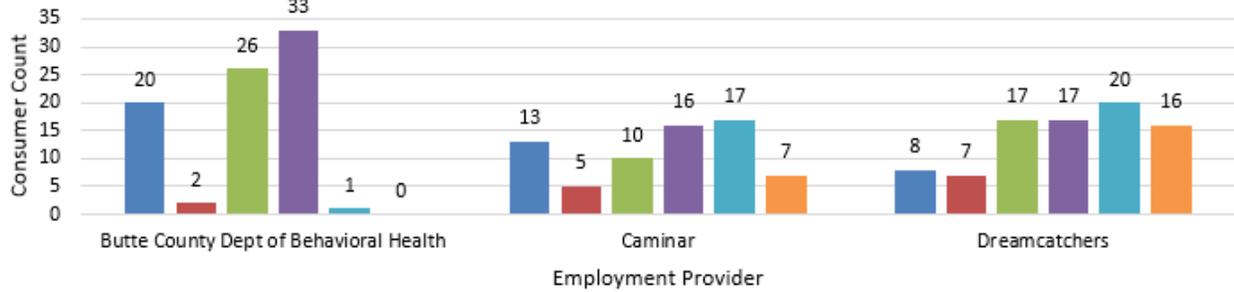
**NEW INDIVIDUALIZED PLANS FOR EMPLOYMENT (IPE)**



	FY 11-12	FY 12-13	FY 13-14	FY 14-15	FY 15-16	FY 16-17
<b>Total # of IPEs</b>	98	52	70	73	78	59

Outcome 3: Close 28 cases successfully.

**CLOSED SUCCESSFULLY AFTER AT LEAST 90 DAYS OF EMPLOYMENT**



N = 235

■ FY 11-12 ■ FY 12-13 ■ FY 13-14 ■ FY 14-15 ■ FY 15-16 ■ FY 16-17

	FY 11-12	FY 12-13	FY 13-14	FY 14-15	FY 15-16	FY 16-17
<b>Total # of Successfully Closed Cases</b>	41	14	53	66	38	23

<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	General (Non-FSP)	<input type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input type="checkbox"/>	Children (0-15)		
	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)		
	<input checked="" type="checkbox"/>	Adult (26-59)		
	<input checked="" type="checkbox"/>	Older Adult (60+)		

**PROGRAM DESCRIPTION**

Caminar provides vocational employment development for consumers. Employment services for Butte County Department of Behavioral Health (BCDBH) consumers provide a range of services including employment readiness, on-site supportive employment, and employment placement assistance, connection to the California Department of Rehabilitation (DOR), job training and community-based

*“I have learned how to be responsible and respectful in the workplace. I have learned how to work productively as a member of a work crew. I have learned new skills that I can apply to future employment.”*  
- Consumer

employment. A key aspect of recovery is helping BCDBH consumers identify ways to live a full life, which often includes re-entry into the workforce. It is linked to SEARCH, but open to all programs. Consumers are given paid positions that build expectations of a community job.

Vocational Training and consumer employment services will be part of the first set of contracted services that will be sent out for Request for Proposals. Caminar will be funded for six months during this process.

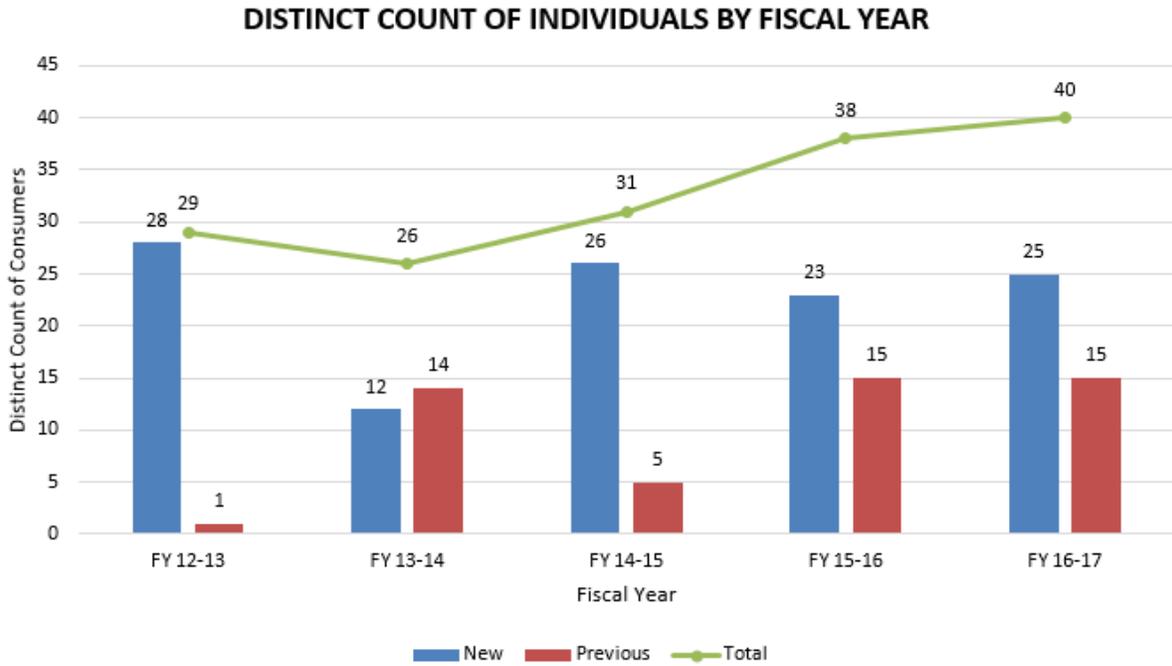
**OUTCOMES**

1. Increase number of consumers participating in supported employment vocational training.
2. Provide a variety of employment/training opportunities.
3. Transition to community employment and/or higher level of vocational services (DOR Co-Op).

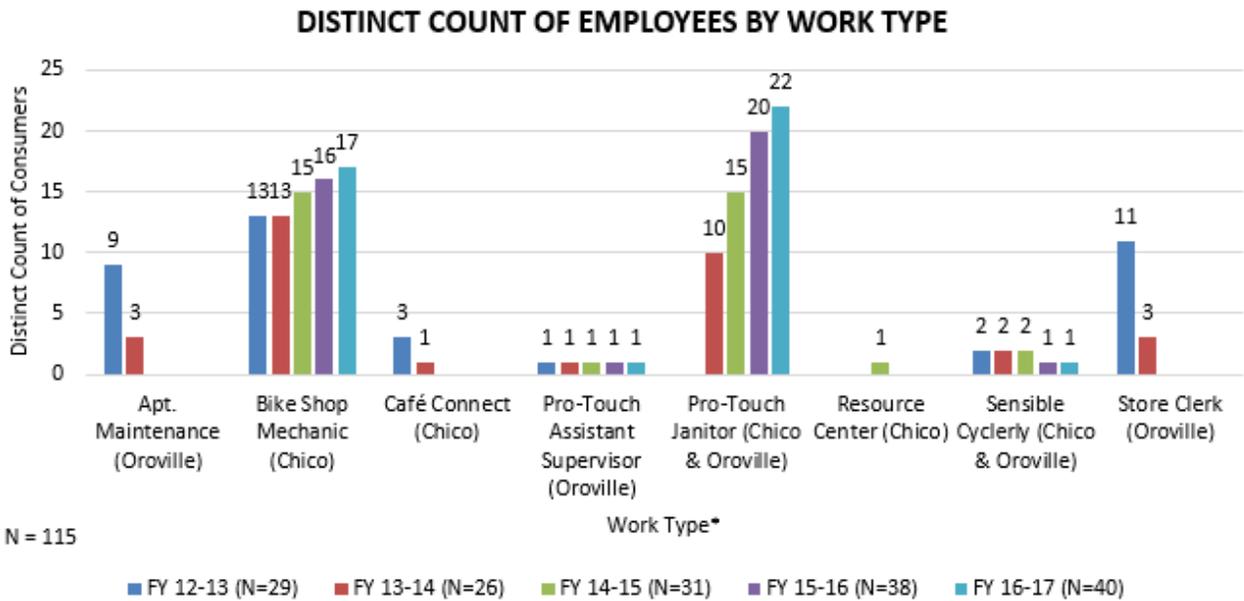
**MEASUREMENTS**

1. Number of consumers employed
  - a. Overall quarterly totals
  - b. Quarterly total of new consumers employed
2. Number of consumers participating by type of employment
  - a. Number of consumers in each type/position
3. Number of consumers
  - a. Transitioned and/or referred to DOR Co-Op
  - b. Maintained DOR Co-Op training

Outcome 1: Increase number of consumers participating in supported employment vocational training.



Outcome 2: Provide a variety of employment/training opportunities.



\*Consumers may be employed in more than one program.

Outcome 3: Transition to community employment and/or higher level of vocational services (DOR Co-Op).

### NUMBER OF INDIVIDUALS WHO GAINED EMPLOYMENT AT DISCHARGE

	FY 11-12	FY 12-13	FY 13-14	FY 14-15	FY 15-16	FY 16-17
Gained Employment	10	2	7	7	2	9

<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	General (Non-FSP)	<input type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input type="checkbox"/>	Children (0-15)		
	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)		
	<input checked="" type="checkbox"/>	Adult (26-59)		
	<input checked="" type="checkbox"/>	Older Adult (60+)		

**PROGRAM DESCRIPTION**

Dreamcatchers Supported Employment Program helps individuals build skills and obtain work experience in a supportive environment. Dreamcatchers work with BCDBH consumers to develop positions in which individuals can obtain basic skills for employability. Employment opportunities are both in-house with BCBH or within the community. This program provides the ability for consumers to work on effective communication, multi-tasking skills, following directions and time management skills as well as understanding the importance of attendance and punctuality, responsibility, appearance and attitude. These basic employability skills are the foundational skills needed for becoming employed regardless of job level or industry.

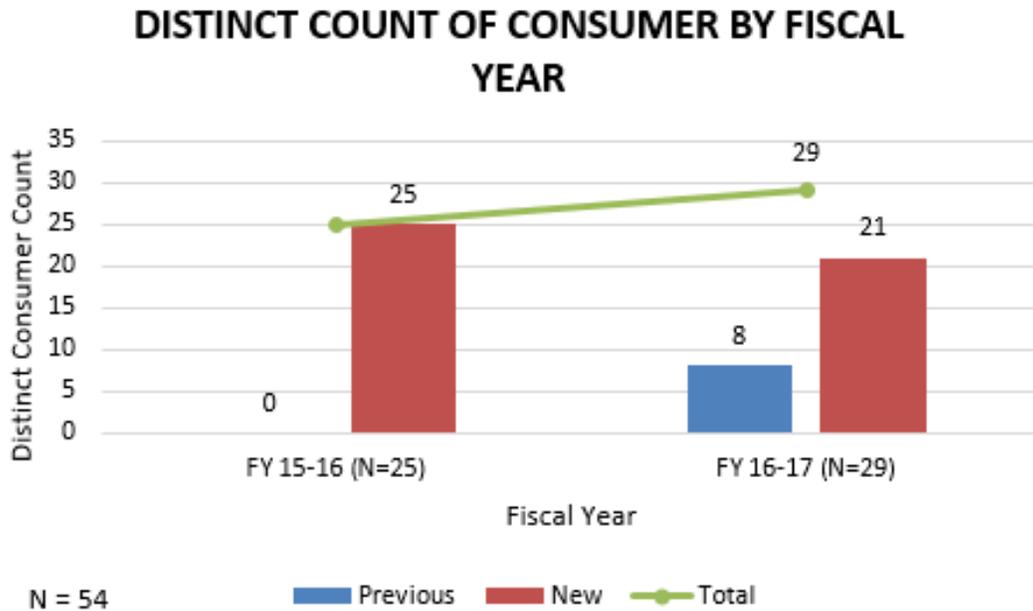
**OUTCOMES**

1. Increase number of consumers participating in supported employment vocational training.
2. Provide a variety of employment/training opportunities.
3. Transition to community employment and/or higher level of vocational services (DOR Co-Op).

**MEASUREMENTS**

1. Number of consumers employed:
  - a. Overall quarterly totals
  - b. Quarterly total of new consumers employed
2. Number of consumers participating by type of employment:
  - a. Number of consumers in each type/position
3. Distinct count of consumer who gained employment upon discharge.

Outcome 1: Increase number of consumers participating in supported employment vocational training.



Outcome 2: Provide a variety of employment/training opportunities.

### NUMBER OF CONSUMERS PARTICIPATING BY TYPE OF EMPLOYMENT

WORK TYPE*	FY 15-16	FY 16-17
Consumer Presenter	1	0
Custodian/Janitorial	5	6
Landscaper	4	5
Office Assistant	3	5
Store Clerk	12	17
Youth Mentor	2	4

\*Consumers may work in more than one vocational program.

Outcome 3: Transition to community employment and/or higher level of vocational services (DOR Co-Op).

	FY 15-16	FY 16-17
Gained Employment	16	13

<b>STATUS</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/> General (Non-FSP)	<input type="checkbox"/> Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input type="checkbox"/> Children (0-15)	
	<input checked="" type="checkbox"/> Transitional Age Youth (16-25)	
	<input checked="" type="checkbox"/> Adult (26-59)	
	<input checked="" type="checkbox"/> Older Adult (60+)	

**PROGRAM DESCRIPTION**

The Jesus Center is a job readiness program that engages consumers in volunteer positions with a long term goal of helping consumer’s re-entry into the workforce. The employment services for the individuals that are currently receiving behavioral health services through the county include: on site supportive employment, employment readiness, job training and community-based employment, and connection to the California Department of Rehabilitation (DOR). The services offered at the Jesus Center are based around community collaboration, cultural competency, client/family driven mental health system, recovery and resilience, and integrated service experiences.

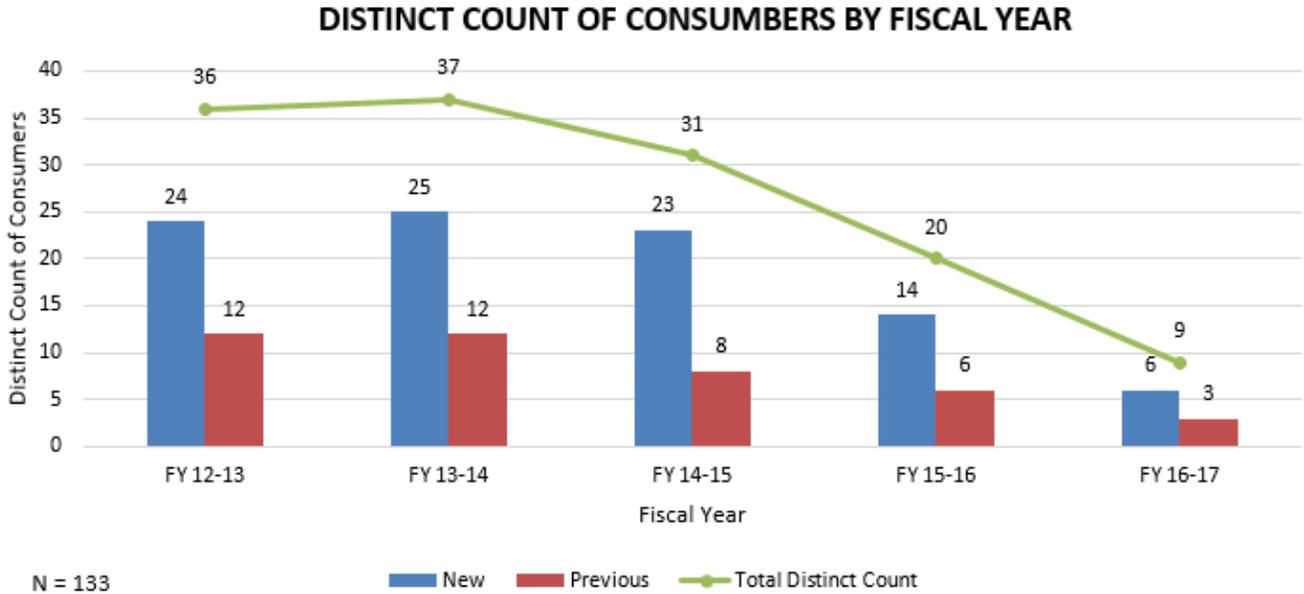
**OUTCOMES**

1. Increase number of consumers participating in supported employment vocational training.
2. Provide a variety of employment/training opportunities.
3. Transition to community employment and/or higher level of vocational services (DOR Co-Op).

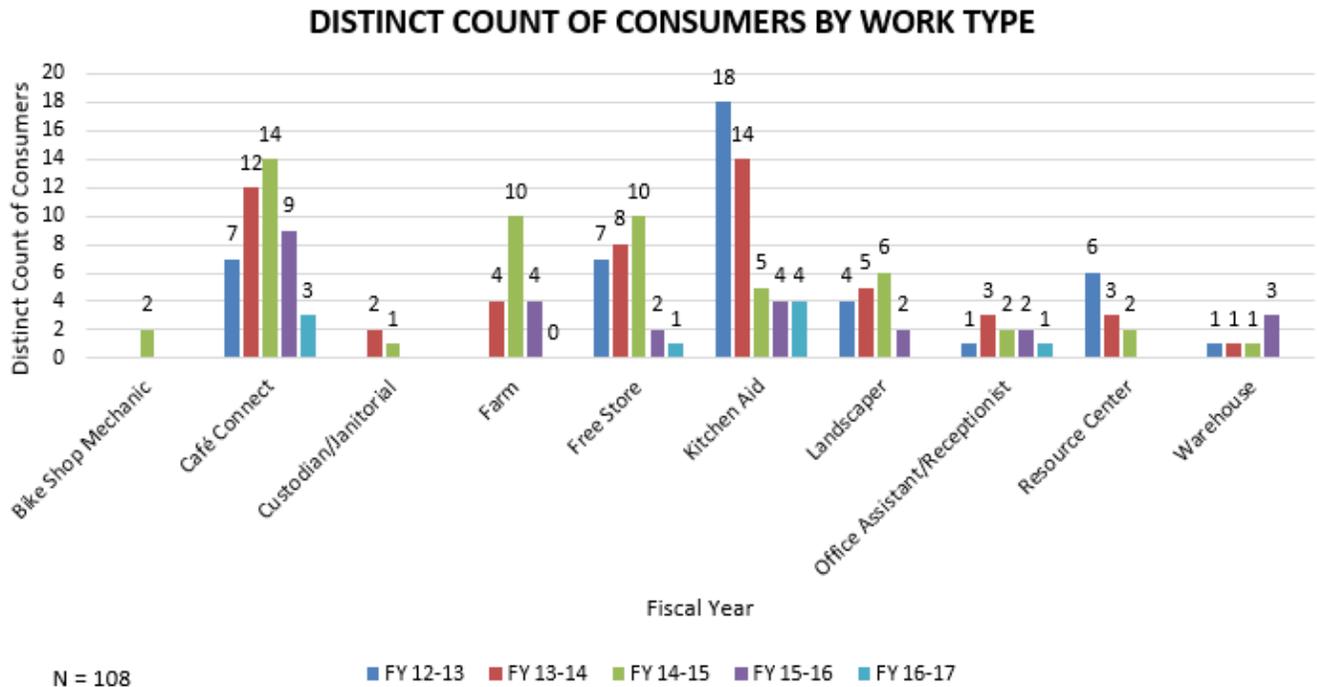
**MEASUREMENTS**

1. Number of consumers employed:
  - a. Overall totals
  - b. Total of new consumers employed
1. Number of consumers participating by type of employment:
  - a. Number of consumers in each type/position
2. Number of individuals that gained employment at discharge.

Outcome 1: Increase number of consumers participating in supported employment vocational training.



Outcome 2: Provide a variety of employment/training opportunities.



\*Consumers may be employed in more than one program.

Outcome 3: Transition to community employment and/or higher level of vocational services (DOR Co-Op).

**NUMBER OF INDIVIDUALS THAT GAINED EMPLOYMENT AT DISCHARGE**

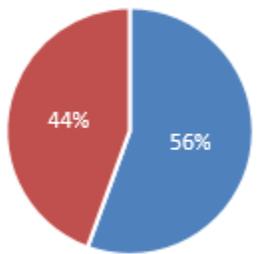
	FY 12-13	FY 13-14	FY 14-15	FY 15-16	FY 16-17
Gained Employment	16	17	17	10	4

**DEMOGRAPHICS OF DISTINCT CLIENTS SERVED**

FY 16-17

*Number Served: 9*

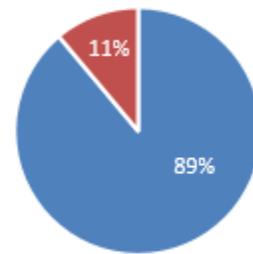
**DISTINCT COUNT BY GENDER**



MALE (5) FEMALE (4)

N=9

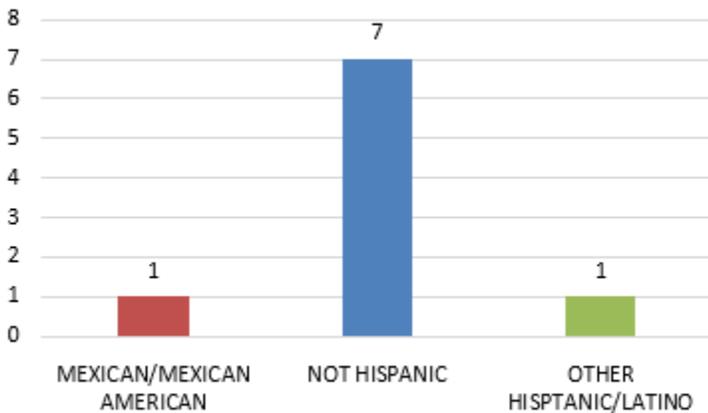
**DISTINCT COUNT BY AGE GROUP**



26-59 (8) 60+ (1)

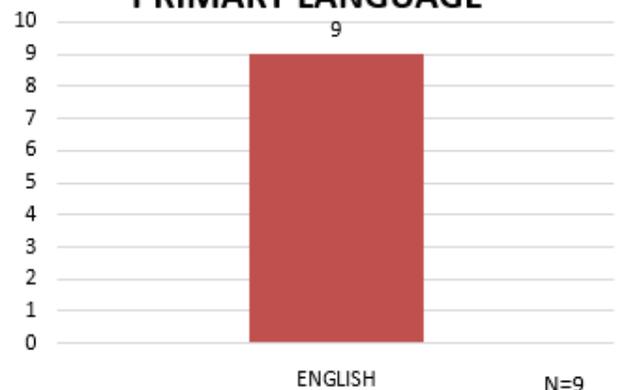
N=9

**DISTINCT COUNT BY ETHNICITY**



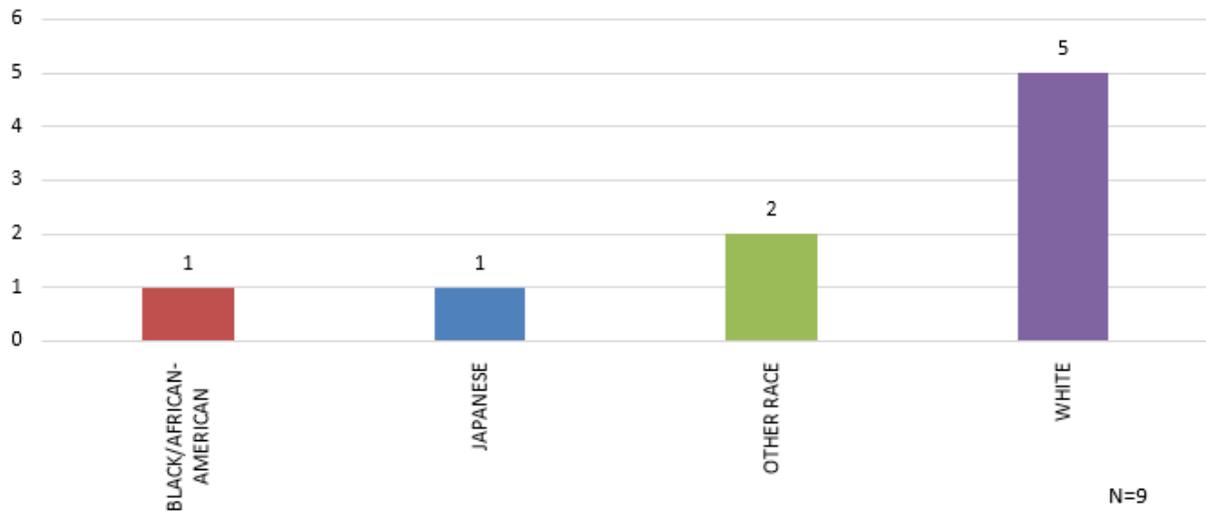
N=9

**DISTINCT COUNT BY PRIMARY LANGUAGE**



N=9

### DISTINCT COUNT OF RACE



<b>STATUS</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/> General (Non-FSP)	<input type="checkbox"/> Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input checked="" type="checkbox"/> Children (0-15)	
	<input checked="" type="checkbox"/> Transitional Age Youth (16-25)	
	<input type="checkbox"/> Adult (26-59)	
	<input type="checkbox"/> Older Adult (60+)	

**PROGRAM DESCRIPTION**

The 6<sup>th</sup> Street Center in Chico provides services to homeless youth between the ages of 14-24. Drop-in hours are Monday through Friday 10:30-5:30. The majority of the youth served are between 18 and 24 years old and a large percentage have been in foster care. Many of the youth have had traumatic experiences with families, friends, schools, and other community support systems which have caused them to be wary of accessing services. Thus, a major focus of the program is trust building.

*“6<sup>th</sup> Street is AMAZING I wouldn’t be alive if I didn’t have it. Hot food, showers, and clean clothing really make a difference on the street.”*

*- Consumer*

Youth initially contact the center to utilize shower facilities, access computers, use laundry services, and get food. Groups, classes, and workshops are offered focusing on development of independent living skills, youth leadership opportunities, and healthy use of leisure time. The weekly activity schedule includes art, yoga, and cooking. Music time occurs daily where youth have access to the center piano, keyboard and guitars. Field trips occur approximately four times per year and have included rafting, rock-climbing, swimming and hiking.

Once a 6<sup>th</sup> street member, each youth is issued a benefits card indicating the number of clothing and hygiene items they are able to access for the month. Community donations supply the clothing closet, hygiene room, and the 6<sup>th</sup> Street Little Box store; containing essentials such as socks, underwear, deodorant, dental care, food, games, and basic household supplies. Youth earn TAY Bucks to use at the Little Box store by attending appointments, completing goals, and helping out with chores. The store serves both as a participation incentive and practice for learning to save and budget. Coffee, pastries, and food for the daily hot meal are provided by a local coffee shop and Trader Joe’s. Youth and staff work together to plan and prepare center meals.

6th Street case managers work one-on-one with youth to access counseling, employment readiness, educational advocacy, housing opportunities, and public benefits through:

- Partnership with the Butte County Office of Education School Ties program to meet the educational needs of the youth. School Ties provides weekly on-site tutoring and GED preparation. 6th St staff are ready to assist youth within enrolling in school and for those attending college, complete the FAFSA.
- Collaboration with Job Steps, a privately funded project, designed to provide supportive services to prepare at-risk/homeless youth for today's workforce. The 6th Street TAY Employment Specialist helps each youth assess their individual strengths, skills, and qualifications to help determine what different employment opportunities might best fit their needs.
- Olive House is a privately funded supportive housing project providing 2 beds for young women between 18-24 years old who are either working or attending an educational program. A live-in mentor provides support and models healthy independent living for Olive House participants. Other supportive housing opportunities through 6<sup>th</sup> street membership include Master Lease and TAY Transitional Housing.

6<sup>th</sup> Street clinicians provide therapy services on site. If a youth is in need of medication or has mental health symptoms requiring a higher level of care, a referral to Butte County Behavioral Health is completed. 6<sup>th</sup> Street staff and BCBH work closely to coordinate care and assist the youth towards wellness and recovery.

#### OUTCOMES

1. Reduce homelessness.
2. Consumers attain employment.
3. Increase consumer access to educational services.
4. Increase school retention/admission.

#### MEASUREMENTS

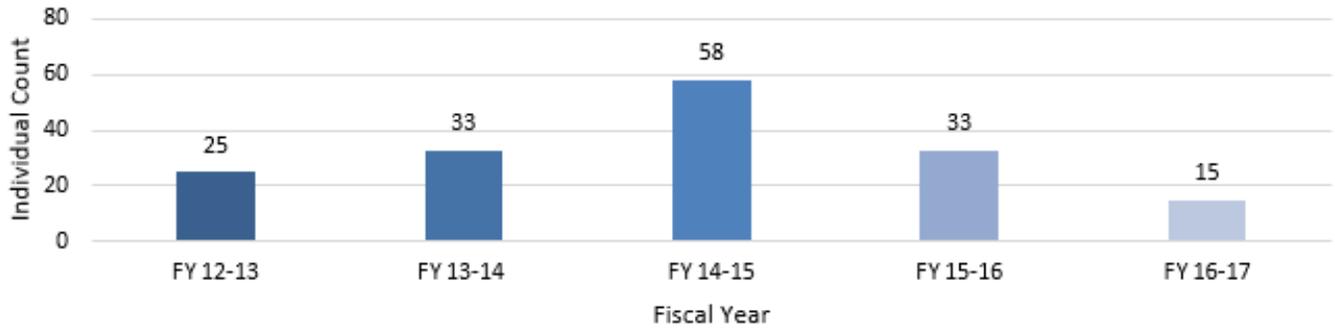
1. Number of TAY/youth transitioned to stable housing.
2. Number participating in employment services.
  - a. Identify types of employment.
  - b. Number employed.
3. Number enrolled in educational program:
  - a. Identify types of educational programs (school, vocational and/or trade)\*.
  - b. Number attending educational programs.
4. Number completing educational programs.

*\*This data was not collected for FY 16-17 but is being collected for FY 17-18.*

**The distinct number of individuals reported to have been served in Fiscal Year 2016-2017 was 168.**

Outcome 1: Reduce homelessness.

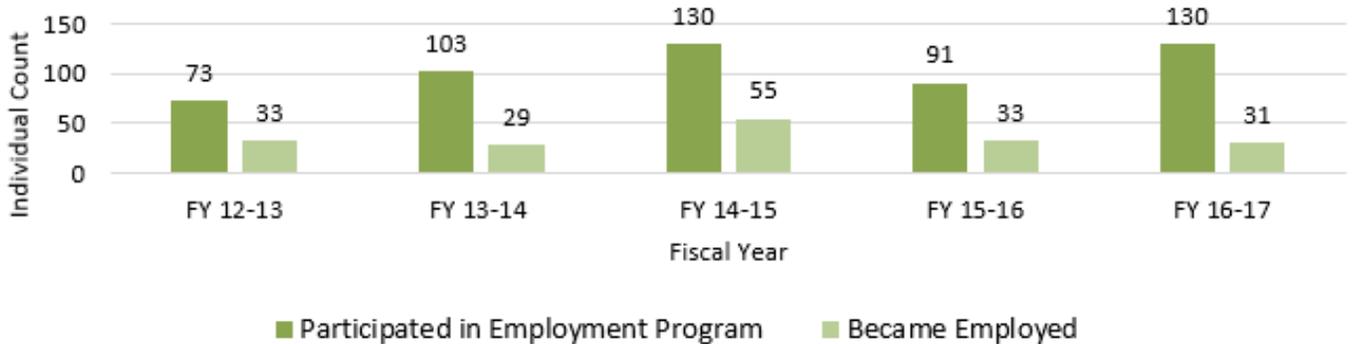
### TRANSITIONED TO HOUSING



N = 164

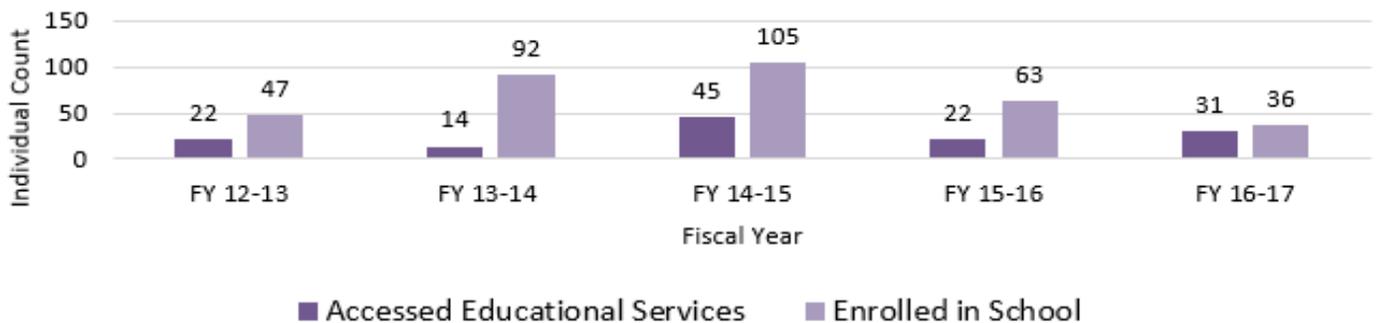
Outcome 2: Consumers attain employment.

### EMPLOYMENT OUTCOMES



Outcome 3 & 4: Increase consumer access to educational services and Increase school retention/admission.

### EDUCATION OUTCOMES



**OUTREACH AND ENGAGEMENT OF SERVICES**

GROUP ATTENDANCE & OCCURRENCES	FY 16-17	
	ATTENDANCE	OCCURRENCES
Academic Skills	109	24
Cultural Activity	44	9
Health Education	15	4
Life Skills	67	23
Physical Activity	26	12
<b>Group Totals</b>	<b>261</b>	<b>72</b>

EVENT & TRAINING TOTALS	FY 16-17
<i>Total Count of Events &amp; Trainings</i>	<b>3</b>
<i>Estimated Number of Attendees</i>	<b>380</b>

VISITOR DEMOGRAPHICS (NON-DISTINCT COUNT)	FY 16-17
<b>Age</b>	
0-15	95
16-25	1134
Unknown	427
<b>Gender</b>	
Female	367
Male	800
Transgender	47
Not Disclosed	5
Unknown	437
<b>Primary Language</b>	
English	1239
Other	4
Unknown	413
<b>Cultural Groups (visitor can identify with multiple cultural groups)</b>	
Foster Care	217
LGBTQ	226
Veterans	4
Other	990
Unknown	443

Race/Ethnicity	
African American	49
American Indian or Alaskan Native	45
Asian or Hmong	2
Hispanic or Latino	68
Multi	190
Native Hawaiian or Other Pacific Islander	4
Other	52
White	747
Unknown	499

<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	General (Non-FSP)	<input type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input type="checkbox"/>	Children (0-15)	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)
	<input checked="" type="checkbox"/>	Adult (26-59)		
	<input checked="" type="checkbox"/>	Older Adult (60+)		

**PROGRAM DESCRIPTION**

*“My home away from home. I enjoy groups, community, and interacting. This place [Iversen Center] saved my life! We’re a big family.”*  
- Consumer

Three Wellness and Recovery Centers operate in Butte County: *The Iversen Center* in Chico, *The Hub* in Paradise, and *The Oroville Wellness and Recovery Center* in Oroville.

Each center is unique to its community yet they all have similar goals. The consumer-driven centers embody the “Recovery Philosophy;” this is a focus on learning how to live to the fullest while managing the ups and downs that accompany mental health challenges. Consumers who take part in center activities

include those who receive a wide array of behavioral health services as well as those who seek only medication management. Consumers have praised the centers, commenting on the benefits that they receive from their participation in consumer-run support groups, meditation, WRAP® (Wellness & Recovery Action Plans), group activities, computer labs, and employment services.

In general, Wellness and Recovery Centers provide consumers opportunities to find ways to increase their ability to live life at its fullest.

*“I have finally found a group where I feel like I belong [The Hub]. They are supportive and caring.”*  
- Consumer

**OUTCOMES**

1. Provide support, education, and tools to integrate into the community through groups held at the center.
2. Provide medication services.
3. Monitor vital signs.
4. Tracking or connecting consumers to primary care.

**MEASUREMENTS**

1. Capture usage of groups and computer lab.
2. Number of consumers utilizing medication services.
3. Number of consumers with vital signs taken.
4. Number of consumers with primary care physicians or referred to primary care.

Outcome 1: Provide support, education, and tools to integrate into the community.

A.

THE WELLNESS & RECOVERY CENTERS PROVIDE:
Groups, reading materials, peer advocates, medication clinics, and counseling services.

B.

IVERSEN CENTER COMMUNITY AWARENESS TOTALS*	FY 15-16	FY 16-17
Advertisement	6	9
Article	0	1
Brochure	598	405
Calendar	5204	3620
Emails	2264	6715
Fliers	119	89
Information Booth	78	69
Other Outreach	2184	857
Radio/TV	1	0
<b>Total Number of Community Awareness Occurrences</b>	<b>10454</b>	<b>11765</b>

*\*Only collected from Iversen Center Wellness & Recovery Center*

### NUMBER OF DISTINCT PARTICIPANTS PER WELLNESS CENTER GROUP

**FY 16-17**

(DOES NOT INCLUDE VISITORS OR MED CLINIC)

NUMBER OF DISTINCT PARTICIPANTS PER GROUP	IVERSEN CENTER (CHICO)	OROVILLE WELLNESS & RECOVERY CENTER	THE HUB (PARADISE)
Community Organization	208		
Computer Lab	147		34
Cultural Activity	201	16	26
Front Door	677		76
Health Education	35	38	1
Life Skills	95	40	39
Mental Health and Substance Abuse Education	5		
Mental Health Education	403	34	41
Physical Activity	70	25	18
Social Activity	136	33	28
Substance Abuse Education	33		2
<b>Total</b>	<b>2010</b>	<b>186</b>	<b>265</b>

**NUMBER OF PARTICIPANTS PER WELLNESS CENTER GROUP  
FY 16-17**

(DOES NOT INCLUDE VISITORS OR MED CLINIC)

NUMBER OF DISTINCT PARTICIPANTS PER GROUP	IVERSEN CENTER (CHICO)	OROVILLE WELLNESS & RECOVERY CENTER	THE HUB (PARADISE)
Community Organization	1457		
Computer Lab	1026		278
Cultural Activity	1184	24	135
Front Door	14236		1189
Health Education	123	93	3
Life Skills	456	165	281
Mental Health and Substance Abuse Education	5		
Mental Health Education	4085	103	289
Physical Activity	260	32	282
Social Activity	614	56	106
Substance Abuse Education	101		
<b>Total</b>	<b>23547</b>	<b>473</b>	<b>2577</b>

C.

DISTINCT PARTICIPANTS COUNTS FOR FY 16-17	IVERSEN CENTER (CHICO)	OROVILLE WELLNESS & RECOVERY CENTER	THE HUB (PARADISE)
Total Distinct Participants	911	43	88

MEDICATION CLINIC OUTCOMES		FY 15-16	FY 16-17
<b>Outcome 2: Provide Medication Support Services.</b>	Chico	80	65
	Oroville	137	111
	Paradise*	0	0
<b>Outcome 3: Monitor Vital Signs.</b>	Chico	86	82
	Oroville	107	94
	Paradise	1	2
<b>Outcome 4A. Connected with Primary Care.</b>	Chico	0	2
	Oroville	36	10
	Paradise*	0	0
<b>Outcome 4B. Referred to Primary Care Providers.</b>	Chico	18	1
	Oroville	33	11
	Paradise*	0	0

\*Above outcomes are currently not available at The Hub in Paradise.

STATUS	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
EMPHASIS	<input checked="" type="checkbox"/>	General (Non-FSP)	<input type="checkbox"/>	Full-Service Partnership (FSP)
AGE GROUP	<input checked="" type="checkbox"/>	Children (0-15)		
	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)		
	<input checked="" type="checkbox"/>	Adult (26-59)		
	<input checked="" type="checkbox"/>	Older Adult (60+)		

#### PROGRAM DESCRIPTION

Services at the Torres Shelter utilize peer partner(s) to provide support to shelter guests who are experiencing mental illness. The goal is to increase the shelter guests' ability to effectively partake in services and to reinforce stable and secure housing. Peer partner(s) are available during the Torres Shelter evening hours, building relationships with shelter guests, decreasing stigma around mental health issues and guiding guests towards self-sufficiency. The Homeless Peer Partner Program is funded through federal funds (PATH) and MHSA funds.

#### OUTCOMES

1. Increase length of stay in shelter will reduce recidivism/chronically homeless
2. Increase number of consumers gaining employment.
3. Transition consumers to housing.
4. Increased number of referrals to County and/or community services.
5. Report the number of contacts made to link homeless individuals to services.

#### MEASUREMENTS

1. Average length of stay in the shelter (12 month period).
2. Number of guests placed in vocational training or employment.
3. Number of guests placed in housing outside the shelter.
4. Number of guests:
  - a. Referred to DESS eligibility worker\*
  - b. Referred to BCDBH\*
  - c. Referred to community or private mental health services\*
  - d. Referred to mental health and/or SUD services
5. Distinct count of persons contacted/outreached by PATH-funded staff cumulatively for each fiscal year.

*\*Outcomes were added to Fiscal Year 2017-2018 contract and data collection started July 2017.*

Outcome 1: Increase length of stay in shelter will reduce recidivism/chronically homelessness.



	FY 12-13	FY 13-14	FY 14-15	FY 15-16	FY 16-17
OUTCOME 2: Number of guests placed in vocational training or employed	177	152	139	153	172
OUTCOME 2: Number of guests placed in housing outside the shelter	296	322	303	201	228
OUTCOME 4: Number of guests referred to mental health and/or SUD services	0	81	285	312	386

Outcome 5: Report the number of contacts made to link homeless individuals to services.

	FY 12-13	FY 13-14	FY 14-15	FY 15-16	FY 16-17
Distinct Count of Client	685	732	712	729	963

<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	General (Non-FSP)	<input type="checkbox"/>	Full-Service Partnership (FSP)
<b>AGE GROUP</b>	<input checked="" type="checkbox"/>	Children (0-15)		
	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)		
	<input checked="" type="checkbox"/>	Adult (26-59)		
	<input checked="" type="checkbox"/>	Older Adult (60+)		

**PROGRAM DESCRIPTION**

Some people who seek services at Butte County Department of Behavioral Health (BCDBH) have conditions that do not qualify for county-based behavioral health services, or are resistant to be seen in a mental health services agency due to the stigma that they feel accompanies mental health care. Conversely, sometimes BCDBH consumers have a difficult time negotiating the medical system for a variety of reasons, which include feelings of being uncomfortable in medical waiting rooms and sometimes medical providers’ inexperience treating mental illness.

*“I have had beneficial results and they have helped me in my daily life. I feel like I am heard and given good counseling.”*  
 - Consumer

MHSA is developing integrated behavioral health services in community-based primary care settings through collaborative agreements with Federally Qualified Health Centers (FQHC) and other community health clinics in Chico, Oroville, Paradise, and Gridley. Mental health clinicians will be co-located at these primary care facilities and BCDBH consumers will be able to access medical and mental health care at the same site. The program will increase

the capacity of primary care clinics, particularly those that have large underserved cultural populations, so that they can see more people with mental health conditions.

**OUTCOMES**

1. Refer consumers to primary-care providers.
2. Connect consumer to primary care providers.

**MEASUREMENTS**

1. Distinct number of consumers discharged and where they were referred.
2. Distinct number of consumers who were connected to primary-care providers.

Outcome 1: Refer consumer to primary care providers.

	FY 13-14	FY 14-15	FY 15-16	FY 16-17
Distinct Count of Discharged Clients:	339	233	225	153

REFERRED TO:	FY 13-14	FY 14-15	FY 15-16	FY 16-17
AMPLA Chico	24	10	10	2
AMPLA Gridley	1	1	0	0
AMPLA Oroville	61	3	2	0
Enloe Hospital	0	0	0	0
Feather River Health Center	4	4	2	2
Feather River Hospital	4	0	0	1
Feather River Tribal Health (FRTH)	3	1	1	0
Gridley Hospital (Orchard Hospital)	0	0	0	0
North Valley Indian Health	0	3	0	0
Primary Care Doctors	47	19	32	33
Pvt Providers if clients have insurance	6	1	0	0

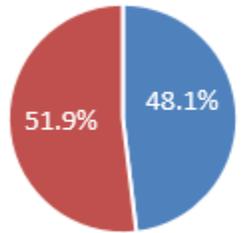
Outcome 2: Connect consumers to primary-care providers.

DURING THS EPISODE THIS CLIENT:	FY 13-14	FY 14-15	FY 15-16	FY 16-17
Connected with Primary Care	6	11	14	5

**DEMOGRAPHICS OF DISTINCT CLIENTS SERVED  
FY 16-17**

*Number Served: 395*

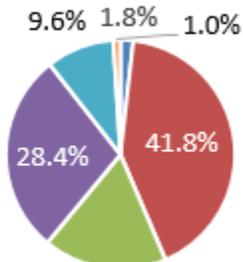
**GENDER**



N = 395

■ FEMALE ■ MALE

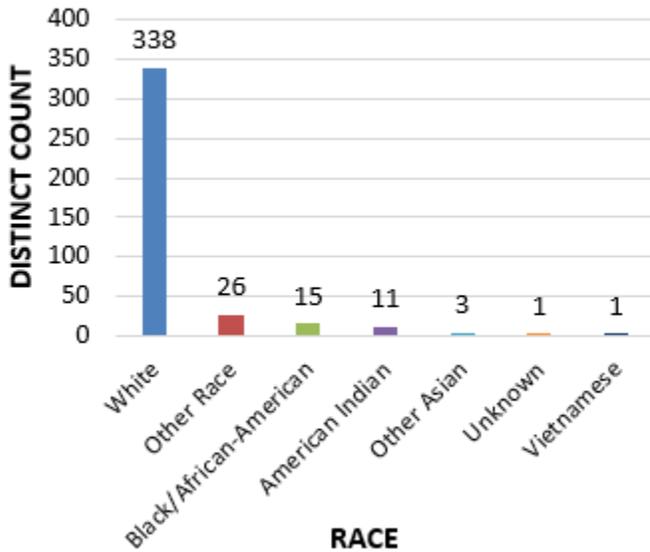
**AGE GROUP**



N = 395

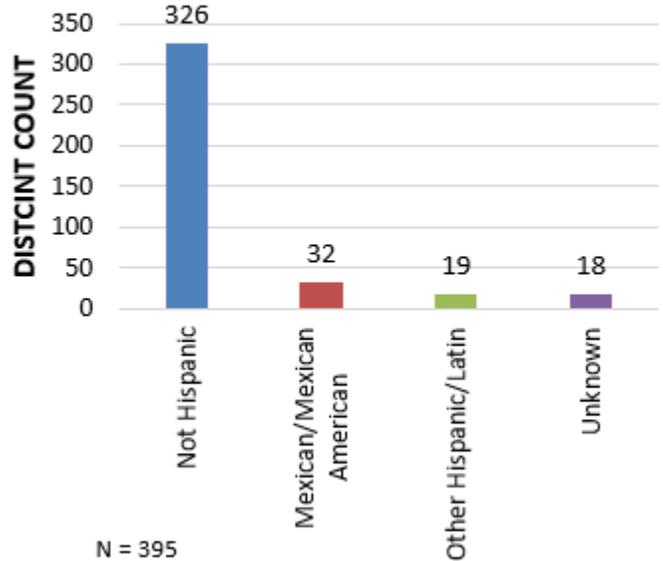
■ 0-5 ■ 6-16 ■ 17-25 ■ 26-59 ■ 60-74 ■ 75+

**RACE**



N = 395

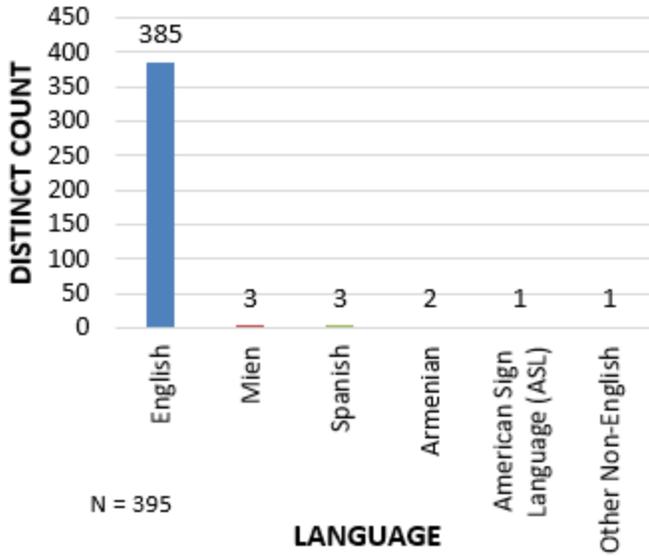
**ETHNICITY**



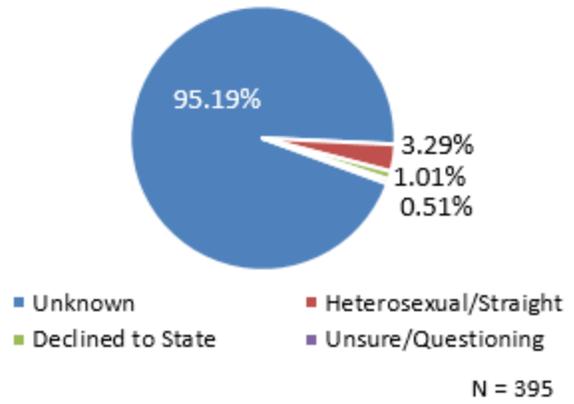
N = 395

**ETHNICITY**

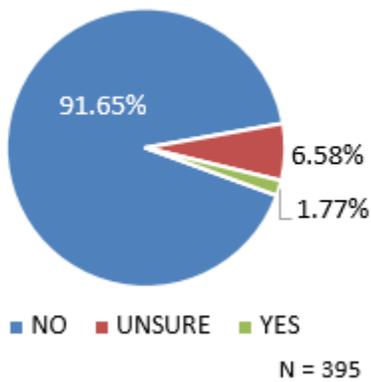
**PRIMARY LANGUAGE**



**SEXUAL ORIENTATION**



**VETERAN STATUS**



## SECTION 2: PREVENTION & EARLY INTERVENTION

PEI

LIVE SPOT & PREVENTION – GRIDLEY & OROVILLE

<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	Prevention	<input type="checkbox"/>	Early Intervention
<b>AGE GROUP</b>	<input checked="" type="checkbox"/>	Children (0-15)	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)
	<input checked="" type="checkbox"/>	Adult (26-59)	<input checked="" type="checkbox"/>	Older Adult (60+)
<b>SERVICES/ACTIVITIES</b>	<input type="checkbox"/>	Access & Linkage	<input type="checkbox"/>	Early Intervention
	<input type="checkbox"/>	Outreach	<input checked="" type="checkbox"/>	Prevention
	<input type="checkbox"/>	Stigma & Discrimination	<input type="checkbox"/>	Other

### PROGRAM DESCRIPTION

The Gridley and Oroville Live Spot & Prevention program provides hope and reassurance, as well as a safe place for young people after school when they need support and supervision. At the Live Spot, young people have the opportunity to build skills and relationships in a positive, supportive environment. The Live Spot offers daily activities, workshops, school success services, special events and employment opportunities for youth. An integral part of the Live Spot service design is employing young people to plan, implement and evaluate all of the Live Spot programs and services. The programs and services of the Oroville and Gridley Live Spot also reach far beyond the youth center doors. Through Friday Night Live and Club Live Chapters, young people on high school and middle school campuses are engaged in the Committed Program Model. The Committed Program Model blends youth development principles with innovative youth-led environmental prevention strategies and school climate initiatives. The Committed Program Model is designed to build leadership skills, broaden young peoples' social network and implement youth-led projects to improve school climate and reduce youth access to alcohol. The program organizes youth into clubs called Chapters that are comprised of Chapter officers/leaders and general members.

The Live Spot also implements Impact Mentoring. Impact Mentoring is a peer mentoring program that matches high school role models with junior high school protégés in a cross-age mentoring experience. Mentors and protégés meet weekly in a supervised and structured mentoring session. During the session protégés set academic and personal goals and receive coaching from their mentors on ways to achieve those goals. This 25 week program lasts throughout the school year. Additional programs and conferences include: the Reach for the Future Conference which is a three day/two night experience based on a youth development framework, providing leadership/life skills, support and opportunities for young people. The Athlete Committed Conference which is designed to provide support to athletes, coaches and administrators. Also, the Strengthening Families Program (SFP) provides a comprehensive approach to increasing skills and knowledge for parents/care givers and children critical to healthy behaviors and relationships.

OUTCOMES

1. Unduplicated numbers of individuals served.
2. Strategies:
  - a. Access and Linkage
  - b. Improving Timely Access to Services for Underserved Populations
  - c. Be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory
3. Evidence-Based Practice Standard.

MEASUREMENTS

1. Number of individuals served.
2. Include all Strategies as referenced in Section 3735.
3. Include answers from the Consumer Perception Survey (CPS).

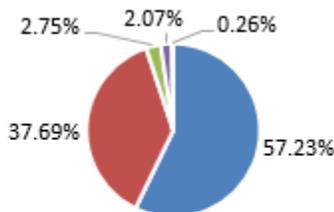
Outcome 1: Unduplicated number of individuals served.

**DEMOGRAPHICS OF DISTINCT CLIENTS SERVED**

FY 16-17

*Number Served: 1162*

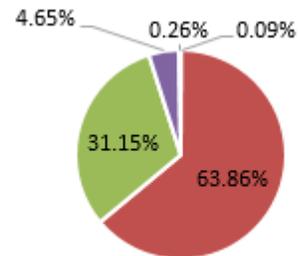
**DISTINCT COUNT BY GENDER**



■ FEMALE (665) ■ MALE (438) ■ UNIDENTIFIED (32)  
 ■ NOT DISCLOSED (24) ■ TRANSGENDER (3)

N=1162

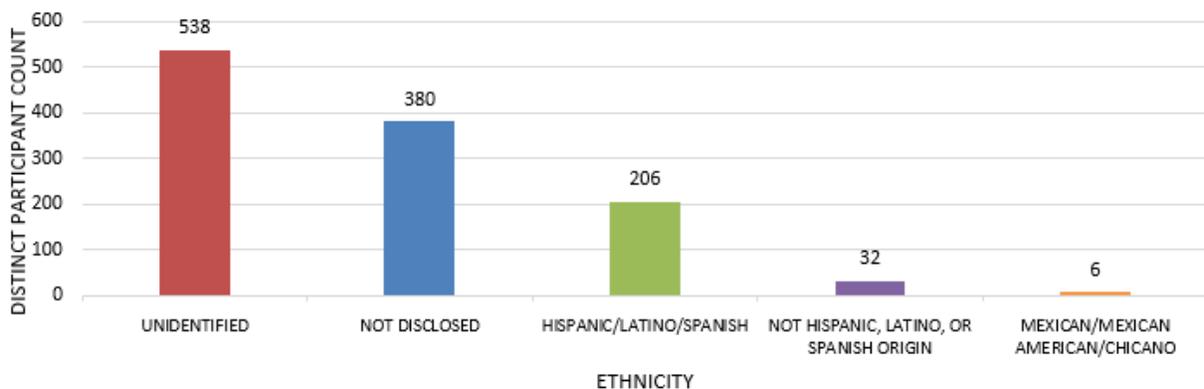
**DISTINCT COUNT BY AGE GROUP**



■ 0-5 (1) ■ 6-15 (742) ■ 16-25 (362) ■ 26-59 (54) ■ 60+ (3)

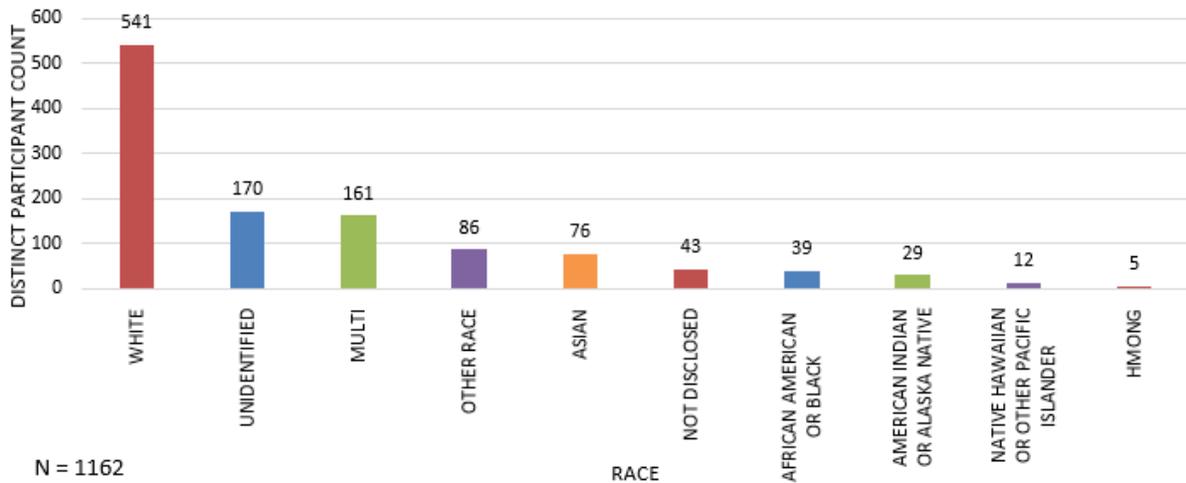
N=1162

**DISTINCT COUNT BY ETHNICITY**



N = 1162

**DISTINCT COUNT OF RACE**



**DISTINCT COUNT BY PRIMARY LANGUAGE**



Outcome 2: Strategies.

***Be designed and implemented to help create Access and Linkage to treatment.***

The Gridley and Oroville communities have long advocated for youth services. These communities have seen their vision become a reality. Each community has a Live Spot Youth Center as a cornerstone for supportive youth services creating access and linkages to prevention, early intervention and treatment services. The Live Spot services provide hope and reassurance, a safe place for young people after school when they need support and supervision and supportive services in the school/community. Through the Live Spot services, young people have the

opportunity to build skills and relationships in a positive, supportive environment that is welcoming and safe. The Live Spot offers daily activities, workshops, school success services, special events, and employment opportunities for youth. These activities and events are designed to not only engage young people, but also increase their knowledge around mental health issues (i.e.: stress, depression and anxiety). The activities and events are intentionally designed to include education and opportunities to increase skills on how to cope with risk factors that can contribute to mental health issues.

***Be designed, implemented, and promoted in ways that Improve Timely Access to Mental Health Services for individuals and/or families from underserved populations.***

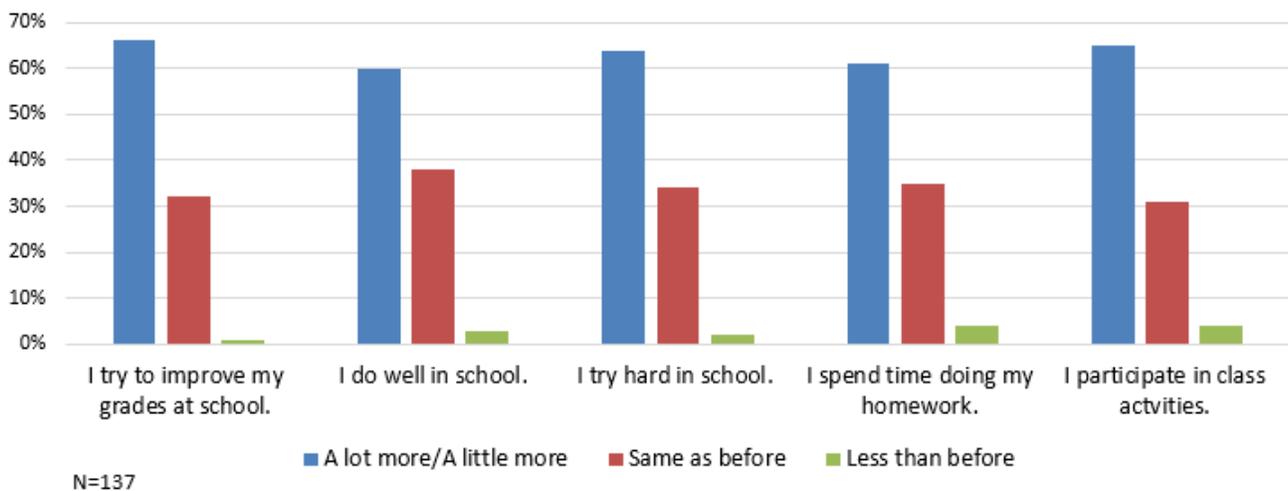
Due to the diverse program/service opportunities available, as well as the continuous open membership, youth/families are not forced to wait for services. In addition, the programs and services of the Oroville and Gridley Live Spot also reach far beyond the youth center doors with services provided on the middle school and high school campuses. In addition, traditional barriers such as transportation, insurance, membership fees, or childcare are eliminated ensuring that there is no delay or barrier to services due to these factors.

***Be designed, implemented, and promoted using Strategies that are non-stigmatizing and non-discriminatory.***

Through the Live Spot programs and services, young people are experiencing a non-stigmatizing and non-discriminatory environment. This is captured through the demographic information, the participant survey responses, interviews and focus groups.

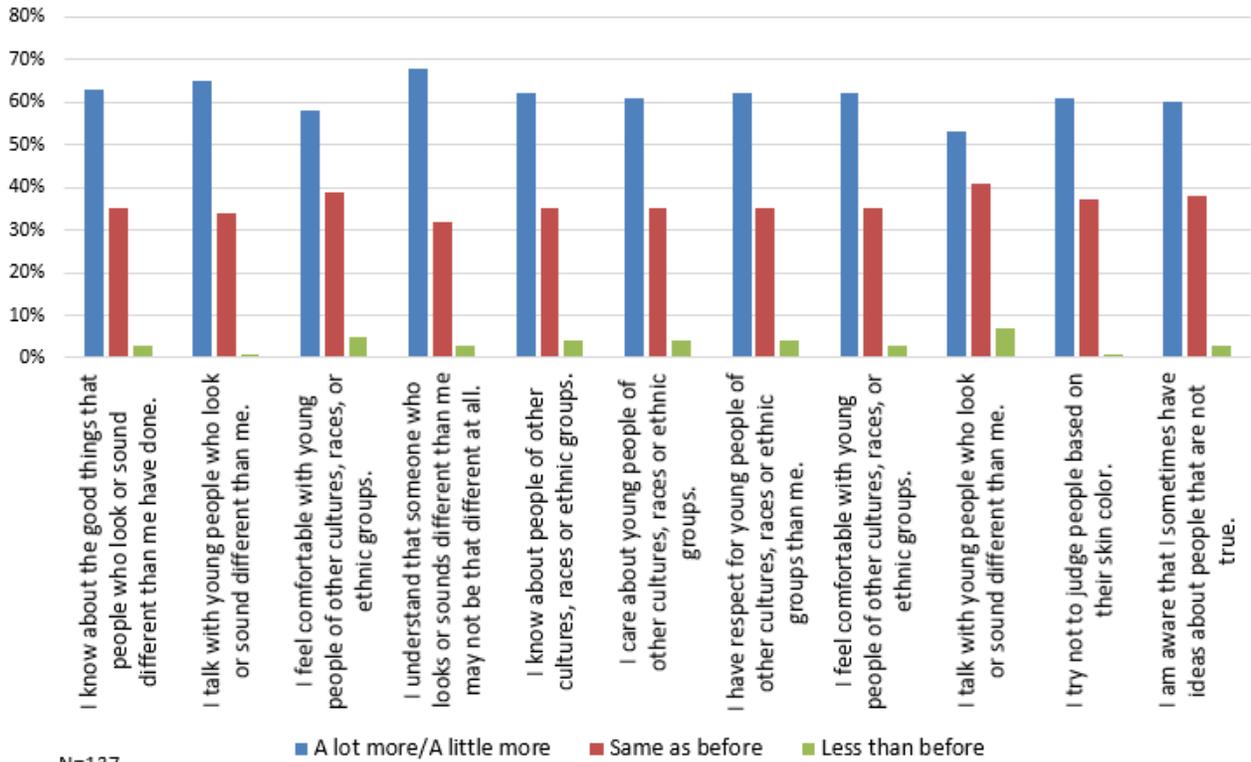
Outcome 3: Evidence-based practice standard.

**COMMITTMENT TO ACADEMIC ACHIEVEMENT**  
**Because I have been in this program:**



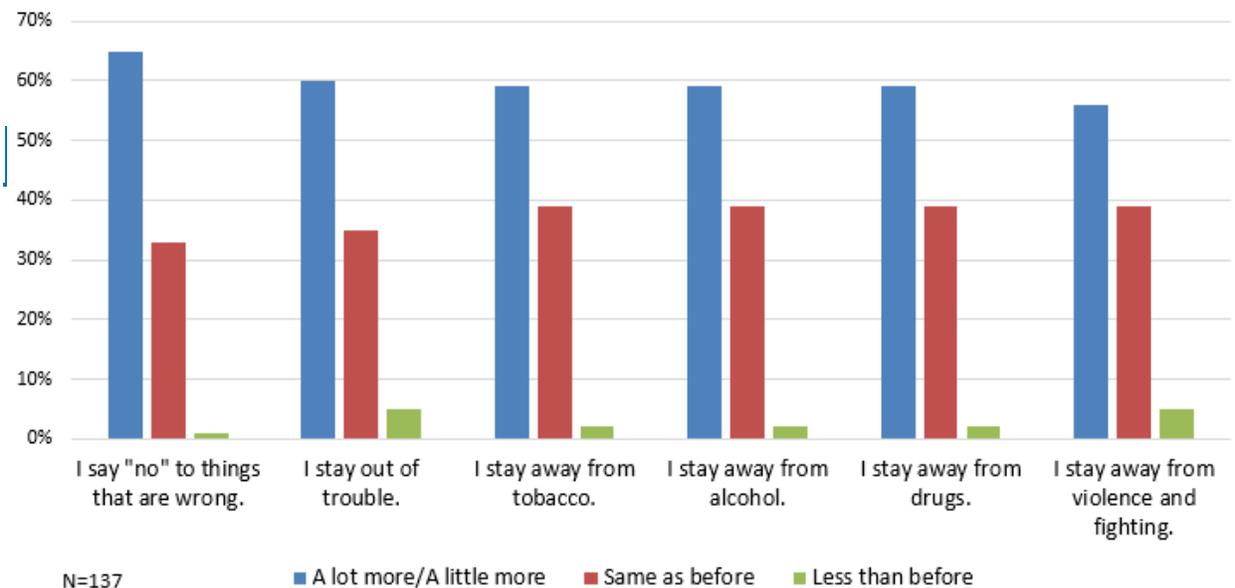
**CULTURE DOMAIN**

Because I have been in this program:

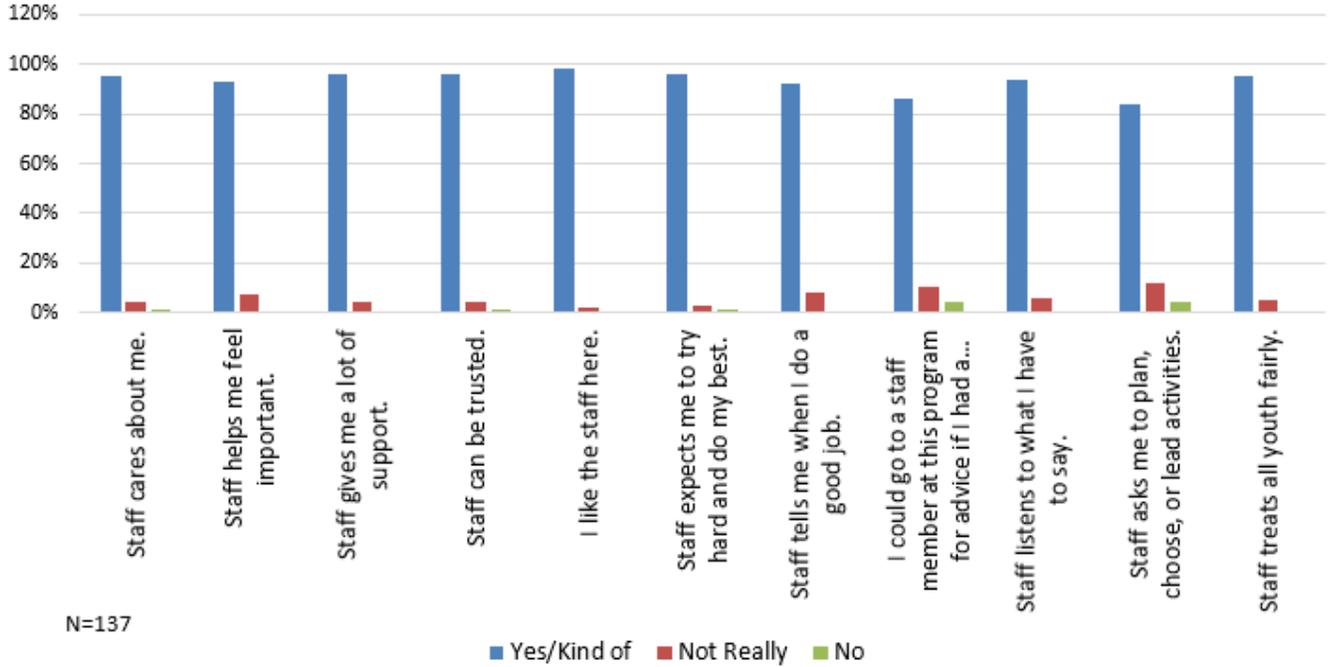


**LIFE CHOICES DOMAIN**

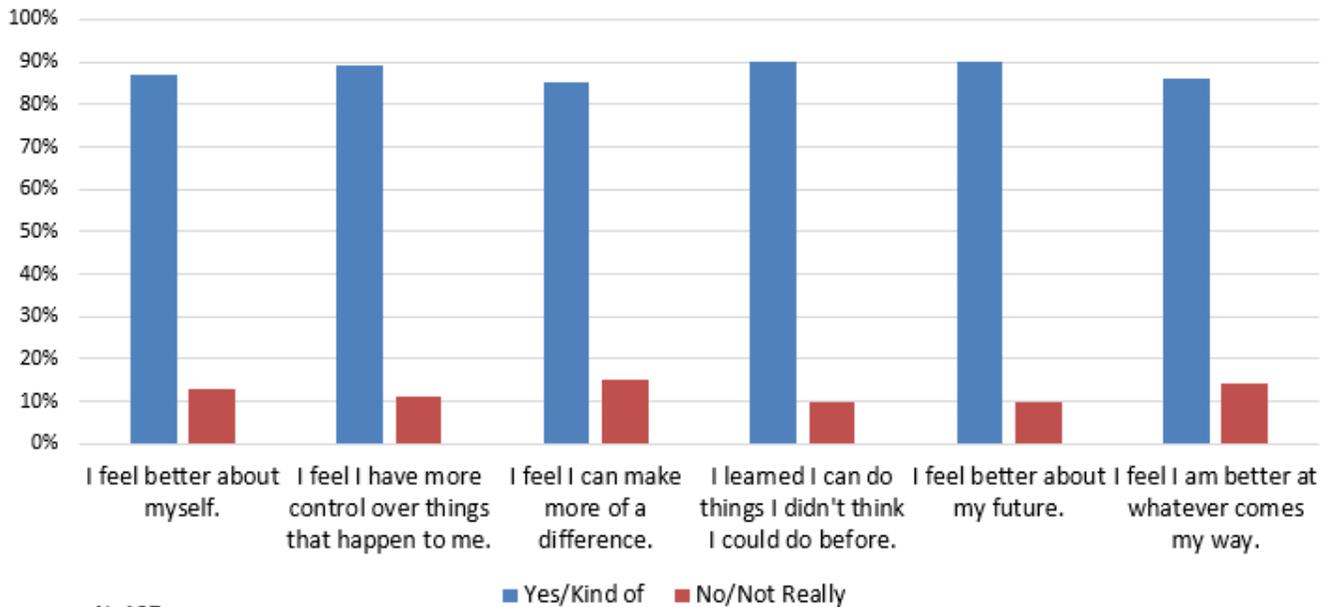
Because I have been in this program:



**STAFF INTERACTION & IMPACT**



**MENTAL & EMOTIONAL HEALTH DOMAIN**



**PARTICIPANT SATISFACTION & SAFETY**



<b>STATUS</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing
<b>EMPHASIS</b>	<input type="checkbox"/> Prevention	<input checked="" type="checkbox"/> Early Intervention
<b>AGE GROUP</b>	<input type="checkbox"/> Children (0-15)	<input type="checkbox"/> Transitional Age Youth (16-25)
	<input type="checkbox"/> Adult (26-59)	<input checked="" type="checkbox"/> Older Adult (60+)
<b>SERVICES/ACTIVITIES</b>	<input type="checkbox"/> Access & Linkage	<input checked="" type="checkbox"/> Early Intervention
	<input type="checkbox"/> Outreach	<input type="checkbox"/> Prevention
	<input type="checkbox"/> Stigma & Discrimination	<input type="checkbox"/> Other

#### PROGRAM DESCRIPTION

The Connections program provided by Passages seeks to serve older adults (age 60 and above) throughout Butte County who are at risk of, experiencing, exposed to, or interested in learning about mental illness and who are not, for reasons of stigma, lack of personal understanding, lack of transportation, and/or functional disability, presently connected to appropriate information or services.

Connections services seek to establish a network of information, services, and supports throughout the county designed with the unique needs of older adults in mind. The program works to reduce stigma around issues of mental illness and treatment, promote recognition and early intervention for in regards to challenges to mental health, decrease the incidence of psychological crisis, and improve suicide prevention efforts. These actions aim to encourage appropriate measures related to the consideration and treatment of mental health issues in not only Butte County's older adult population, but community as a whole.

#### OUTCOMES

1. Unduplicated numbers of individuals served.
2. Strategies:
  - a. Access and Linkage
  - b. Improving Timely Access to Services for Underserved Populations
  - c. Be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory
3. Evidence-Based Practice Standard

#### MEASUREMENTS

1. Number of individuals served.
2. Include all Strategies as referenced in Section 3735.
3. Include answers from the Consumer Perception Survey (CPS).

Outcome 1: Unduplicated number of individuals served.

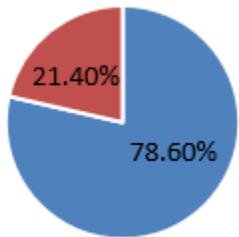
	FY 14-15	FY 15-16	FY 16-17
Distinct Count of Participants Served	20	18*	25

\*Due to PEI requirements changing mid-year, these counts are from QTR 3-4

**DEMOGRAPHICS OF DISTINCT CLIENTS SERVED  
FY 16-17**

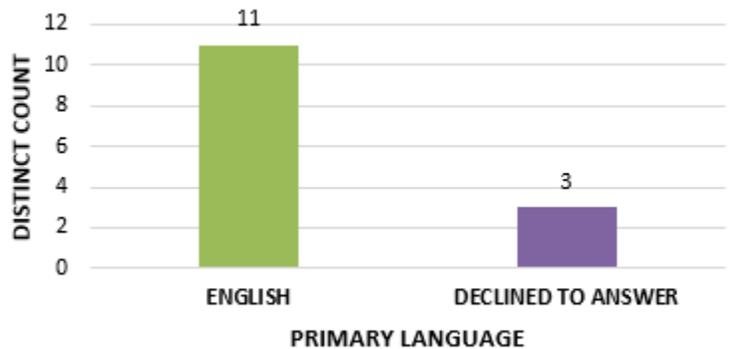
Number Admitted During This Period: 14

**AGE GROUP**



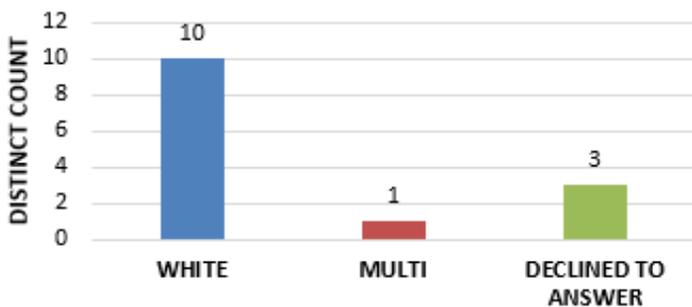
■ 60+ (OLDER ADULTS), 11 ■ DECLINED TO ANSWER, 3  
N=14

**PRIMARY LANGUAGE**



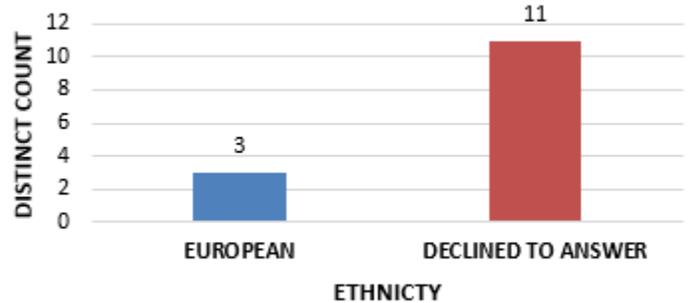
N=14

**RACE**



N=14

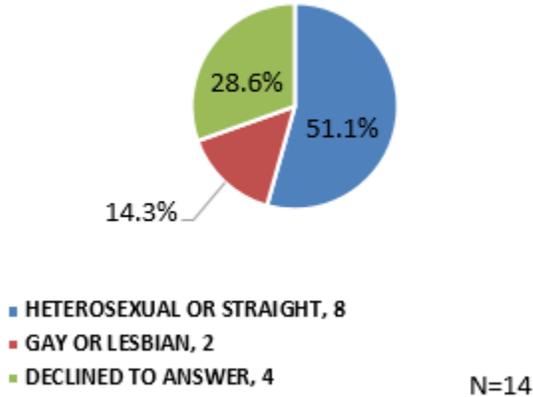
**ETHNICITY\*  
(Non-Hispanic & Non-Latino)**



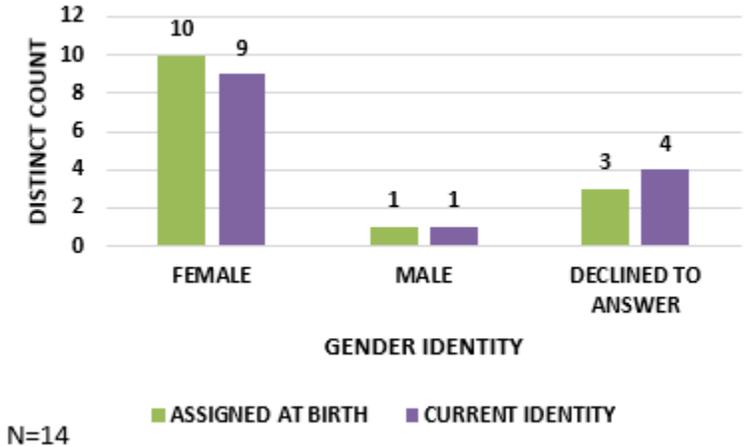
N=14

\*All individuals identified "Unknown" for Ethnicity Hispanic/Latino

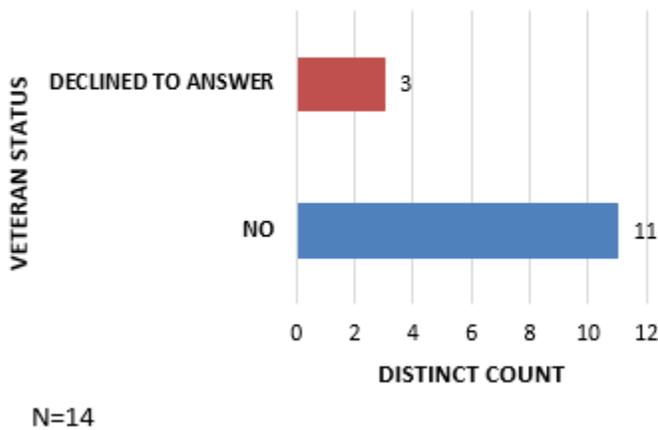
**SEXUAL ORIENTATION**



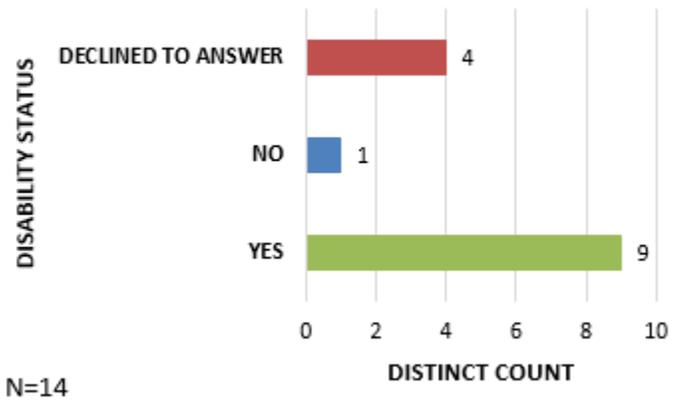
**GENDER**



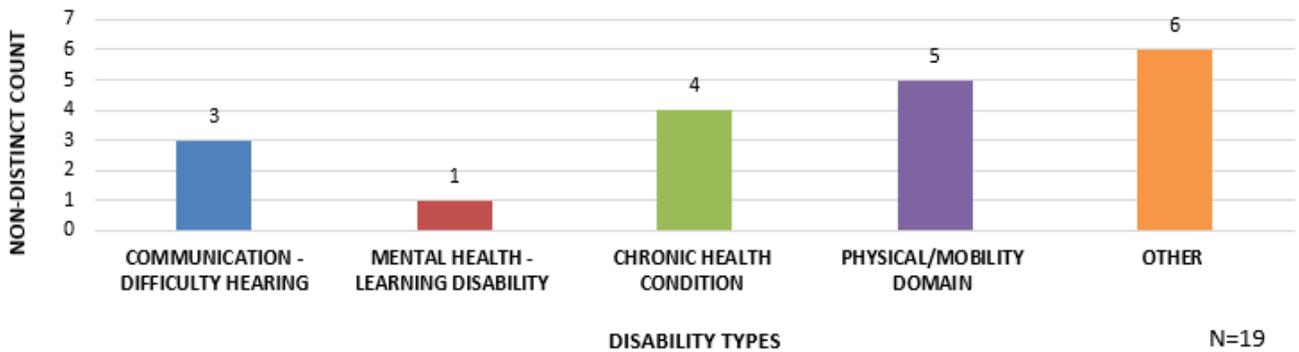
**VETERAN STATUS**



**DISABILITY STATUS**



**DISABILITY TYPES**



\*Clients can enter multiple entries

Outcome 2: Strategies:

***Be designed and implemented to help create Access and Linkage to treatment.***

The Passages Connections program include phone intake, face-to-face psychosocial assessment, and short-term counseling of older adults who are experiencing mild-to-moderate mental illness, and referral of anyone who may be experiencing SMI to county behavioral health programs or crisis intervention services as appropriate. This includes frequently providing referrals to psychiatrists or primary care physicians to clients who are engaged in Individualized Services and are not currently connected to either.

***Be designed, implemented, and promoted in ways that Improve Timely Access to Mental Health Services for individuals and/or families from underserved populations.***

Providing home-based counseling services to adults 60 and older at no cost to the recipient. By providing the vast majority of counseling services in the client's home often eliminates the present transportation barriers, while also enabling clients the opportunity to receive counseling and referral services that otherwise wouldn't be unavailable. This helps to reduce the risk of out-of-home placement for older adults served through Connections. Furthermore, through the process of in home psychosocial assessment, the Connections program is able to provide referrals to other programs through Passages and in Butte County that serve to enhance each client's mental wellness and maintain independent living in their homes.

***Be designed, implemented, and promoted using Strategies that are non-stigmatizing and non-discriminatory.***

Connections provides services that are promoted using strategies that are non-stigmatizing and non-discriminatory in a number of ways. Individuals referred for counseling services are almost always served on a first-come, first-serve basis, as long as they meet the criteria for receiving services through the program. The staff through Connections strives to utilize client-centered, strength-based, and community-oriented treatment models that are congruent with Recovery and Wellness standards. This includes empowering the client through all stages of the treatment process, starting with the assessment, through treatment planning, through termination of services. Person-first language and accurate psychoeducation are provided frequently in hope of reducing stigma and self-stigma often present in the course of treatment. Frequent advertising through local newspapers (such as the Chico News and Review) and other media sources aim to reduce stigma and increase culturally competent education of mental illness in older adult communities through targeted campaigns. Professional and community trainings have been provided specifically on topics of older adult resiliency, mental health stigma, and topics that often pertain to mental illness in aging populations.

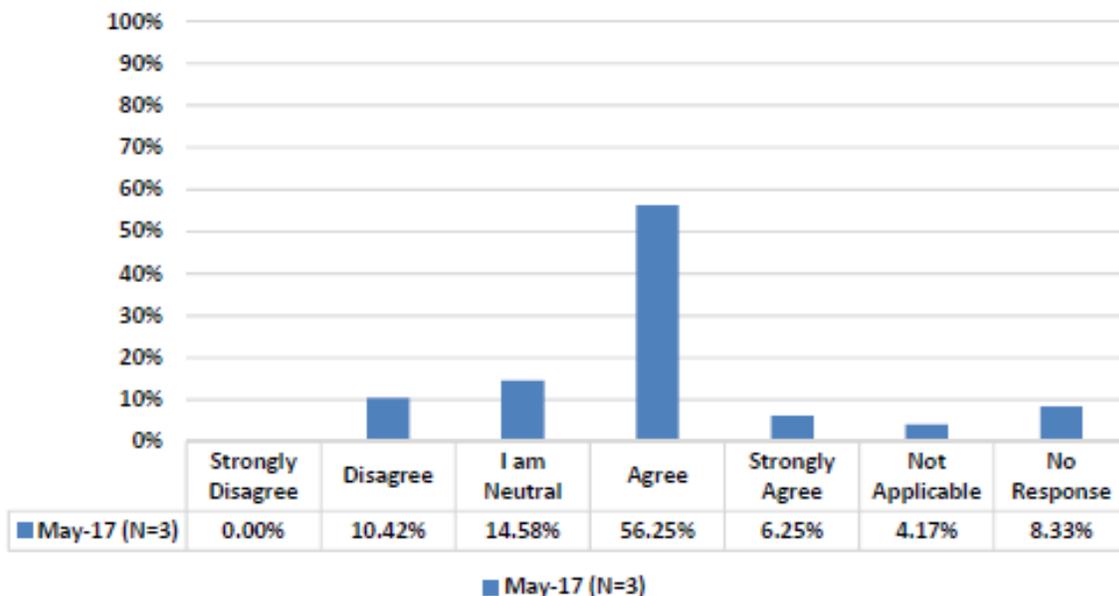
Outcome 3: Evidence-based practice standard.

**CONSUMER PERCEPTION SURVEY: OLDER ADULT  
MAY 2017**

Answers are based on the aggregated responses from the following questions; however full survey is available upon request:

- I deal more effectively with daily problems.
- I am better able to control my life.
- I am better able to deal with crisis.
- I am getting along better with my family.
- I do better in social situations.
- I do better in school and/or work.
- My housing situations has improved.
- My symptoms are not bothering me as much.
- I do things that are more meaningful to me.
- I am better able to take care of my needs.
- I am better able to handle things when they go wrong.
- I am better able to do things that I want to do.
- I am happy with the friendships I have.
- I have people with whom I can do enjoyable things.
- I feel I belong in my community.
- In a crisis, I would have the support I need from family or friends.

**As a Direct Result of Services (Older Adult)**



<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	Prevention	<input type="checkbox"/>	Early Intervention
<b>AGE GROUP</b>	<input checked="" type="checkbox"/>	Children (0-15)	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)
	<input checked="" type="checkbox"/>	Adult (26-59)	<input checked="" type="checkbox"/>	Older Adult (60+)
<b>SERVICES/ACTIVITIES</b>	<input type="checkbox"/>	Access & Linkage	<input type="checkbox"/>	Early Intervention
	<input type="checkbox"/>	Outreach	<input checked="" type="checkbox"/>	Prevention
	<input type="checkbox"/>	Stigma & Discrimination	<input type="checkbox"/>	Other

### PROGRAM DESCRIPTION

The African American Family & Cultural Center (AAFCC) integrates African American culture into the services that focus on early detection, prevention, and awareness of mental health illness in Butte County. These services include: outreach to families, increasing access and linkage to medical care, reducing stigma associated with mental illness and reducing discrimination against people with mental illness. Being located in Southside Oroville allows for convenient community engagement in a non-stigmatizing environment.

The AAFCC was planned and designed by community residents to address a wide array of issues with the goal of decreasing the impact of historic and current trauma which impact the African American community. All programs increase the knowledge and skills that reduce the risk factors for African American population but all cultures are invited to learn, embrace and take part in the center activities. The AAFCC aims to establish programs that are connected to “Reclaiming, restoring, and revitalizing the African American culture, heritage, values and identity.”

*“It helps me get along with others and talk out loud.”*

*“It helps me deal emotionally.”*

*“...a safe haven for us – friendly staff – glad its here.”*

*- Consumers*

### OUTCOMES

1. Unduplicated numbers of individuals served.
2. Strategies:
  - a. Access and Linkage
  - b. Improving Timely Access to Services for Underserved Populations
  - c. Be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory
3. Evidence-Based Practice Standard

### MEASUREMENTS

1. Number of individuals served.
2. Include all Strategies as referenced in Section 3735.
3. Include answers from the Consumer Perception Survey (CPS).

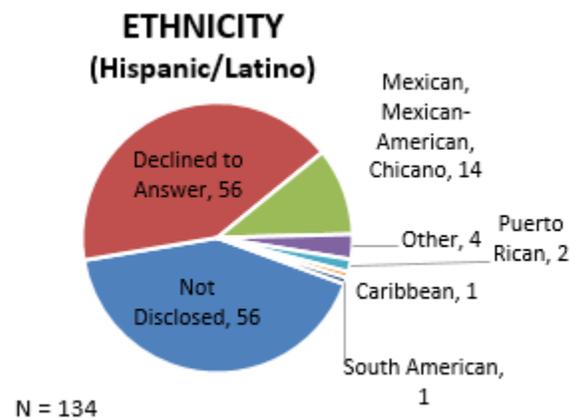
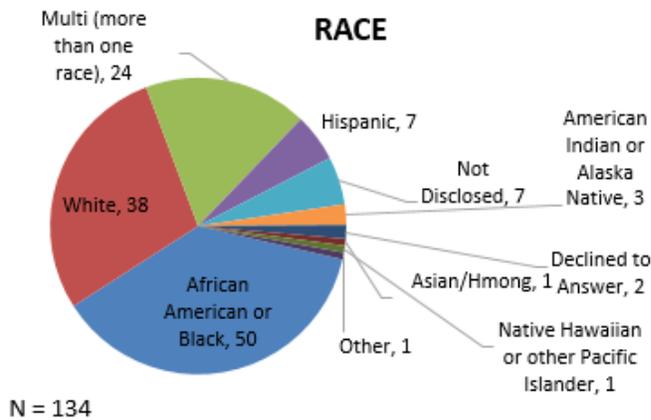
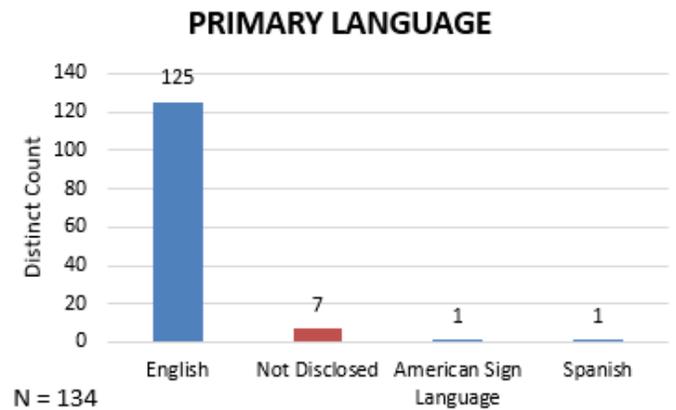
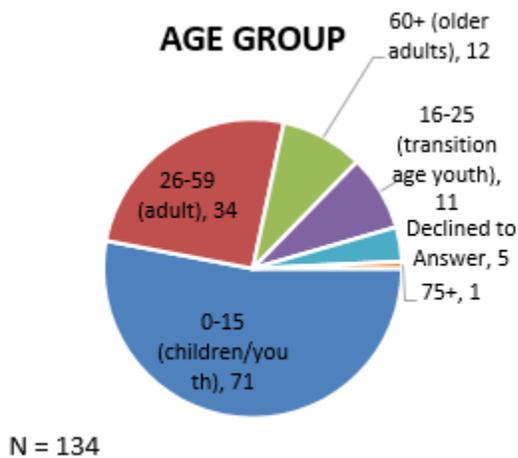
Outcome 1: Unduplicated number of individuals served.

	FY 12-13	FY 13-14	FY 14-15	FY 15-16*	FY 16-17
Distinct Count of Participants Served	234	148	210	67	134

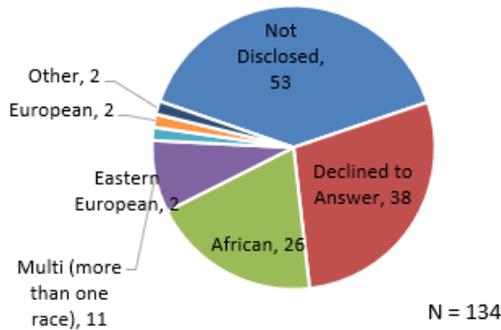
\*Due to PEI requirements changing mid-year, these counts are from QTR 3-4

### DEMOGRAPHICS OF DISTINCT CLIENTS SERVED FY 16-17

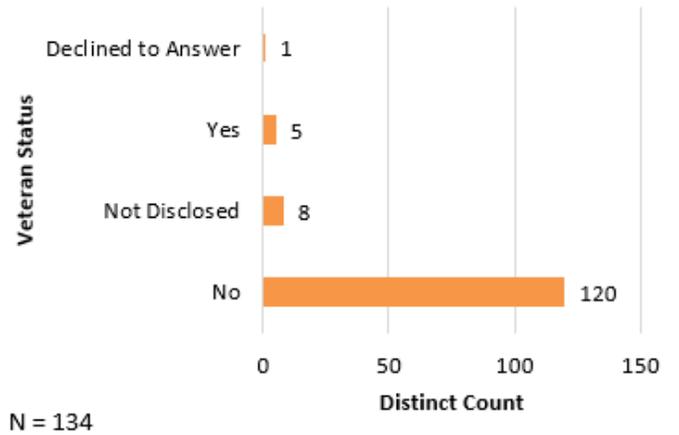
Number Served: 134



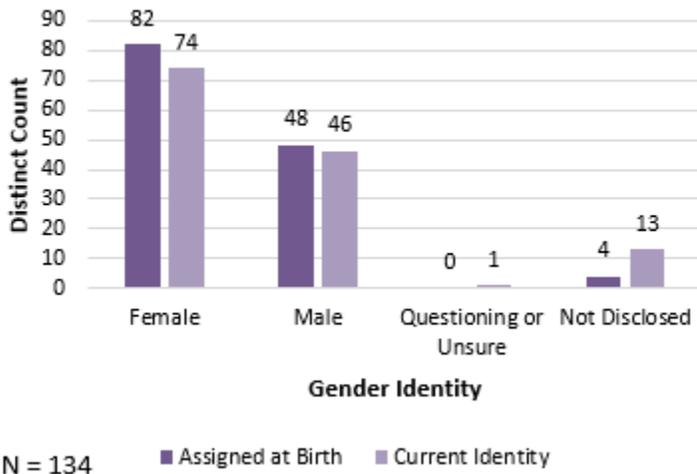
**ETHNICITY**  
(Non-Hispanic/Non-Latino)



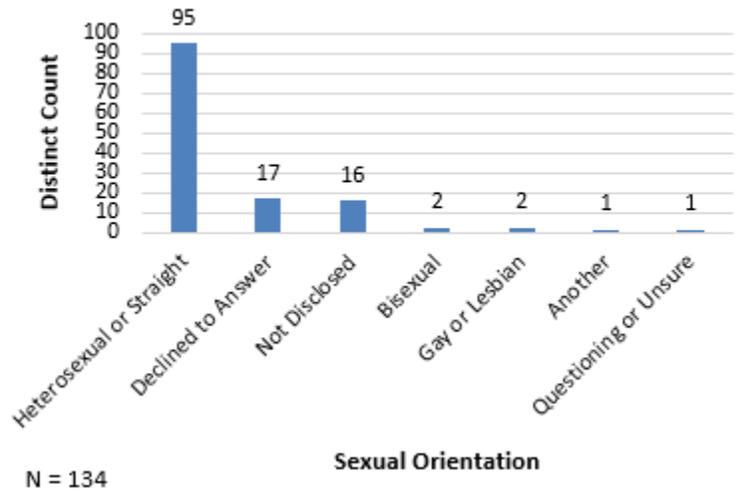
**VETERAN STATUS**



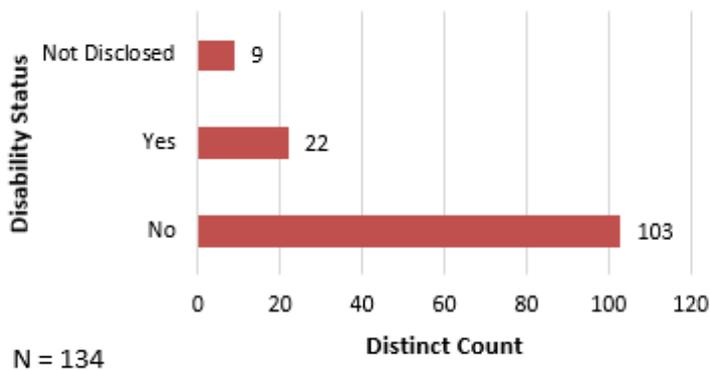
**GENDER**



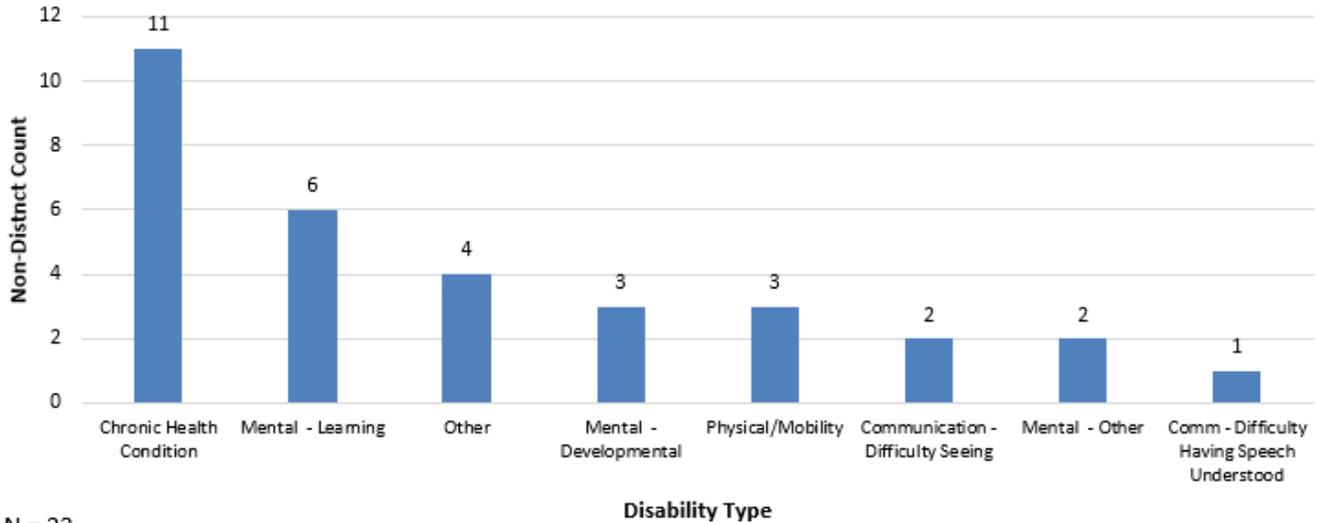
**SEXUAL ORIENTATION**



**DISABILITY STATUS**



**DISABILITY TYPES**



Outcome 2: Strategies:

***Be designed and implemented to help create Access and Linkage to treatment.***

The African American Family and Cultural Center is centrally located in the heart of Oroville, California’s Southside community. Being located in the heart of this community the center has tremendously impacted the amount of information on services provided to its underserved population. These services are based on a prevention-and-early intervention structure that enables clients to become self-sustaining and resilient.

***Be designed, implemented, and promoted in ways that Improve Timely Access to Mental Health Services for individuals and/or families from underserved populations.***

All services, groups and events that the African American Family and Cultural Center provide are free of charge to the community. This assists the underserved population in the centers community that could not otherwise afford services. To have services easily available at the client’s disposal and center staff that can access mental health services quickly increase the client’s timely access to available services. The center also provides transportation for clients to receive the treatment needed at Butte County Behavioral Health offices to aid in timely access.

*Be designed, implemented, and promoted using Strategies that are non-stigmatizing and non-discriminatory.*

The African American Family and Cultural Center operate as a family setting as well as from an Afrocentric perspective to make the client feel comfortable and welcome. When speaking to the client the center staff do so in a calm and non-confrontational/condemning voice and try to get to the root of the issue the client has. Giving the client different options of what the African American Family and Cultural Center offers as to services, programs and groups so the choice is that of the client. The client is not pressured but guided in the direction of the appropriate groups to attend.

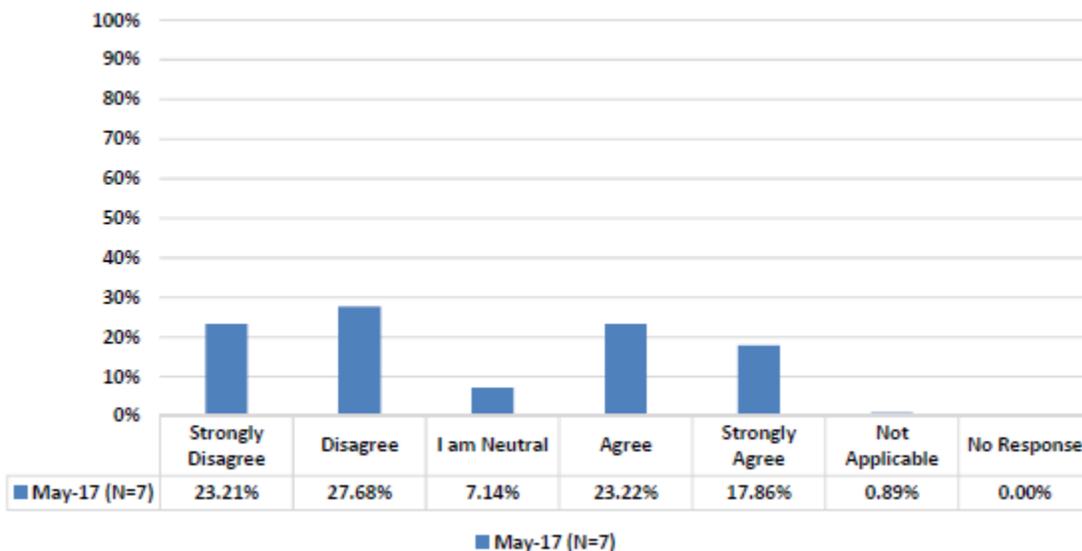
Outcome 3: Evidence-based practice standard.

### CONSUMER PERCEPTION SURVEY: ADULT & OLDER ADULT MAY 2017

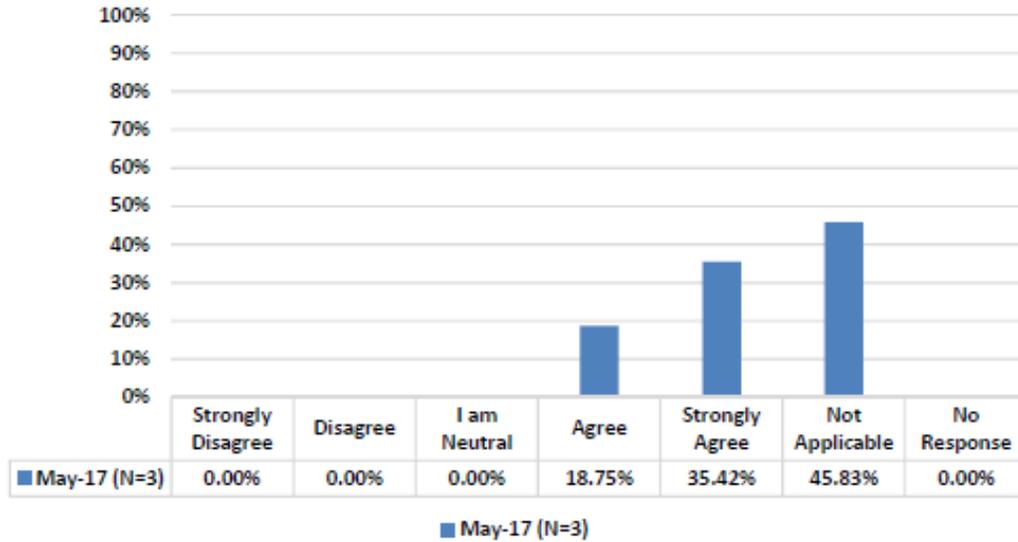
Answers are based on the aggregated responses from the following questions; however full survey is available upon request:

- I deal more effectively with daily problems.
- I am better able to control my life.
- I am better able to deal with crisis.
- I am getting along better with my family.
- I do better in social situations.
- I do better in school and/or work.
- My housing situations has improved.
- My symptoms are not bothering me as much.
- I do things that are more meaningful to me.
- I am better able to take care of my needs.
- I am better able to handle things when they go wrong.
- I am better able to do things that I want to do.
- I am happy with the friendships I have.
- I have people with whom I can do enjoyable things.
- I feel I belong in my community.
- In a crisis, I would have the support I need from family or friends.

#### As a Direct Result of Services (Adult)



**As a Direct Result of Services (Older Adult)**

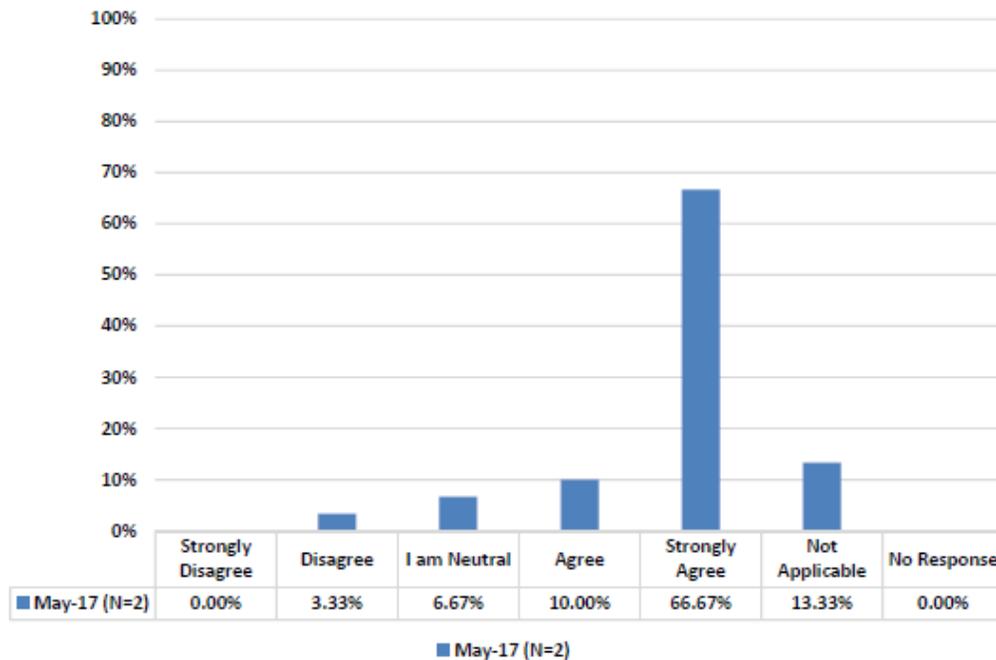


**CONSUMER PERCEPTION SURVEY: YOUTH  
MAY 2017**

Answers are based on the aggregated responses from the following questions; however full survey is available upon request:

- I am better at handling daily life.
- I get along better with family members.
- I get along better with friends and other people.
- I am doing better in school and/or work.
- I am better able to cope when things go wrong.
- I am satisfied with my family life right now.
- I am better able to do things I want to do.
- I know people who will listen and understand me when I need to talk.
- I have people that I am comfortable talking with about my problem(s).
- In a crisis I would have the support I need from family or friends.
- I have people with whom I can do enjoyable things.

**General Services Quality (Youth)**

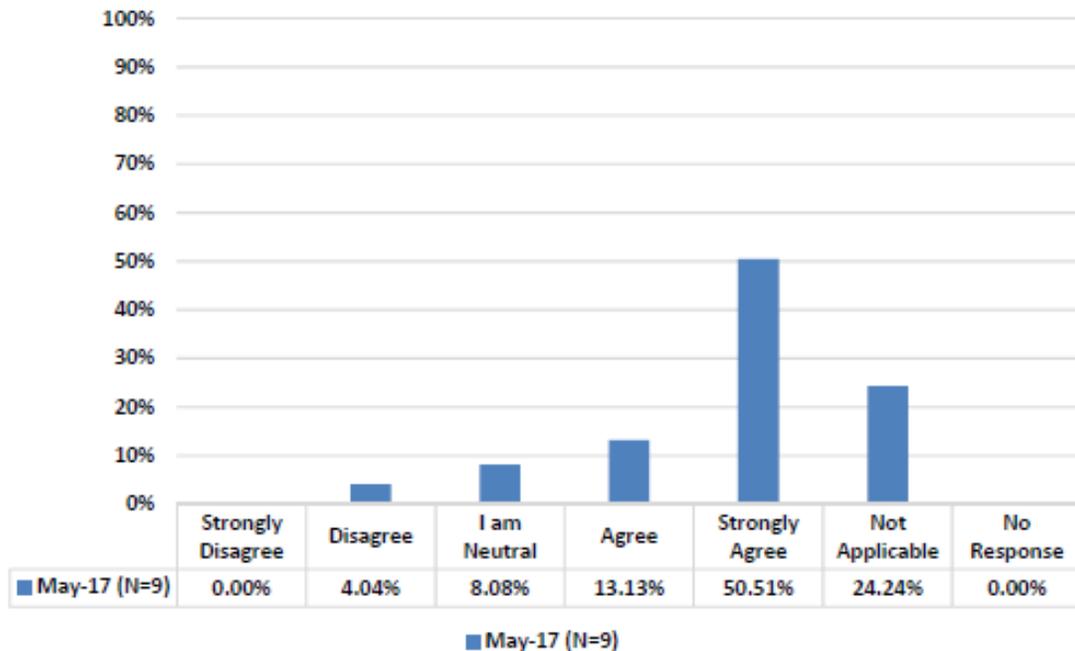


**CONSUMER PERCEPTION SURVEY: FAMILY  
MAY 2017**

Answers are based on the aggregated responses from the following questions; however full survey is available upon request:

- My child is better at handling daily life.
- My child gets along better with family members.
- My child gets along better with friends and other people.
- My child is doing better in school and/or work.
- My child is better able to cope when things go wrong.
- I am satisfied with our family life right now.
- My child is better able to do things he or she wants to do.
- I know people who will listen and understand me when I need to talk.
- I have people that I am comfortable talking with about my child’s problem.
- In a crisis, I would have the support I need from family or friends.
- I have people with whom I can do enjoyable things.

**As a Direct Result of Services (Family)**



<b>STATUS</b>	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/> Prevention	<input type="checkbox"/> Early Intervention
<b>AGE GROUP</b>	<input checked="" type="checkbox"/> Children (0-15)	<input checked="" type="checkbox"/> Transitional Age Youth (16-25)
	<input checked="" type="checkbox"/> Adult (26-59)	<input checked="" type="checkbox"/> Older Adult (60+)
<b>SERVICES/ACTIVITIES</b>	<input type="checkbox"/> Access & Linkage	<input type="checkbox"/> Early Intervention
	<input type="checkbox"/> Outreach	<input checked="" type="checkbox"/> Prevention
	<input type="checkbox"/> Stigma & Discrimination	<input type="checkbox"/> Other

**PROGRAM DESCRIPTION**

The Latino and Hmong *Promotores* program is designed to provide strength-based, wellness-focused services and support which includes outreach/ education, mental health consultation and early intervention services building on individual and family strengths. Vital to this strategy is the involvement of mental health consultants—*promotores*—who are local residents trained as community health promoters and community liaisons. While the Latino and Hmong communities value the expertise of professionals, members also find reassurance by speaking with locally trained residents that share their culture and language. Services are provided in Gridley and Chico.

**OUTCOMES**

1. Unduplicated numbers of individuals served in the preceding fiscal year.
2. Strategies:
  - a. Access and Linkage
  - b. Improving Timely Access to Services for Underserved Populations
  - c. Be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory
3. Evidence-Based Practice Standard.

**MEASUREMENT**

1. Number of individuals served:
  - a. Demographics of those individuals from Participant Enrollment form data.
2. Address all Strategies as reference in Section 3735.
3. Include results of Consumer Perception Survey Results.

Outcome 1: Unduplicated number of individuals served.

	FY 12-13	FY 13-14	FY 14-15	FY 15-16*	FY 16-17
Distinct Count of Participants	190	107	104	166	270

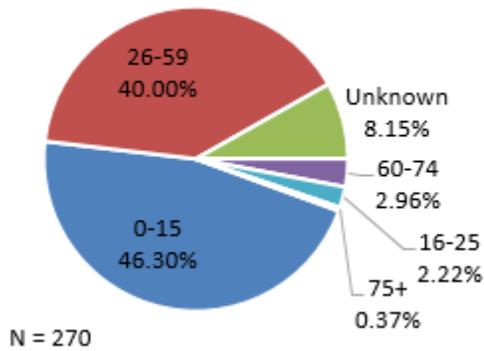
\*Due to PEI requirements changing mid-year, these counts are from QTR 3-4

**DEMOGRAPHICS OF DISTINCT CLIENTS SERVED**

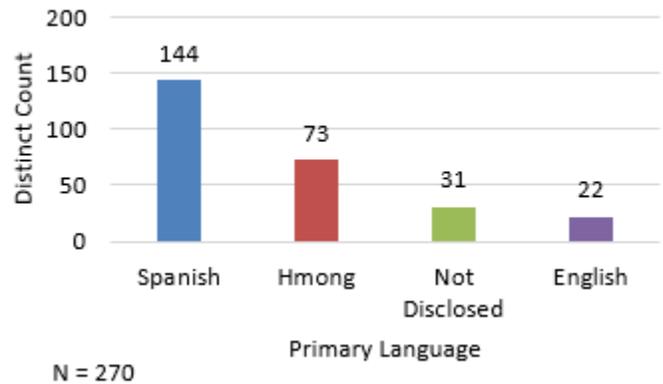
**FY 16-17**

*Number Served: 270*

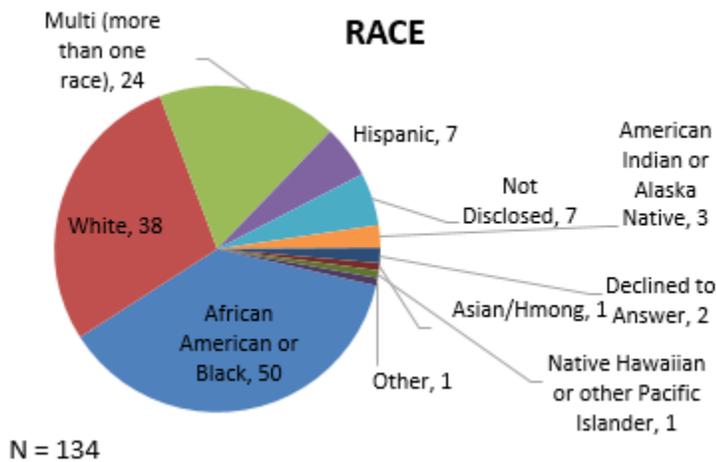
**AGE GROUP**



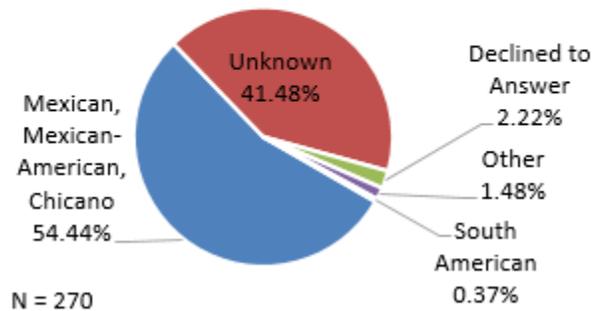
**PRIMARY LANGUAGE**



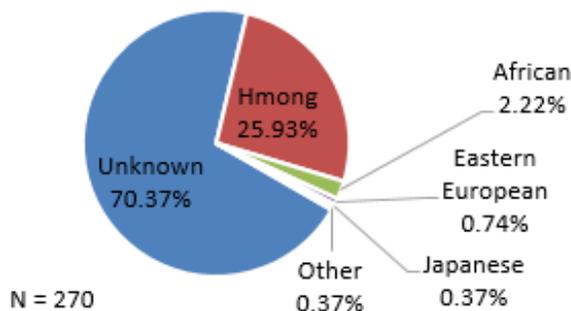
**RACE**



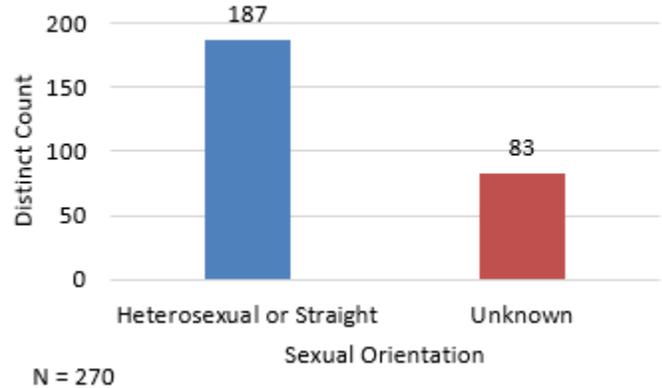
**ETHNICITY  
Hispanic/Latino**



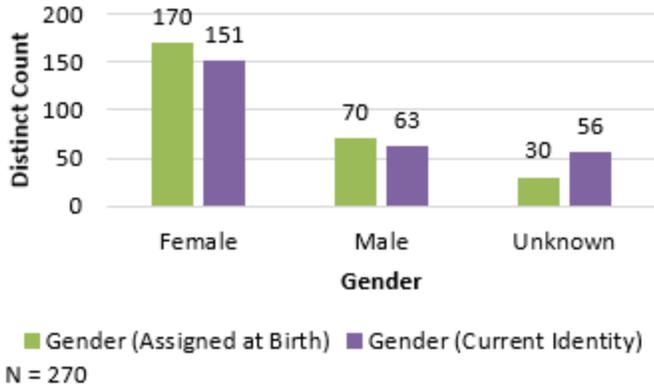
**ETHNICITY  
Non-Hispanic/Non-Latino**



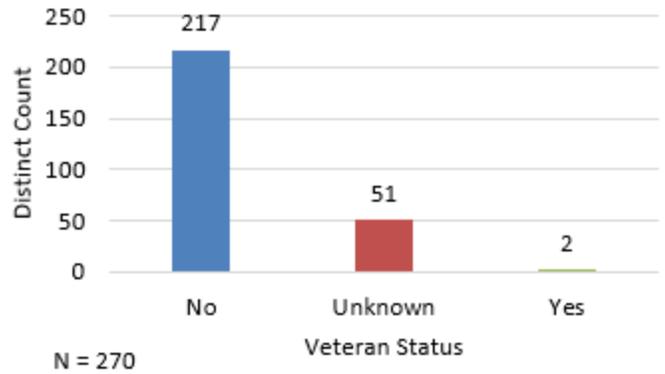
**SEXUAL ORIENTATION**



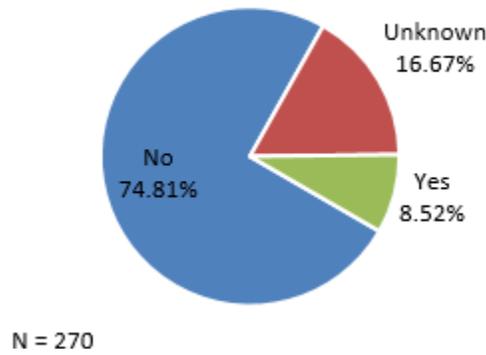
**GENDER**



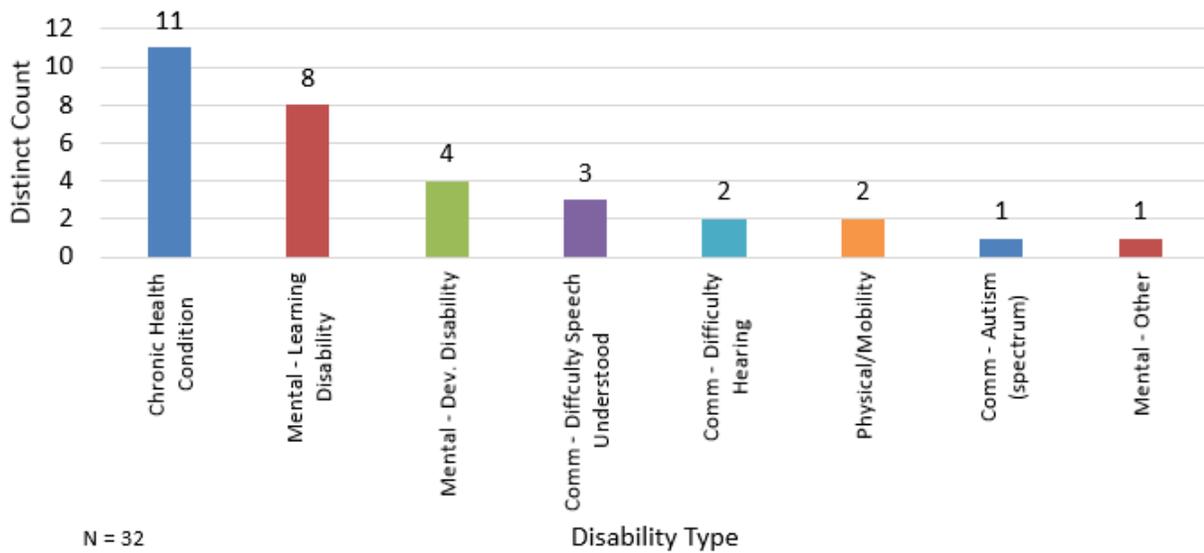
**VETERAN STATUS**



**DISABILITY**



**DISABILITY TYPE**



Outcome 2: Strategies.

***Be designed and implemented to help create Access and Linkage to treatment.***

The Promotores program frequent community meetings, provides educational presentations and conducts groups in which the program is able to outreach to not only a vast variety of community partners but also its participants. The outreach provided consists of the Promotores newsletter, the monthly calendar, along with flyers for groups. All materials are provided in English, Spanish and Hmong. The educational presentations highlight mental health and wellness while embracing the Latin and Hmong culture. These presentations focus on reducing stigma of mental health while promoting the wellbeing of the Latino and Hmong communities. Additionally, Promotores has provided presentations to community partners to raise cultural awareness and identify cultural norms for the Latino and Hmong community. An individual who is referred to Promotores can attend mutual support groups or receive support through one on one services. The Promotora can refer individuals or families to additional services when needed.

***Be designed, implemented, and promoted in ways that Improve Timely Access to Mental Health Services for individuals and/or families from underserved populations.***

The Promotores program provides a variety of weekly groups in Chico, Gridley and Biggs. The group topics focus on mental health and wellness, self-advocacy, parenting, life skills, physical health, cultural awareness, Wellness and Recovery Action Plan, self-esteem and leadership. All groups are presented in Spanish or Hmong and all materials are provided to participants in their native language. Through groups or one on one support Promotoras are able to identify needs and discuss linkage to services with individuals and/or families. Referrals are made immediately and the Promotora follows up on the referral with the individual and the service provider. The Promotoras also will make follow up phone calls to the participants to remind them of groups and or one on one meetings.

***Be designed, implemented, and promoted using Strategies that are non-stigmatizing and non-discriminatory.***

Promotores provides services in Spanish and Hmong and all materials are in English, Spanish and Hmong. Groups are strength based and individualized to meet the needs of the community and individuals. Services focus on wellbeing while exploring and educating how ones mental health can impact daily living and the different roles each individual plays. Cultural norms and practices regarding mental health are also discussed throughout service. Participants share their feeling about losing their culture traditions due to assimilation and are able to find ways through Promotores services to keep their cultural traditions alive.

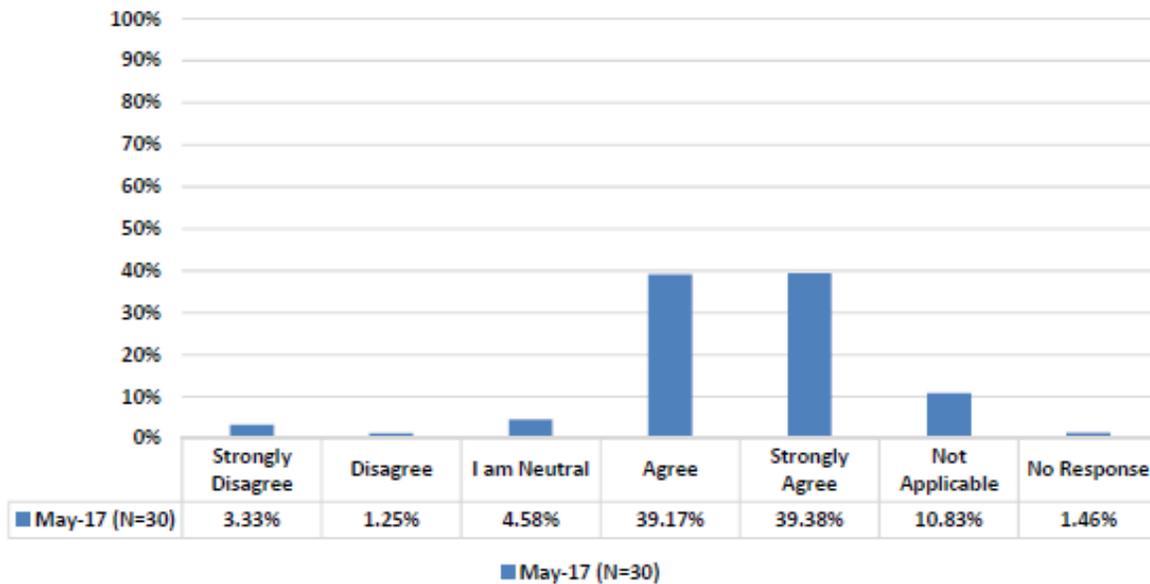
Outcome 3: Evidence-based practice standard.

### CONSUMER PERCEPTION SURVEY: ADULT MAY 2017

Answers are based on the aggregated responses from the following questions; however full survey is available upon request:

- I deal more effectively with daily problems.
- I am better able to control my life.
- I am better able to deal with crisis.
- I am getting along better with my family.
- I do better in social situations.
- I do better in school and/or work.
- My housing situations has improved.
- My symptoms are not bothering me as much.
- I do things that are more meaningful to me.
- I am better able to take care of my needs.
- I am better able to handle things when they go wrong.
- I am better able to do things that I want to do.
- I am happy with the friendships I have.
- I have people with whom I can do enjoyable things.
- I feel I belong in my community.
- In a crisis, I would have the support I need from family or friends.

**As a Direct Result of Services (Adult)**

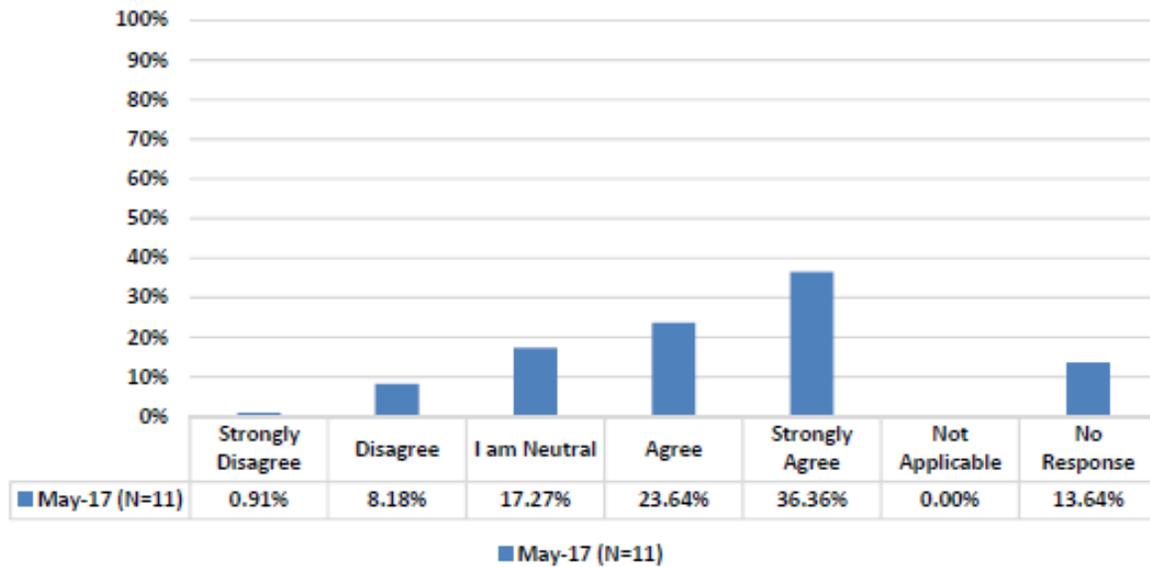


### CONSUMER PERCEPTION SURVEY: YOUTH MAY 2017

Answers are based on the aggregated responses from the following questions; however full survey is available upon request:

- I am better at handling daily life.
- I get along better with family members.
- I get along better with friends and other people.
- I am doing better in school and/or work.
- I am better able to cope when things go wrong.
- I am satisfied with my family life right now.
- I am better able to do things I want to do.
- I know people who will listen and understand me when I need to talk.
- I have people that I am comfortable talking with about my problem(s).
- In a crisis I would have the support I need from family or friends.
- I have people with whom I can do enjoyable things.

#### As a Direct Result of Services (Youth)

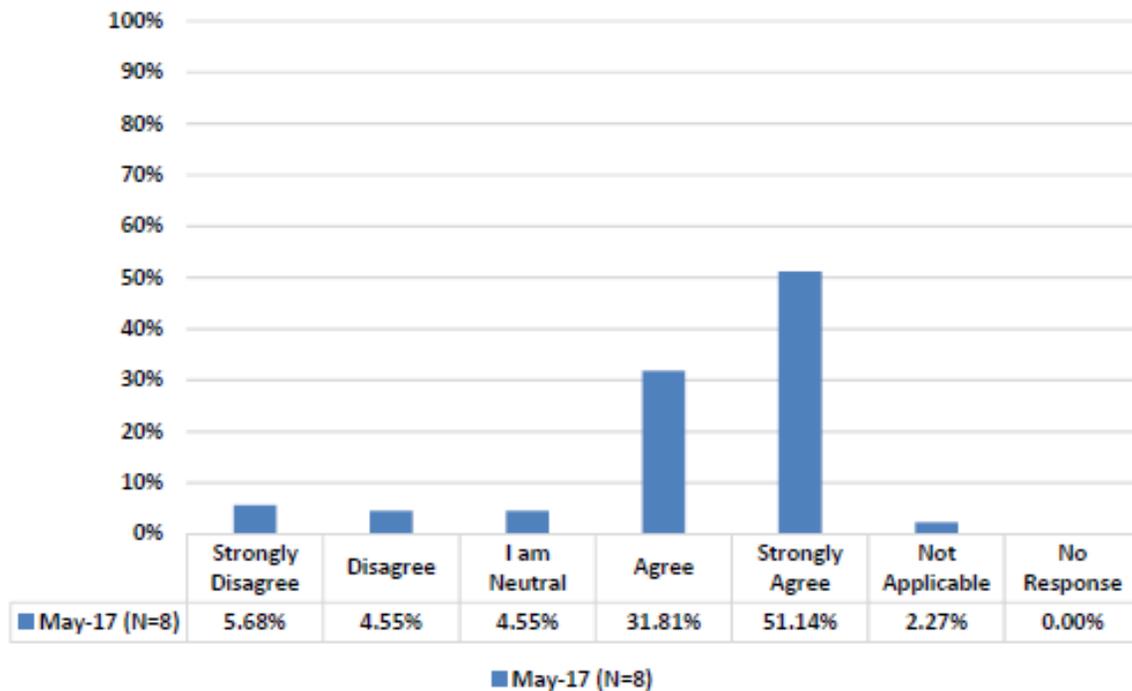


### CONSUMER PERCEPTION SURVEY: FAMILY MAY 2017

Answers are based on the aggregated responses from the following questions; however full survey is available upon request:

- My child is better at handling daily life.
- My child gets along better with family members.
- My child gets along better with friends and other people.
- My child is doing better in school and/or work.
- My child is better able to cope when things go wrong.
- I am satisfied with our family life right now.
- My child is better able to do things he or she wants to do.
- I know people who will listen and understand me when I need to talk.
- I have people that I am comfortable talking with about my child’s problem.
- In a crisis, I would have the support I need from family or friends.
- I have people with whom I can do enjoyable things.

#### As a Direct Result of Services (Family)



<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	Prevention	<input type="checkbox"/>	Early Intervention
<b>AGE GROUP</b>	<input type="checkbox"/>	Children (0-15)	<input type="checkbox"/>	Transitional Age Youth (16-25)
	<input checked="" type="checkbox"/>	Adult (26-59)	<input checked="" type="checkbox"/>	Older Adult (60+)
<b>SERVICES/ACTIVITIES</b>	<input type="checkbox"/>	Access & Linkage	<input type="checkbox"/>	Early Intervention
	<input type="checkbox"/>	Outreach	<input checked="" type="checkbox"/>	Prevention
	<input type="checkbox"/>	Stigma & Discrimination	<input type="checkbox"/>	Other

## PROGRAM DESCRIPTION

**“When I attend Zoosiab, I am relieved of my depression and stress. I am able to learn coping skills and use them in my everyday life. I am able to seek support with my peers during Zoosiab group.”**

**- Consumer**

The Zoosiab Program is a community-based program serving Hmong elders who have experienced historical trauma often associated with the Vietnam War. It combines Western and traditional cultural practices to decrease the negative impacts of stress, isolation, stigmatization, depression and trauma, common among the Hmong elders decades after the Vietnam War.

Zoosiab staff perform outreach activities to assist elders in successfully accessing culturally relevant behavioral health and other services in the community. Staff coordinate services for Hmong Elders in an effort to develop a cohesive system of care for this underserved population. Staff work with the elders to reduce the stigma of mental health disorders and improve participation in western mental health county services. Outreach efforts combine an attractive and pertinent blend of traditional Hmong approaches to healing with the *Recovery Model* and contemporary approaches to mental health services. Client support services provide on-going case management services for Hmong Elders. Case managers offer home visits to assess, intervene and problem solve with elders. Linkage to appropriate resources in the community is essential to reduce isolation.

## OUTCOMES

1. Unduplicated number of individuals served.
2. Strategies:
  - a. Access and Linkage
  - b. Improving Timely Access to Services for Underserved Populations
  - c. Be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory
3. Evidence-based practice standard.

MEASUREMENTS

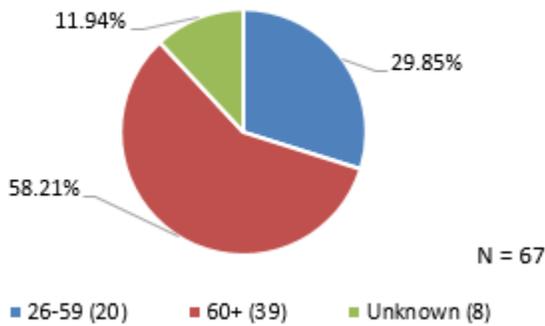
1. Number of individuals served.
2. Include all Strategies as referenced in Section 3735.
3. Include answers from the Consumer Perception Survey (CPS).

Outcome 1: Unduplicated number of individuals served.

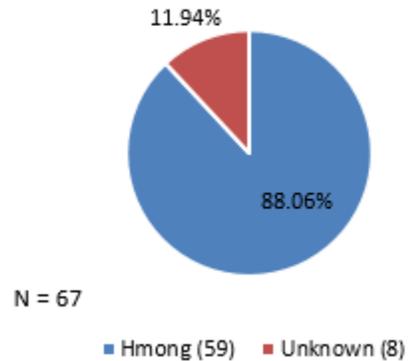
**DEMOGRAPHICS OF DISTINCT CLIENTS SERVED  
FY 16-17**

*Number Served: 67*

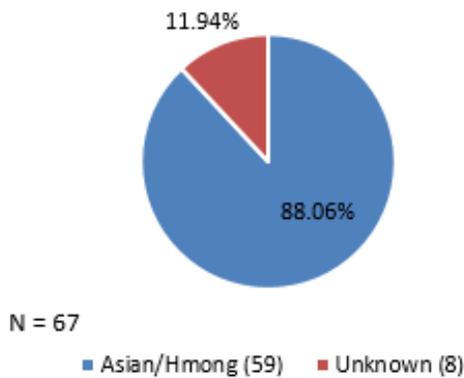
**AGE GROUP**



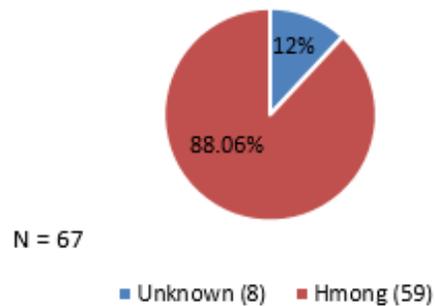
**PRIMARY LANGUAGE**



**RACE**

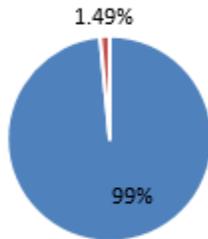


**ETHNICITY  
Non-Hispanic/Non-Latino**



Outcome 1: Unduplicated number of individuals served.

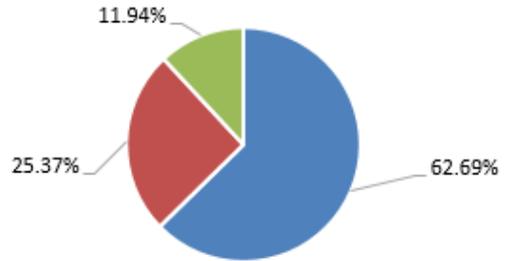
**ETHNICITY**  
Hispanic/Latino



N = 67

■ Unknown (66) ■ South American (1)

**GENDER\***

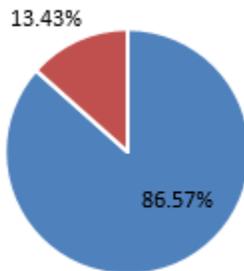


N = 67

■ Female (42) ■ Male (17) ■ Unknown (8)

\*Gender assigned at birth and current identity were the same numbers.

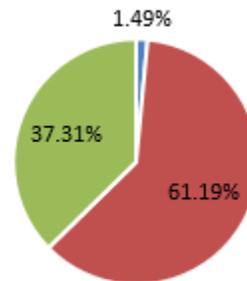
**SEXUAL ORIENTATION**



N = 67

■ Heterosexual (58) ■ Unknown (9)

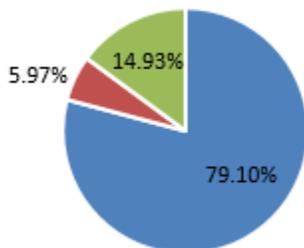
**VETERAN STATUS**



N = 67

■ Yes (1) ■ No (41) ■ Unknown (25)

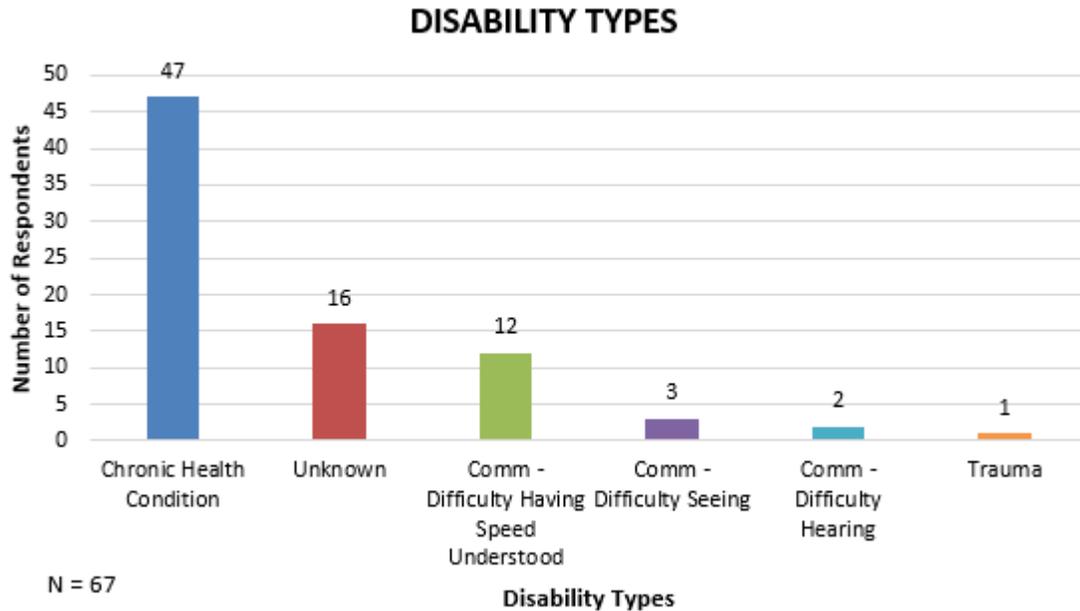
**DISABILITY**



N = 67

■ Yes (53) ■ No (4) ■ Unknown (10)

Outcome 1: Unduplicated number of individuals served.



Outcome 2: Strategies.

***Be designed and implemented to help create Access and Linkage to treatment.***

Zoosiab outreaches to Hmong elders and the Hmong community in Butte County. Zoosiab also encourages and educates participants to advocate for themselves to get the treatment they need. Additionally, Zoosiab refers consumers to Butte County Department of Behavioral Health.

***Be designed, implemented, and promoted in ways that Improve Timely Access to Mental Health Services for individuals and/or families from underserved populations.***

Ways to promote timely access to mental health services is through accessible cultural and linguistic services and linkage/navigation for consumers in regards to resources or services that meet their needs.

***Be designed, implemented, and promoted using Strategies that are non-stigmatizing and non-discriminatory.***

The Hmong Cultural Center is a safe and non-stigmatizing place for consumers to socialize and talk about their mental health with staff.

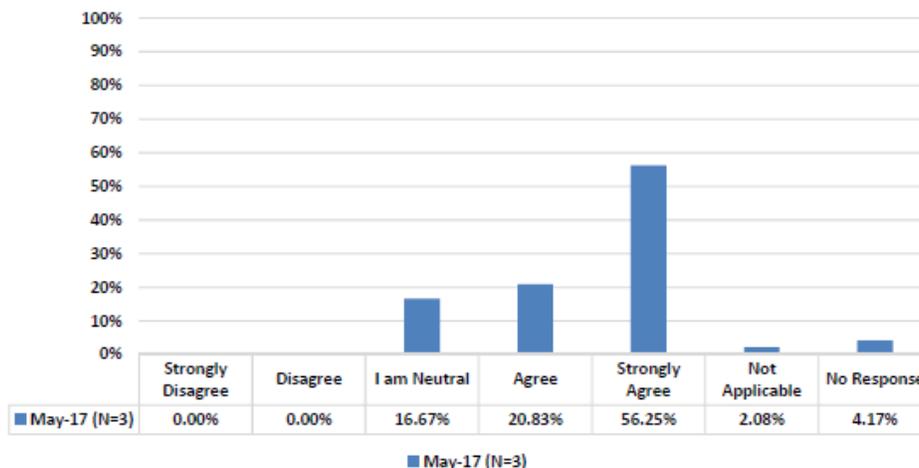
Outcome 3: Evidence-based practice standard.

### CONSUMER PERCEPTION SURVEY: ADULT & OLDER ADULT MAY 2017

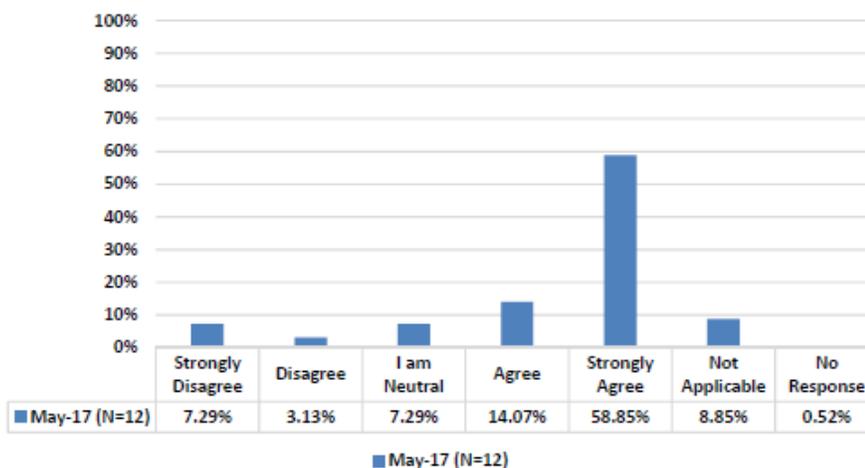
Answers are based on the aggregated responses from the following questions; however full survey is available upon request:

- I deal more effectively with daily problems.
- I am better able to control my life.
- I am better able to deal with crisis.
- I am getting along better with my family.
- I do better in social situations.
- I do better in school and/or work.
- My housing situations has improved.
- My symptoms are not bothering me as much.
- I do things that are more meaningful to me.
- I am better able to take care of my needs.
- I am better able to handle things when they go wrong.
- I am better able to do things that I want to do.
- I am happy with the friendships I have.
- I have people with whom I can do enjoyable things.
- I feel I belong in my community.
- In a crisis, I would have the support I need from family or friends.

**As a Direct Result of Services (Adult)**



**As a Direct Result of Services (Older Adult)**



<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	Prevention	<input checked="" type="checkbox"/>	Early Intervention
<b>AGE GROUP</b>	<input checked="" type="checkbox"/>	Children (0-15)	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)
	<input checked="" type="checkbox"/>	Adult (26-59)	<input checked="" type="checkbox"/>	Older Adult (60+)
<b>SERVICES/ACTIVITIES</b>	<input type="checkbox"/>	Access & Linkage	<input type="checkbox"/>	Early Intervention
	<input type="checkbox"/>	Outreach	<input type="checkbox"/>	Prevention
	<input checked="" type="checkbox"/>	Stigma & Discrimination	<input type="checkbox"/>	Other

### PROGRAM DESCRIPTION

Stonewall Alliance of Chico is a community center that supports and advocates for the Gender, Sex, and Sexuality Minority (GSSM) community. Stonewall provides suicide prevention, education, and outreach services throughout Butte County to youth and young adults, as well as their families, friends and allies. These services include low-cost/no-cost counseling for individuals, support and discussion groups, positive social and recreational activities, and referrals to allied service providers, organizations, agencies or institutions, and educational resources.

SAYes! Is a program specifically designed to prevent suicide by decreasing the stigma surrounding mental illness and increase access to mental health care services, while providing social and educational frameworks for youths and their families to embrace their diverse identities. SAYes! reduces mental health challenges, which research has shown to be much higher within the GSSM community when compared to the community at large.

### OUTCOMES

1. Number of individuals served.
2. Include approaches that are culturally congruent with the values of the populations for whom changes in attitudes, knowledge, and behavior are intended.
3. Strategies:
  - a. Access and Linkage to Treatment.
  - b. Improving Timely Access to Services for Underserved Populations.
  - c. Be designed, implemented, and promoted using Strategies that are Non-Stigmatizing and Non-Discriminatory.

### MEASUREMENTS

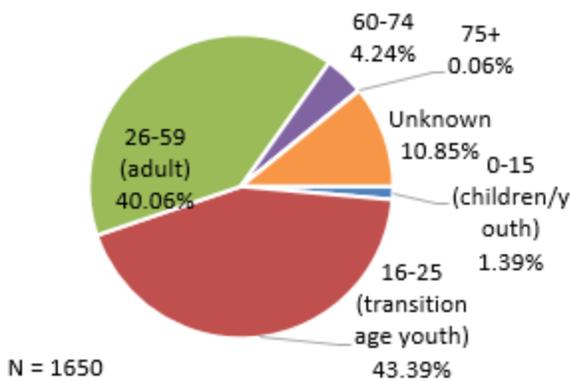
1. Non-distinct count of participants.
2. Changes in attitudes, knowledge, and/or behavior related to mental illness that are applicable to the specific program:
  - a. Pre/Post Presentation Survey
3. Include all Strategies as referenced in Section 3735.

Outcome 1: Number of individuals served

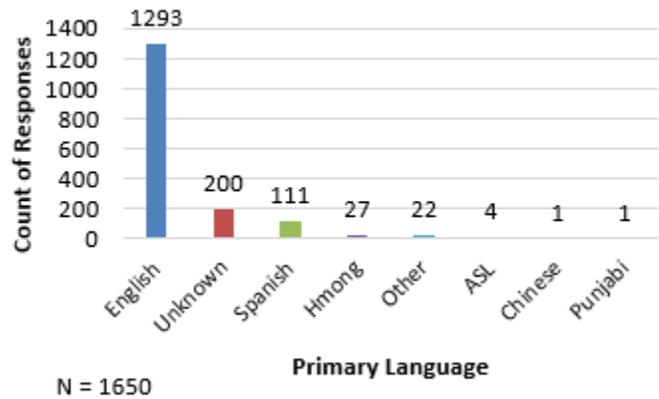
**DEMOGRAPHICS OF NON-DISTINCT PARTICIPANTS SERVED  
FY 16-17**

*Number Served: 1650*

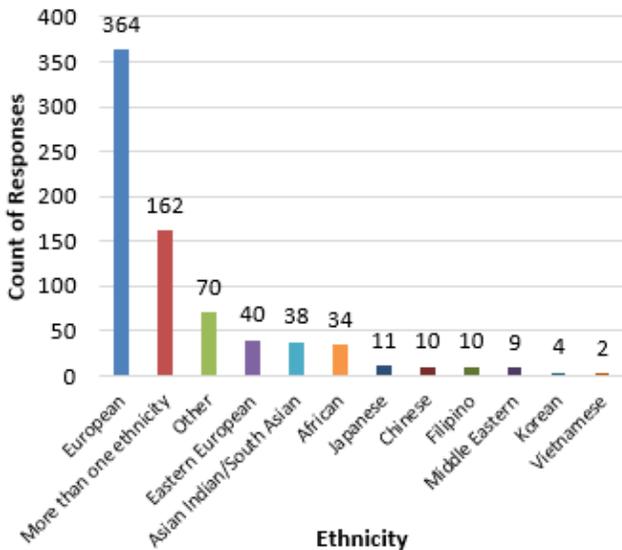
**AGE GROUP**



**PRIMARY LANGUAGE**

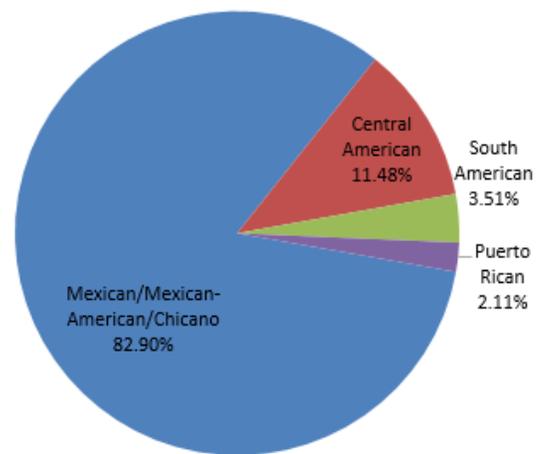


**ETHNICITY  
(Non-Hispanic/Non-Latino)**



\*Respondents may be of hispanic/latino ethnicity only

**ETHNICITY  
(Hispanic/Latino)**



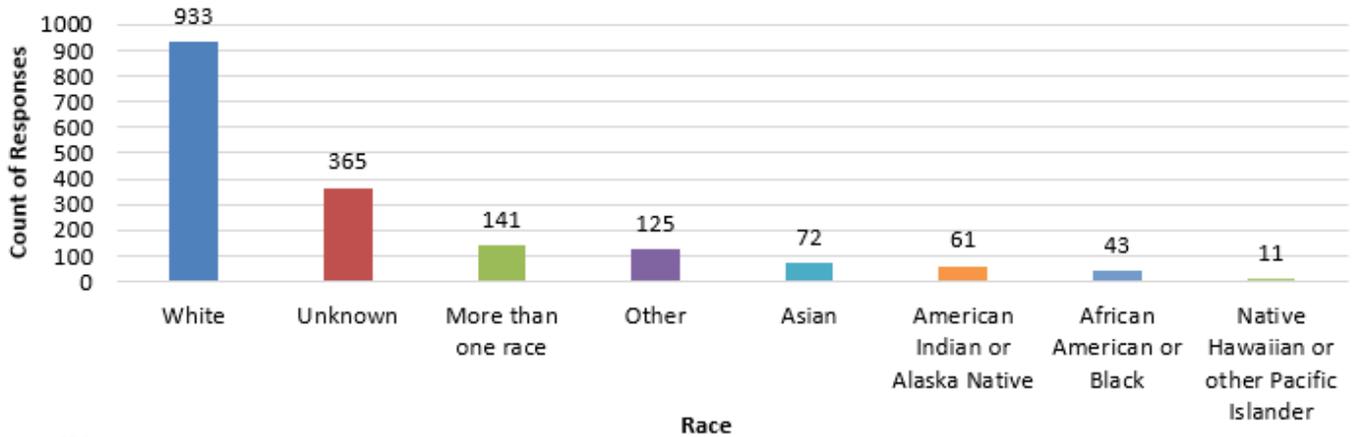
\*Respondents may be of non-hispanic/non-latino ethnicity only

# OUTCOME DATA

## LGBTQ OUTREACH, EDUCATION, TRAINING & SUICIDE PREVENTION

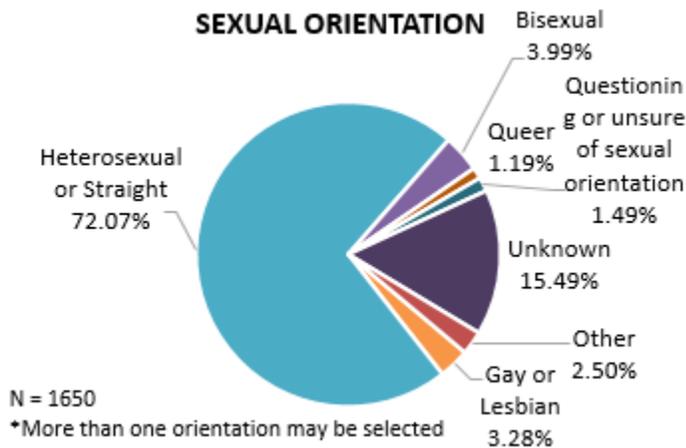
Outcome 1: Number of individuals served.

### RACE

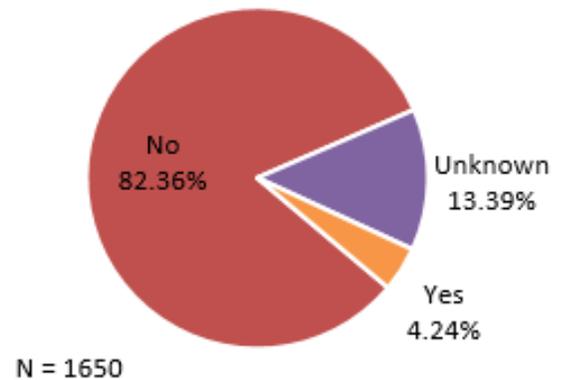


N = 1650

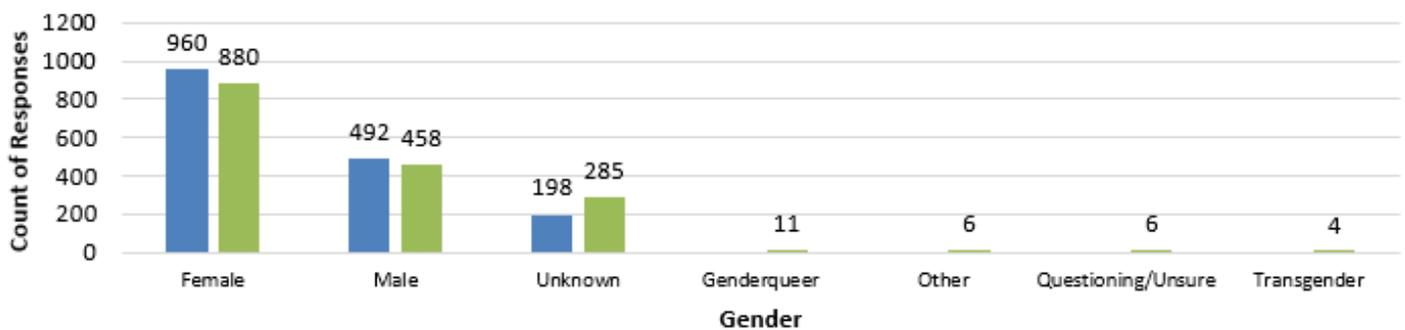
### SEXUAL ORIENTATION



### VETERAN STATUS



### GENDER

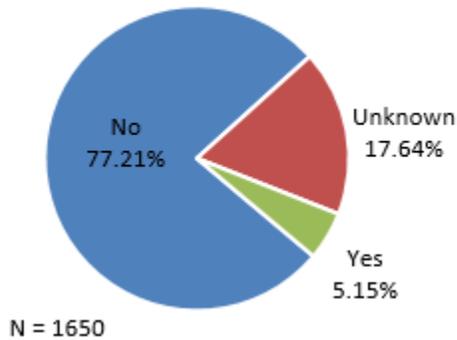


N = 1650

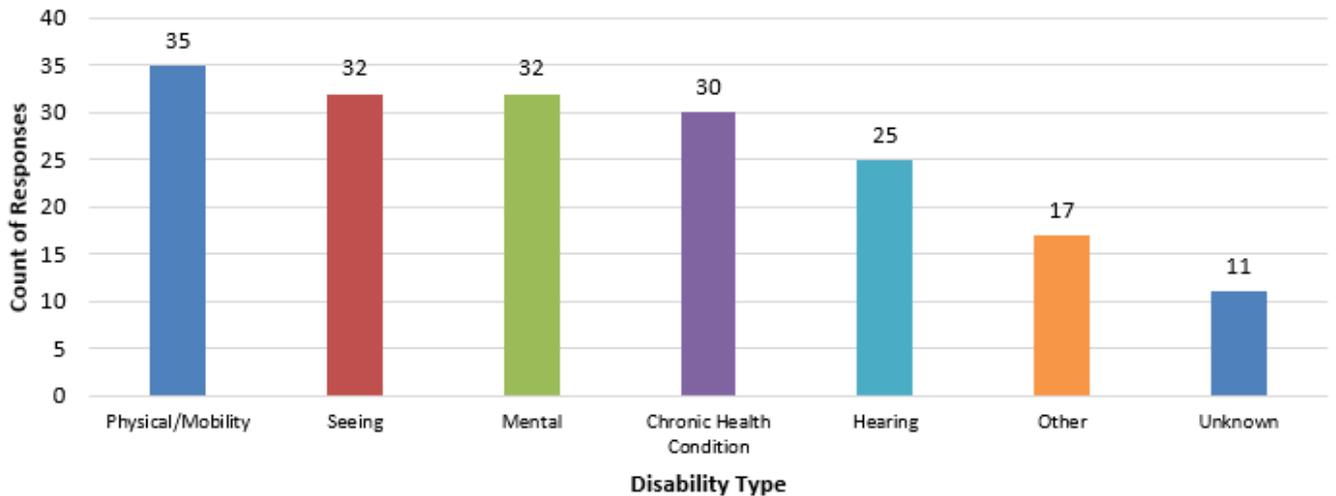
■ Gender (Assigned at Birth) ■ Gender (Current Identity)

Outcome 1: Number of individuals served.

**DISABILITY STATUS**



**DISABILITY TYPE**



Outcome 2: Strategies:

***Be designed and implemented to help create Access and Linkage to treatment.***

The Stonewall Alliance program distributes referral information face-to-face at every training, tabling event, outreach event, as well as electronically through Facebook, program websites and emails. The center and staff provide specific referrals to: BCDBH, crisis services, counseling services, Stonewall program services, as well as countless community affiliates. These referrals are provided through trainings administered by the program staff to agencies that need assistance in expanding their knowledge of the GSM community and how to better serve them.

Outcome 2: Strategies:

***Be designed, implemented, and promoted in ways that Improve Timely Access to Mental Health Services for individuals and/or families from underserved populations.***

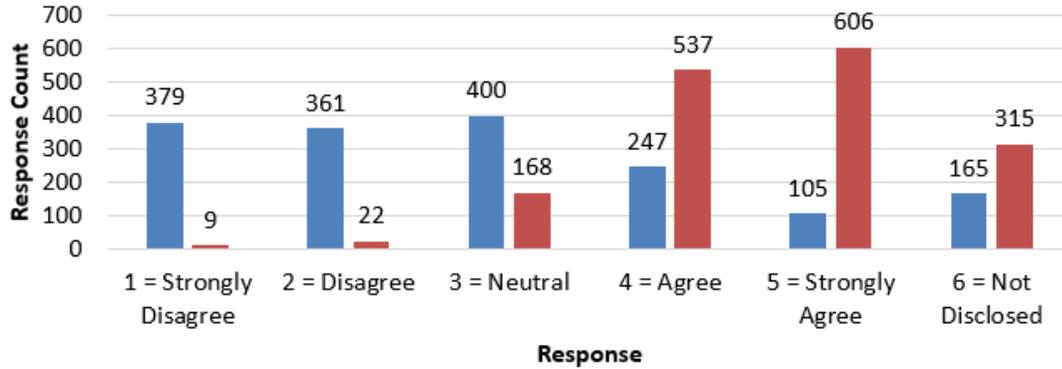
The goal of Stonewall Alliance is that its *direct services* (counseling and support groups) is ultimately to improve the mental health, wellness, resilience, and recovery for members of our community. To facilitate this, the programs *indirect services* (outreach and education, subgroup-specific provider training, referrals and linkages, social supports, and events) aim to provide the earliest possible access to culturally competent services. Combined, the impact of these two services will measurably *reduce disparities in mental health services for the rural LGBTQ population we serve*. When making referrals we often state specific people to contact that are more open and aware of the needs of the community to help cut out potential obstacles. Stonewall Alliance also provides insightful information about the best ways to go about accessing the services needed. Warm hand offs are made to the appropriate providers, through coordination of care between the centers groups, counseling program advocacy coordinators, and outside agencies. Which in turn strengthens the collaboration with other agencies to provide a wider range of services.

***Be designed, implemented, and promoted using Strategies that are non-stigmatizing and non-discriminatory.***

The Stonewall Alliance trainings are about being safe, non-stigmatizing and non-discriminatory. The staff teach how to be a good ally, how to be accepting, use proper language, listening and using language and identities that are given by the consumer. Stonewall Alliance of Chico is a LGBTQ community-based, community-driven organization founded, directed, and managed by local LGBTQ people and their allies, and represents the demographics of the broader LGBTQ community. All staff, board members, and volunteers are required to attend diversity training prior to service. In addition, Stonewall is an active member of the Butte County Behavioral Health Cultural Competence Committee and we partner with Promotores which provides services to the Hispanic and Hmong communities in our area. The center also works with the Hmong Cultural Center and the African American Family Cultural Center in Oroville.

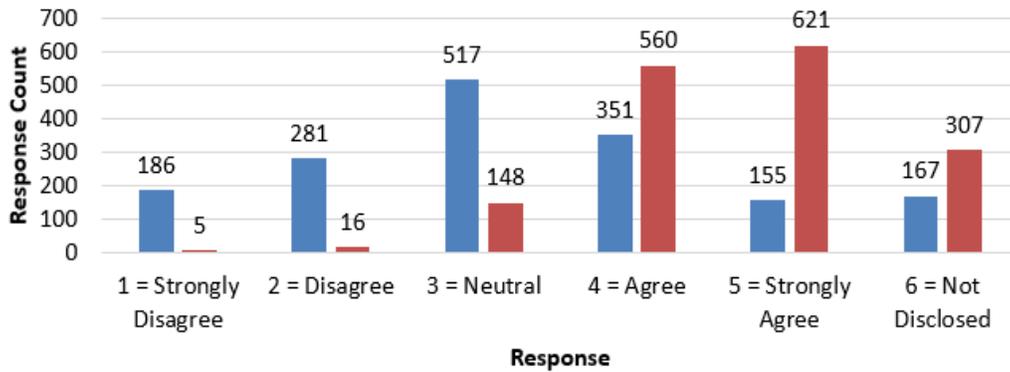
Outcome 3: Changes in attitudes, knowledge, and/or behavior related to mental illness that are applicable to the program – 1657 pre/post surveys were collected.

**KNOWLEDGE OF RESOURCES AVAILABLE TO OUR LGBTQ+ COMMUNITY**



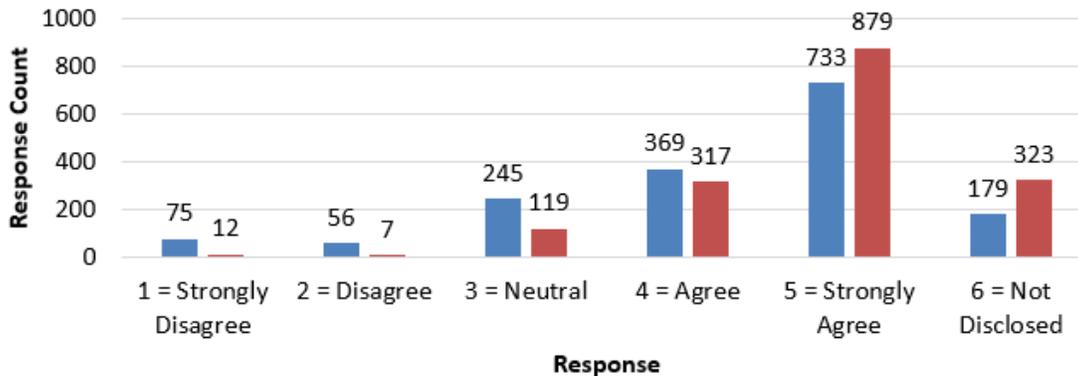
N = 1657

**A STRONG UNDERSTANDING OF LGBTQ+ IDENTITIES**



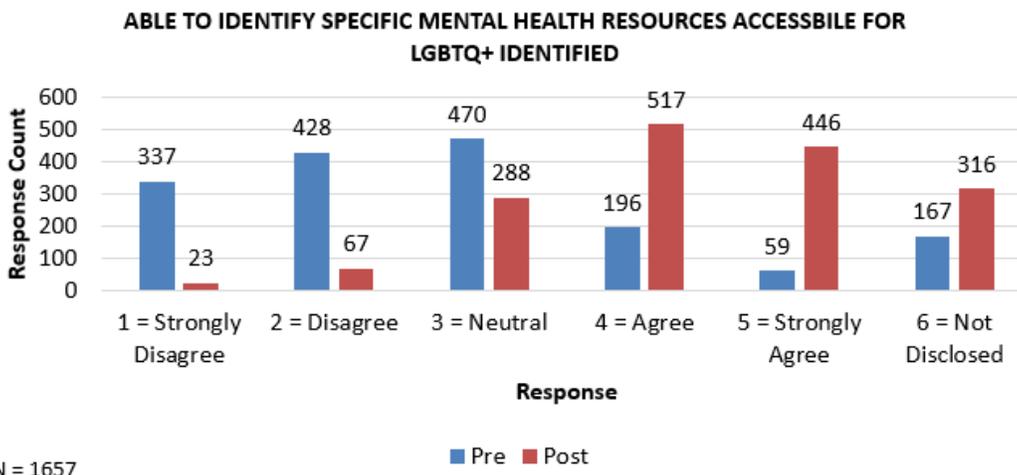
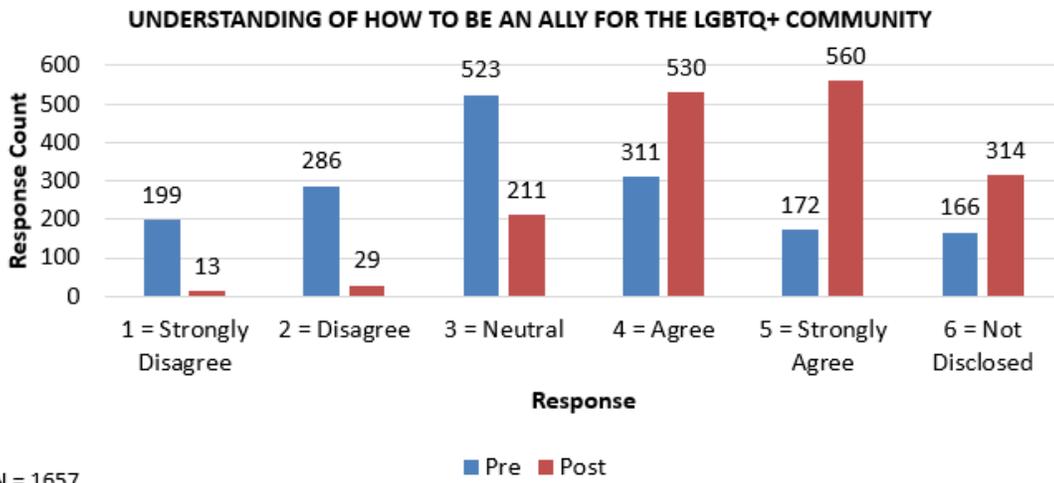
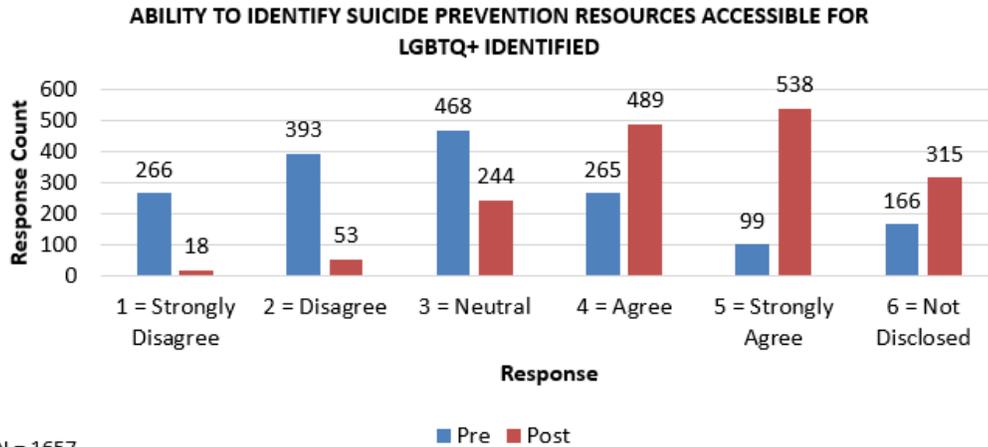
N = 1657

**HAVING COMPANSSION FOR THE LGBTQ+ COMMUNITY**



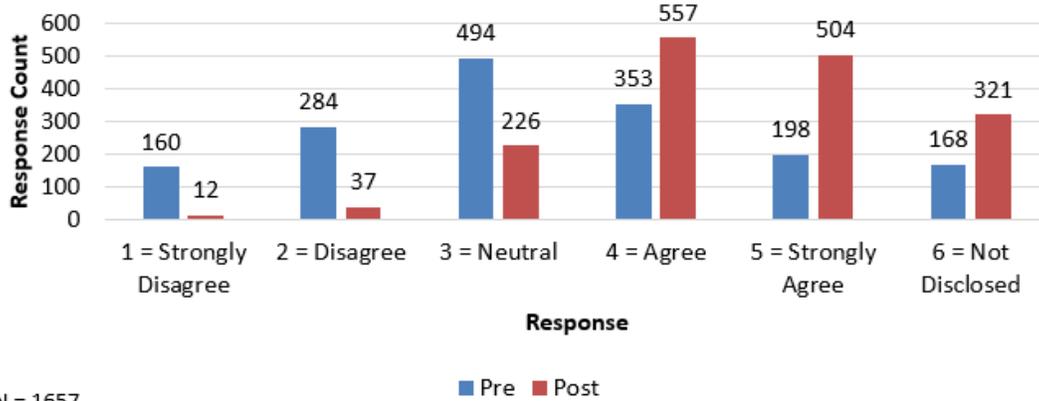
N = 1657

Outcome 3: Changes in attitudes, knowledge, and/or behavior related to mental illness that are applicable to the program – 1657 pre/post surveys were collected.

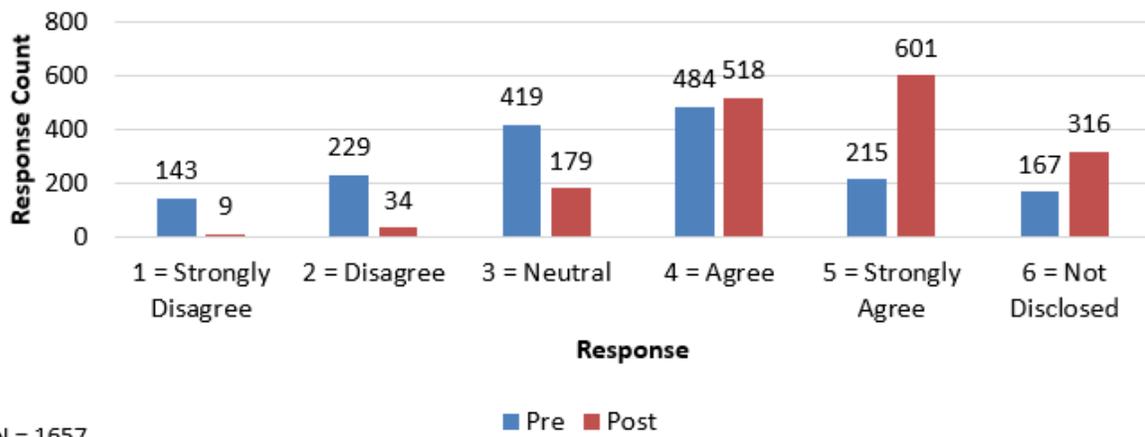


Outcome 3: Changes in attitudes, knowledge, and/or behavior related to mental illness that are applicable to the program – 1657 pre/post surveys were collected.

**STRONG UNDERSTANDING OF MENTAL HEALTH ISSUES AFFECTING THE LGBTQ+ COMMUNITY**



**AWARENESS OF SOCIAL CIRCUMSTANCES THAT INFLUENCE DEATH BY SUICIDE AMONG THE LGBTQ+ POPULATION**



<b>STATUS</b>	<input checked="" type="checkbox"/>	New	<input type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	Prevention	<input checked="" type="checkbox"/>	Early Intervention
<b>AGE GROUP</b>	<input checked="" type="checkbox"/>	Children (0-15)	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)
	<input checked="" type="checkbox"/>	Adult (26-59)	<input checked="" type="checkbox"/>	Older Adult (60+)
<b>SERVICES/ACTIVITIES</b>	<input checked="" type="checkbox"/>	Access & Linkage	<input type="checkbox"/>	Early Intervention
	<input type="checkbox"/>	Outreach	<input type="checkbox"/>	Prevention
	<input type="checkbox"/>	Stigma & Discrimination	<input type="checkbox"/>	Other

#### PROGRAM DESCRIPTION

The Crisis Triage program meets the need for an increased crisis triage staff at specific access points to expand current crisis services, as well as help consumers to avoid higher levels of care, in the least restrictive environment available. These access points include: the local hospital emergency rooms, and local homeless service centers. The Crisis Triage team facilitates consumer movement through the crisis continuum; this includes coordinating placement as needed, discharge planning, monitoring, and follow-up case management. This program includes three teams: Hospital Triage Team, Homeless Shelter Triage Team, and Crisis Connect Team. The Hospital Triage Team and the Crisis Connect Team are staffed by Butte County Behavioral Health. The Homeless Shelter Triage Team is staffed by Northern Valley Catholic Social Services (NVCSS), a local contracted non-profit agency. This program was originally generated in 2014 through acquiring \$1,075,070 in grant funding from Senate Bill 82.

#### OUTCOMES

1. Unduplicated number of individuals served.
2. Number of individuals with serious mental illness referred to treatment, and the kind of treatment to which the individual was referred.
3. Average duration of untreated mental illness and standard deviation.
4. Number of crisis calls received and referrals given.

#### MEASUREMENTS

1. Number of individuals served.
2. Number of referrals to treatment, and types of treatment clients were referred to.
3. Average duration (in days/and or years) of untreated mental illness.
4. Number of crisis calls received for the time period and the number of referrals made.

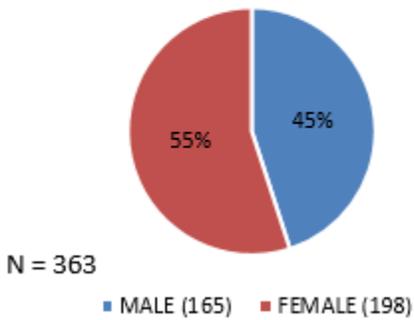
Outcome 1: Unduplicated number of individuals served.

**DEMOGRAPHICS OF DISTINCT CLIENTS SERVED**

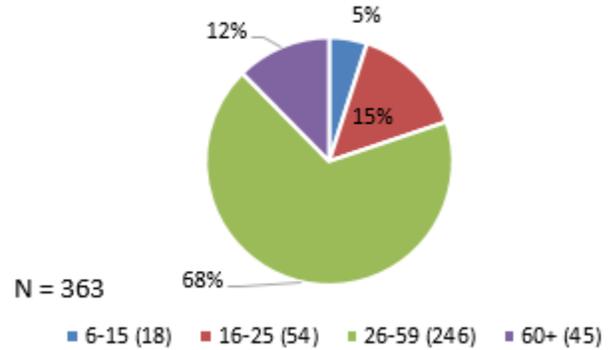
**FY 16-17**

*Number Served: 363*

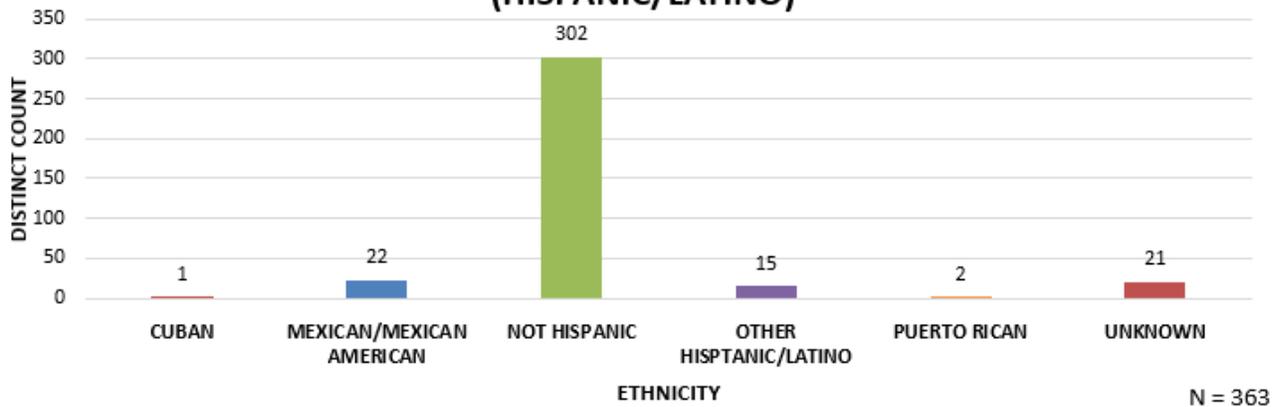
**DISTINCT COUNT BY GENDER**



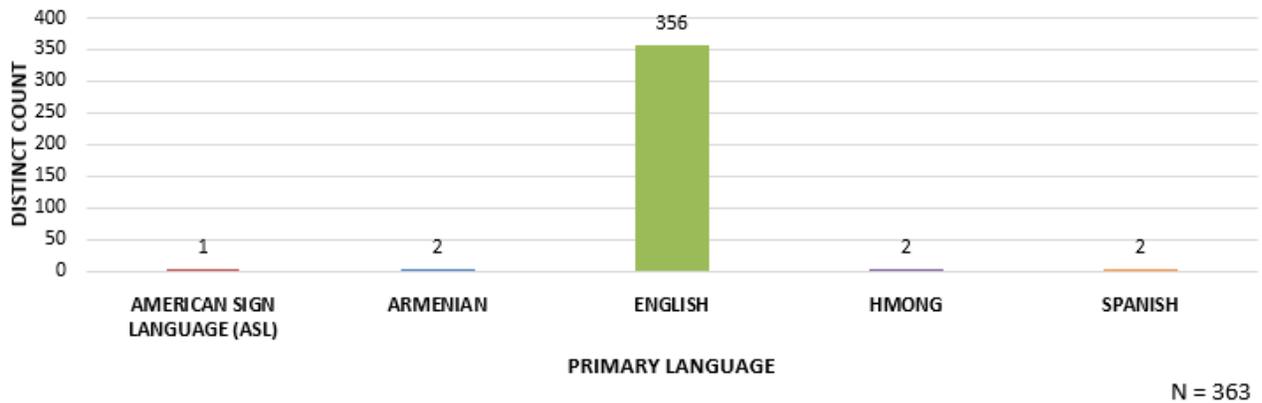
**DISTINCT COUNT BY AGE GROUP**



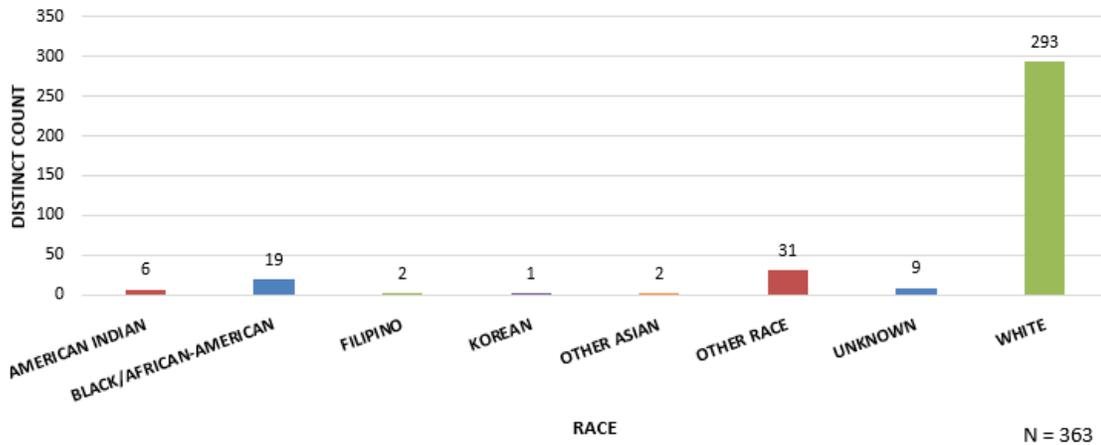
**ETHNICITY (HISPANIC/LATINO)**



**PRIMARY LANGUAGE**



**RACE**



Outcome 2: Number of individuals with serious mental illness referred to treatment, and the kind of treatment to which the individual was referred.

**Number of Referrals to Treatment and Type of Referrals**

*Number of Clients: 435\**

REFERRED TO:	NO:	REFERRED TO:	NO:
AMPLA Health	14	Northern Valley Indian Health	2
California Health and Wellness	2	Northern Valley Catholic Social Services	4
Catalyst	8	Oroville Hospital	3
Children’s Services Division	1	Oroville Rescue Mission	2
Counseling Solutions	2	Other	21
Crisis Triage Connect Team (CTCT)	26	Other DBH Program	9
DBH Adult Outpatient Clinic	215	Other Social Service Organization	12
DBH Crisis Stabilization Unit (CSU)	52	Outside Psychiatrist	2
DBH Youth Outpatient Clinic	28	Passages	4
Department of Employment	3	Primary Care Doctors	45
Eligibility Specialist	2	Probation	1
Enloe Behavioral Health	10	Private Providers	11
Enloe Hospital	1	Rape Crisis	1
Far Northern Regional Center	15	Sabbath House	10
Feather River Health Center	5	Salvation Army	2
Hospital Alternative Program (HAP)	5	Shalom Clinic	2
Housing Authority	5	Sober Living	4
Independent Living Services	3	Therapeutic Behavioral Services	4
Jesus Center	17	Torres Shelter	10
Mediation	1	Veterans Administration	5
NAMI	1	Youth For Change	7

*\*Number of clients is captured on discharge summary so it will differ from number served*

Outcome 3: Average duration of untreated mental illness and standard deviation.

**Average Duration in Months of Untreated Mental Illness: 124 Months\***

*Number of Clients Responses: 3*

Outcome 4: Number of crisis calls received and referrals given.

**Number of Crisis Calls Received and Referrals Given**

*Number of Calls Received: 4128*

REFERRAL	ADULT	YOUTH
Crisis Line	1879	381
Community Referrals	522	69
Outpatient Services	447	97
Crisis Intervention	431	138
Outpatient Services	447	97
Law Enforcement/Welfare Check	207	62
Talk Line/Resource Line	217	15
Hospital	130	26
Alcohol & Drug Services	131	0
Catalyst	37	1
Patient's Rights	27	11
Medical Services (non-urgent)	20	1
Housing Services	11	0
Rape Crisis	4	3
Special Needs	2	2

<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	Prevention	<input checked="" type="checkbox"/>	Early Intervention
<b>AGE GROUP</b>	<input checked="" type="checkbox"/>	Children (0-15)	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)
	<input checked="" type="checkbox"/>	Adult (26-59)	<input checked="" type="checkbox"/>	Older Adult (60+)
<b>SERVICES/ACTIVITIES</b>	<input checked="" type="checkbox"/>	Access & Linkage	<input type="checkbox"/>	Early Intervention
	<input type="checkbox"/>	Outreach	<input type="checkbox"/>	Prevention
	<input type="checkbox"/>	Stigma & Discrimination	<input type="checkbox"/>	Other

#### PROGRAM DESCRIPTION

As the words imply, this is the welcoming service into the behavioral health system. “Welcoming, Triage, & Referral” (WTR) is provided in youth and adult outpatient centers and includes services such as screenings and referral to the appropriate level of treatment throughout Butte County Department of Behavioral Health (BCDBH) and its contract and community providers. A key impact of this change was the creation of urgent level walk-in services at BCDBH clinics. This allows consumers to go to outpatient centers and have an assessment or screening when circumstances need to be immediately addressed.

#### OUTCOMES

1. Distinct number of individuals served.
2. Number of individuals with serious mental illness referred to treatment, and the kind of treatment to which the individual was referred.
3. Number of individuals who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the program to which they were referred.\*
4. Average duration of untreated mental illness and standard deviation.
5. Average interval between the referral and participation in treatment, defined as participating at least once in the treatment to which referred and standard deviation.\*

#### MEASUREMENTS

1. Number of individuals served.
2. Number of referrals to treatment, and types of treatment clients were referred to.
3. Number of referrals that accessed treatment.\*
4. Average duration (in days/and or years) of untreated mental illness.
5. Average number of days between referral and participation site.\*

\*We are currently not collecting data for this outcome.

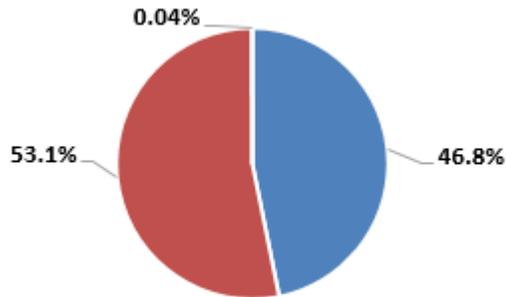
Outcome 1: Unduplicated number of individuals served.

**DEMOGRAPHICS OF DISTINCT CLIENTS SERVED**

**FY 16-17**

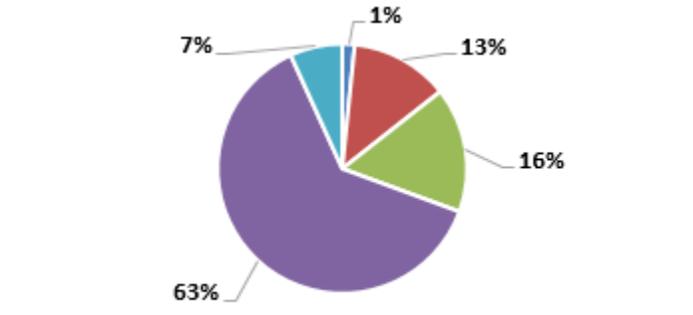
*Number Served: 2851*

**DISTINCT COUNT BY GENDER**



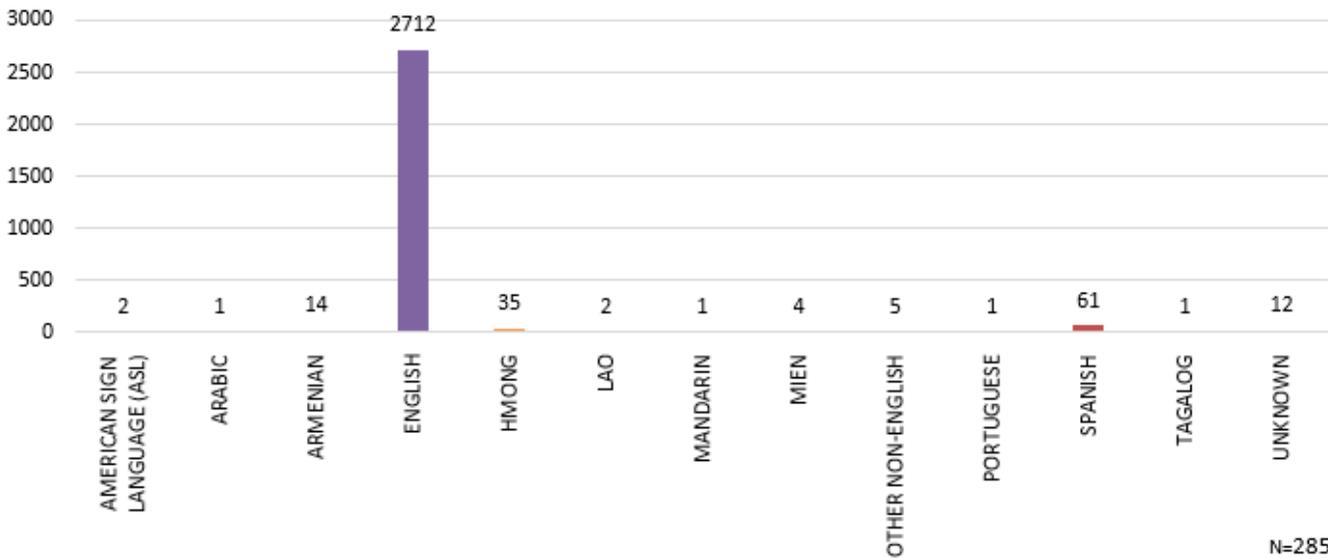
■ MALE (1335) ■ FEMALE (1515) ■ OTHER (1)  
N=2851

**DISTINCT COUNT BY AGE GROUP**



■ 0-5 (47) ■ 6-15 (364) ■ 16-25 (461) ■ 26-59 (1785) ■ 60+ (194)  
N=2851

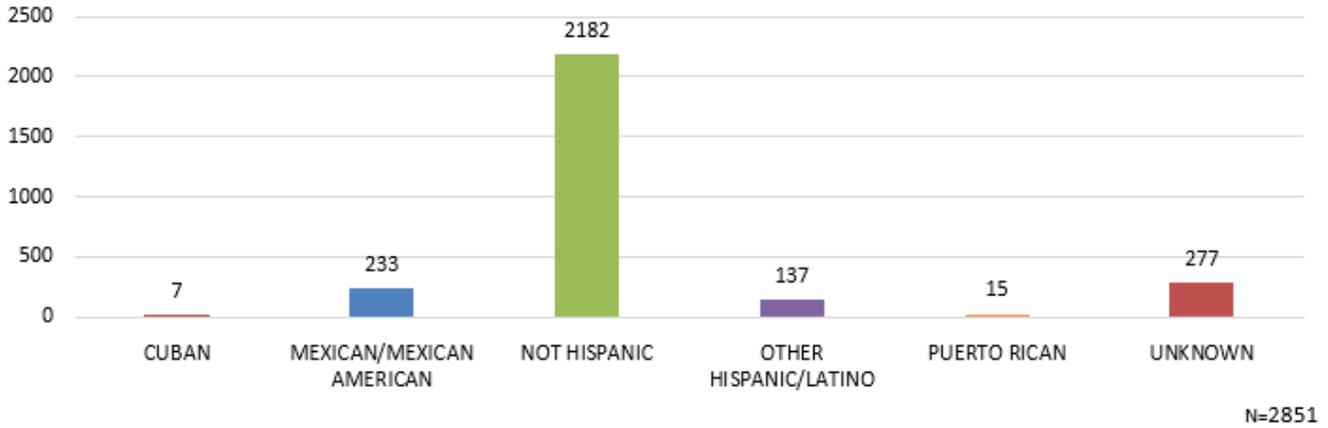
**DISTINCT COUNT BY PRIMARY LANGUAGE**



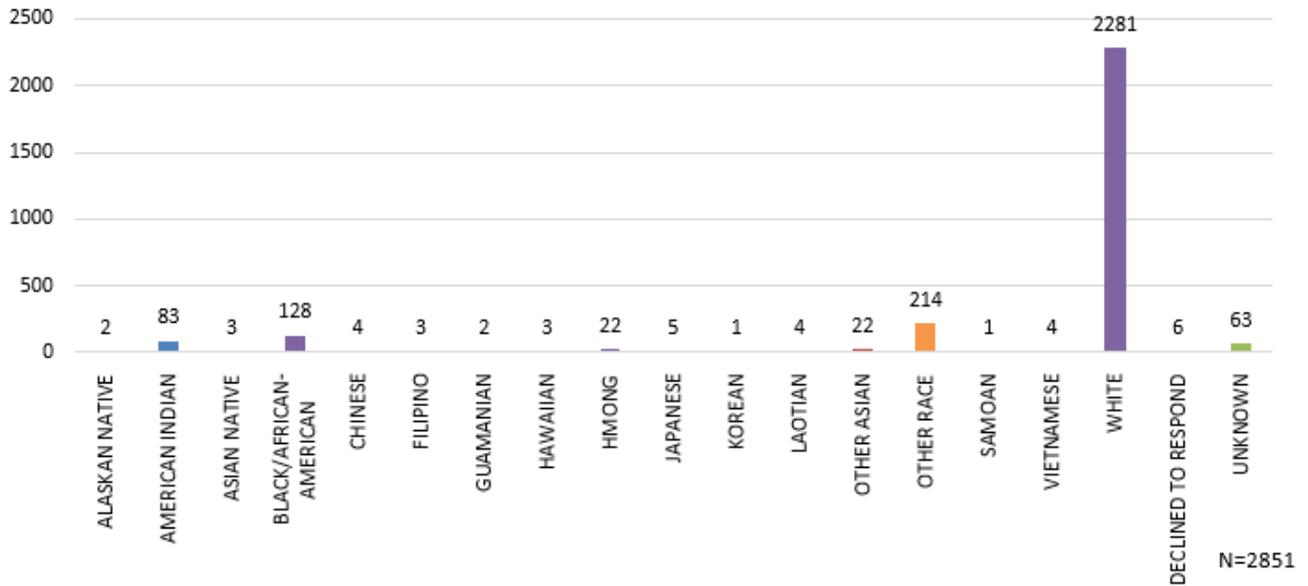
N=2851

Outcome 1: Unduplicated number of individuals served.

### DISTINCT COUNT BY ETHNICITY



### DISTINCT COUNT OF RACE



Outcome 2: Number of individuals with serious mental illness referred to treatment, and the kind of treatment to which the individual was referred.

**Number of Referrals to Treatment and Type of Referrals**

*Number of Clients: 2029\**

REFERRED TO:	NO. OF REFERRALS:	REFERRED TO:	NO. OF REFERRALS:
Adult Managed Care Provider	7	Local Churches	1
AMPLA Health	409	North Valley Indian Health	28
California Health and Wellness	10	Northern Valley Catholic Social Services (NVCSS)	5
Caminar	2	Opt for Health Living	1
Catalyst	9	Oroville Hospital	23
Children’s Services Division	1	Oroville Rescue Mission	2
Counseling Solutions	8	Other	315
Crisis Triage Connect Team (CTCT)	6	Other DBH Program	41
DBH Adult Outpatient Clinic	68	Other Social Service Organization	41
DBH Crisis Stabilization Unit (CSU)	11	Outside Psychiatrist	59
DBH Youth Outpatient Clinic	125	Passages	9
Department of Employment	14	Primary Care Doctors	115
Department of Rehabilitation	4	Probation	4
Dreamcatchers	1	Private Providers	52
Eligibility Specialist	2	Rape Crisis	2
Enloe Behavioral Health	2	Sabbath House	1
Far Northern Regional Center	15	Salvation Army	6
Feather River Health Center	46	School-based counseling	3
Feather River Hospital	5	Shalom Clinic	3
Feather River Tribal Health (FRTH)	27	Triage Connect	1
Hospital Alternative Program (HAP)	1	Torres Shelter	7
Housing Authority	7	Valley Oaks Children Services	1
Independent Living Services	2	Veterans Administration	4
Jesus Center	2	Victor	4
Law Enforcement	1	Youth For Change	18
Local Churches	1	DBH Alcohol and Drug Services	0

*\*Number of clients is captured on discharge summary so it will differ from number served*

Outcome 4: Average duration of untreated mental illness and standard deviation.

**Duration of Untreated Mental Illness**

***Number of Clients: 1702\****

**Average Duration of Untreated Mental Illness: 9.18 YEARS/110.16 MONTHS**

**Standard Deviation: 13.89**

*\*Responses not mandatory upon assessment; number will differ from total number of clients served*

<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	Prevention	<input type="checkbox"/>	Early Intervention
<b>AGE GROUP</b>	<input checked="" type="checkbox"/>	Children (0-15)	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)
	<input checked="" type="checkbox"/>	Adult (26-59)	<input checked="" type="checkbox"/>	Older Adult (60+)
<b>SERVICES/ACTIVITIES</b>	<input type="checkbox"/>	Access & Linkage	<input type="checkbox"/>	Early Intervention
	<input checked="" type="checkbox"/>	Outreach	<input type="checkbox"/>	Prevention
	<input type="checkbox"/>	Stigma & Discrimination	<input type="checkbox"/>	Other

### PROGRAM DESCRIPTION

BCDBH contracts with the National Alliance on Mental Illness (NAMI) of Butte County to support their mission of improving the lives of individuals and families affected by mental illness. NAMI provides a variety of support and education throughout Butte County, including the following:

- Peer To Peer Groups
- Family To Family Groups
- Provider Training
- Community awareness activities include the Annual NAMI Walk for the Mind
- In Our Own Voice (IOOV) is another program that promotes community advocacy and educational outreach dedicated to eliminating the stigma associated with mental illness.

NAMI Butte County implements mental health awareness, education, support and advocacy programs. This NAMI developed structured program embraces an anti-stigma approach which includes creating a forum by which individuals with mental illness share their personal experiences in diverse locations across the county. As well, support systems provide individuals living with experience and family members of those individuals the opportunity to connect and learn from each other.

### OUTCOMES

1. Number of potential responders.
2. Types of potential responders.
3. Types of settings that provided opportunities to identify early signs of mental illness.
4. Strategies:
  - a. Access and Linkage
  - b. Improving Timely Access to Services for Underserved Populations
  - c. Be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory
5. Methods used to reach out and engage potential responders and methods to be used so that responders can learn about identifying and responding to signs and symptoms of mental illness.

MEASUREMENTS

1. Non-distinct count of participants.
2. Sampling of type of participants.
3. Types of settings that support is offered.
4. Include all Strategies as referenced in Section 3735.
5. Number of community contacts and outreach.

OUTCOME 1: NUMBER OF POTENTIAL RESPONDERS (NON-DISTINCT)	FY 15-16*	FY 16-17*
CIT Training	449	211
Family to Family	200	77
Peer to Peer	12	
Community Meetings		297
<b>Total Number of Potential Responders (non-distinct)</b>	<b>661</b>	<b>585</b>

\*Data not collected until Jan 1, 2016

OUTCOME 2: TYPES OF POTENTIAL RESPONDERS

Law enforcement and personnel (police officers, sheriff’s officers, CHP officers and dispatchers) community members, family members, and peers.

OUTCOME 3: TYPES OF SETTINGS THAT PROVIDED OPPORTUNITES TO IDENTIFY EARLY SIGNS OF MENTAL ILLNESS

In the field, community and the home.

Outcome 4: Strategies outlined in section 3725.

***Be designed and implemented to help create Access and Linkage to treatment.***

At the heart of NAMI’s mission is the sharing of information, resources and support, and networking with the general public. These efforts, demonstrated through our educational and support programs, help create access and linkage to treatment.

***Be designed, implemented, and promoted in ways that Improve Timely Access to Mental Health Services for individuals and/or families from underserved populations.***

On a national level, NAMI advocates regularly to help ensure access to a wide range of treatments and services. Some projects focus on increasing access for underserved to appropriate mental health care since these groups receive fewer mental health services and encounter more barriers to illness management than the general population. NAMI also works to identify systemic breakdowns and advocate for improvement within the criminal justice system, hospitals, state and private facilities.

***Be designed, implemented, and promoted using Strategies that are non-stigmatizing and nondiscriminatory.***

NAMI Butte County strives for a community where everyone can live with quality and respect, without discrimination or stigma. We support goals to improve quality of life for people w/ mental illness in our community by working to ensure dignity and securing nondiscriminatory access to quality health care, housing, education and all economic opportunities. Through local educational programs, support groups, community lectures and outreach NAMI Butte county helps reduce the stigma and guilt associated with mental illness. One of national priorities is addressing disparities including studying healthcare approaches that achieve best outcomes in different populations, especially those that tend to have less access to health resources.

Outcome 5: Methods used to reach out and engage potential responders and methods to be used so that responders can learn about identifying and responding to signs and symptoms of mental illness.

NUMBER OF COMMUNITY CONTACTS/OUTREACH	FY 15-16*	FY 16-17*
Field Visits		2
Office Visits		15
Orientation	2	
Phone Calls	143	89
Other		7
<b>Total Count</b>	<b>145</b>	<b>113</b>

*\*Data not collected until Jan 1, 2016*

<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	Prevention	<input type="checkbox"/>	Early Intervention
<b>AGE GROUP</b>	<input checked="" type="checkbox"/>	Children (0-15)	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)
	<input checked="" type="checkbox"/>	Adult (26-59)	<input checked="" type="checkbox"/>	Older Adult (60+)
<b>SERVICES/ACTIVITIES</b>	<input type="checkbox"/>	Access & Linkage	<input type="checkbox"/>	Early Intervention
	<input type="checkbox"/>	Outreach	<input type="checkbox"/>	Prevention
	<input type="checkbox"/>	Stigma & Discrimination	<input checked="" type="checkbox"/>	Other

#### PROGRAM DESCRIPTION

In 2008, the Mental Health Services Oversight & Accountability Commission (MHSOAC) approved statewide PEI initiatives, including: suicide prevention, stigma and discrimination reduction, and student mental health. In 2009, California's counties formed the California Mental Health Services Authority (CalMHSA) as a Joint Powers Authority to implement the statewide PEI initiatives. The MHSOAC committed to fiscal contribution for CalMHSA from 2011 through 2015. The counties now carry-on the investment in PEI strategies through their MHSA allocation by contributing to the CalMHSA Sustainability Plan. This investment results in larger social impact (e.g., changing attitudes, increasing knowledge, and modifying behaviors), implementing programs that can benefit counties regionally and statewide, procuring resources at lower cost (e.g., cost efficiencies), and ultimately making a significant impact on preventing mental illnesses from becoming severe.

The Behavioral Health Board was informed of the benefits of contributing to the CalMHSA Sustainability Plan in FY15/16. Specifically, the Each Mind Matters resources that reach cultural populations to prevent suicide, promote mental health, and decrease stigma and discrimination. The Board of Supervisors approved Butte County's contribution to CalMHSA from the Prevention and Early Intervention annual allocation. The use of CalMHSA resources (Each Mind Matters and Know the Signs) will be infused in the Care Enough to Act (CETA) Taskforce.

#### OUTCOMES

- Suicide Prevention
- Stigma and Discrimination Reduction
- Promotion of Mental Health

*Please see most recent report in Appendix F of the 2017 Three Year Plan.*

<b>STATUS</b>	<input type="checkbox"/>	New	<input checked="" type="checkbox"/>	Continuing
<b>EMPHASIS</b>	<input checked="" type="checkbox"/>	Prevention	<input type="checkbox"/>	Early Intervention
<b>AGE GROUP</b>	<input checked="" type="checkbox"/>	Children (0-15)	<input checked="" type="checkbox"/>	Transitional Age Youth (16-25)
	<input checked="" type="checkbox"/>	Adult (26-59)	<input checked="" type="checkbox"/>	Older Adult (60+)
<b>SERVICES/ACTIVITIES</b>	<input type="checkbox"/>	Access & Linkage	<input type="checkbox"/>	Early Intervention
	<input type="checkbox"/>	Outreach	<input type="checkbox"/>	Prevention
	<input type="checkbox"/>	Stigma & Discrimination	<input checked="" type="checkbox"/>	Other

#### PROGRAM DESCRIPTION

The Suicide Prevention Task Force, named Care Enough to Act (CETA), officially began meeting in November of 2011. CETA is facilitated by Behavioral Health with membership comprised of partner agencies. Past functions of CETA have been sponsoring a summit to raise awareness around suicide, produce an insert) that is circulated through newspapers in Butte County detailing the impact of mental illness and suicide, supporting the Suicide Prevention Week, and increasing agency collaboration.

More recently, CETA has expanded their focus to include community education on mental health and illness, raising awareness of MHSA funded programs, stigma and discrimination reduction and student mental health initiative. Incorporating programs and resources from CalMHSA (Each Mind Matters and Know the Signs) will help CETA accomplish its goal.

A partnership between BCDBH and the Butte County Library resulted in the Library receiving a grant from the California Library Association to implement Each Mind Matters.

#### OUTCOMES

- Mobilize partner agencies in sponsoring community events and educational activities to increase the knowledge around suicide prevention, stigma reductions, and mental health awareness.

*Please see Appendix G of the 2017 Three Year Plan to view an example of the CETA insert.*

## SECTION 3: INNOVATION

### Mental Health Services Act Reversion Plan

#### What is Assembly Bill 114?

AB 114 became effective July 10, 2017. The bill amended certain Welfare and Institution Code (WIC) Sections related to the reversion of MHSA funds.

AB 114 implemented provisions concerning funds subject to reversion as of July 1, 2017. Funds subject to reversion as of July 1, 2017, are deemed to have been reverted and reallocated to the county of origin for the purposes for which they were originally allocated. Funds that could be subject to reversion as of July 1, 2017, were distributed to counties from Fiscal Year (FY) 2005/2006 through FY 2014-15. By July 1, 2018, counties are required to have a plan to spend those funds by July 1, 2020.

Every county must develop a plan to spend its reallocated funds and post it to the county's website. The county must submit a link to the plan to DHCS (Department of Health Care Services) by July 1, 2018. Each county's Board of Supervisors (BOS) must adopt a final plan within 90 days of the county posting the plan to the county's website. Each county must submit its final plan to DHCS and the MHSOAC (Mental Health Services Oversight and Accountability Commission) within 30 days of adoption by the county's BOS. A county may not spend funds that are deemed reverted and reallocated to the county until the county's BOS has adopted a plan to spend those funds.

In addition, each county must comply with the following:

- The expenditure plan must account for the total amount of reverted and reallocated funds for all impacted FYs, as indicated in the applicable notice of unspent funds subject to reversion or in the final determination on an appeal;
- The county must include the plan in the County's Three-Year program and Expenditure Plan or Annual Update, or as a separate update to the County's Three-Year Program and Expenditure Plan, and comply with WIC Section 5847 (a);
- Reallocated funds must be expended on the component for which they were originally allocated to the county;
- If reallocated funds were originally allocated to the INN component, the funds are subject to the requirements of California Code of Regulations, Article 9, sections 3900-3935;
- The county must follow the stakeholder process identified in WIC Section 5848 when determining the use of reallocated funds; and
- The county must report expenditures of reallocated funds, by component, on its Annual MHSA Revenue and Expenditure Report.
- 

A county may expend reallocated funds for an already approved program/project or use the reallocated funds to expand an already approved program/project provided the program/project is the same component as the component for which the funds were originally allocated to the county, which must be in compliance with applicable MHSA statutes and regulations.

If a county fails to prepare a plan and submit a link to the plan by the required deadlines, the county will be substantially out of compliance with the MHSA. Per WIC Section 5899(e), DHCS will work with the SCO (State Controller’s Office) to develop a process to withhold 25% of the county’s monthly allocations from the MHF (Mental Health Fund) until the county submits a link to the plan.

## Butte County

### AB 114 MHSA Funds Subject to Reversion by Fiscal Year by Component:

BUTTE COUNTY	CSS	PEI	INN	TOTAL
Total	\$0	\$0	\$772,693	\$772,693

\*These estimated amounts are based on funds subject to AB114 per DHCS communication, including the amounts subject to AB114 from the submitted FY 16/17 Annual Mental Health Services Act Revenue and Expenditure Report, which are pending confirmation and reconciliation from DHCS.

\*\*These amounts incorporate interest earned.

### Plan to Spend Reallocated Funds

#### CSS (Community Services and Supports)

There are currently no CSS funds at-risk for reversion.

#### PEI (Prevention and Early Intervention)

There are currently no PEI funds at-risk for reversion.

#### INN (Innovation)

The reallocated funds from previous years will be utilized on our next Innovation Plan, Physician Committed, pending approval by the MHSOAC. The Physician Committed Plan will be presented to the MHSOAC on May 24<sup>th</sup>, 2018. The estimated three year budget for Physician Committed is \$767,900, approximately \$255,967 annually. This project would spend the majority of the funds reallocated under AB114.

Congruently, there are two Innovation Plans actively in development:

- Trauma Informed System Mapping- build internal capacity for system review to streamline processes while integrating Trauma Informed practices and principles.
- Research and Wellness Center- a Butte County Office of Education collaboration for the age group of 0-5

This plan will be posted for public comment for 30 days beginning on May 15, 2018 and completed on June 14, 2018. The public comment will be included in the final version of this plan, which will be presented to BOS approval on June 26<sup>th</sup>, 2018.

**This plan is calendared to be presented for approval to The Mental Health Services Act Oversight and Accountability Commission on May 24<sup>th</sup>, 2018.**

**PROGRAM DESCRIPTION**

Physician Committed will transform the primary healthcare setting that traditionally focuses on physical health, into a comprehensive system of care that includes behavioral health and emotional wellness. Behavioral health screening typically only occurs in the behavioral health setting, creating greater likelihood that adolescent behavioral health issues are going undetected in the health care system and in educational settings. This project implements and standardizes mental health and substance use screening process into the primary care settings, as well as high school sports physical screenings. In addition, Physician Committed designates an Intervention Team to provide real time consultation as well as face-to-face interventions (within 48 hours) for the at-risk youth to potentially facilitate a seamless transition into behavioral health services.

This initiative includes:

- Increasing the capacity and reach of the Behavioral Health system of care by integrating primary care facilities as potential access points to services.
- Low cost/no cost high school athletic physicals; access to everyone regardless of insurance coverage or economic status.
- Provide assessments to a significant number of the adolescent population, including diverse populations.
- Increasing skills and comfort level of primary care providers to address behavioral health issues through extensive support and training.
- Behavioral health access line for primary care physicians to relate at-risk youth.
- Promoting early intervention of behavioral health issues.

Practitioners will receive the training and support from Butte County Behavioral Health (BCBH) that they need to enhance their healthcare screening processes. As they practice and experience the dialogue associated with a behavioral health screening, they will feel more comfortable and less apprehensive about addressing these critical issues. By including questions about mental health and substance use in a routine health physical, adolescents will have the opportunity to start a conversation with their physician and determine if their risk level requires a referral to the Intervention Team. If a young person is screened to be at-risk by the physician, an intervention specialist meets with him/her within two days. The follow-up intervention consists of three sessions intended to:

- provide a forum for a young person to talk about their issues,
- give accurate history and information,
- identify related issues,
- empower the young person to set goals and make informed choices,
- assist the young person in accessing other services when appropriate

The brief intervention sessions infuse Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI) approaches.

## Expected Outcomes

### Clients:

- Early detection and access to care for behavioral health issues.
- Reduction in mental health symptoms including depression, anxiety, and stress; increase in coping skills.

### Medical Professionals:

- Physicians, nurse practitioners and physicians’ assistants will increase their knowledge, skill, comfort level, and capacity for implementing the screening questions for behavioral health issues.
- Standardize processes for adolescent behavioral health screening will be incorporated into comprehensive health physicals in pediatric offices.
- Increase in referrals for intervention and/or treatment for behavioral issues in adolescents.

## Learning Questions

1. Can behavioral health screenings be effectively and efficiently integrated into the comprehensive adolescent health physical?
2. Does this project provide the physician/primary care provider with more confidence and capacity in regards to screening for behavioral health issues?
3. Will physicians’ comfort levels with discussing behavioral health and adolescents increase with comprehensive training and the implementation of a standardized tool?
4. Do adolescents feel more capable of managing early symptoms of behavioral health issues?

## Evaluation

The evaluation will be conducted by the Butte County Systems Performance Research and Evaluation team, led by Dr. Sésha Zinn, PsyD and is budgeted at \$64,025 (8.3% of the total budget).

OUTCOME QUESTION	MEASUREMENT
Will physicians experience increased comfort level screening adolescents for behavioral health issues?	<ul style="list-style-type: none"> <li>• Pre/post-training surveys, 30-day follow up surveys</li> </ul>
Can behavioral health screenings be effectively and efficiently integrated into the comprehensive adolescent health physical?	<ul style="list-style-type: none"> <li>• Pre/post-training surveys, 30-day follow up surveys</li> </ul>
Will adolescents feel more capable of managing early symptoms as a result of the intervention received (motivational interviewing and cognitive behavioral therapy techniques)?	<ul style="list-style-type: none"> <li>• Post-intervention survey</li> </ul>
Does early identification and intervention prevent the need for more intensive treatment?	<ul style="list-style-type: none"> <li>• Intervention Team and client survey</li> </ul>
Will adolescents coping skills increase as a result of the intervention received?	<ul style="list-style-type: none"> <li>• Post-intervention survey</li> </ul>
Will adolescents’ mental health symptoms, such as depression, anxiety, and stress be reduced?	<ul style="list-style-type: none"> <li>• Initial screening and post-intervention survey</li> <li>• CANS outcome data</li> </ul>
Was the interagency collaboration between BCBH, BGMS, pediatric offices, and local school districts a success?	<ul style="list-style-type: none"> <li>• Survey feedback from the staff</li> <li>• Number of physicians trained</li> <li>• Number of physicians actively using the screening tool</li> </ul>

## **The Budget**

\$767,900 over three years will include:

- Salaries for 2 FTE (full-time employment) Behavioral Health Education Specialists
- Salary for .5 FTE peer provider
- Training for medical providers
- Production of screening toolkits
- Evaluation of project, .25 FTE Administrative Analyst dedicated
- Administrative costs

## **Reversion Considerations**

Pending DHSC approval, Butte plans to spend all MHSA funding subject to reversion first. This may result in FY 2015-16 and FY 2016-17 funding being spent prior to funding identified as AB 114 funding.

## **Community Input Process**

Physician Committed has been included in four different Community Input Processes:

- Innovation Community Input 2016
- 2017 MHSA Three Year Plan Community Input
- Innovation Community Input 2017 (related documents located in Appendix D-F)
- 2018 MHSA Annual Update (located on page 17)

## **Summary of Community Input**

Actions BCBH took based off community response are:

- Include a budget to increase the line staff at the county agencies to ensure the referring agency has enough staff to support all the referrals.
- Target all providers no matter what type of clientele they serve (low income, middle class, etc.)
- Referral tracking and follow-up
- Making certain that the presentation to new physicians will get them excited about the project.

Feedback on how to strengthen this project:

- “Could you partner with the area hospitals as well? Since they have certain requirements for their affiliated physicians, they could ensure that their providers are participating in the Physician Committed Project.”
- “I would love to see public education on the matter should it get funded. We've all seen the commercials about which medications we should ask our doctor about - what if we also knew we could talk to our doctor about mental health and they would be open to it?”

Top concerns or perceived barriers:

- Finding physicians who want to participate; physician’s level of commitment and participation.
- “There is a shortage of doctors in Butte County so that is something that should be addressed as opposed to just adding more paperwork for families to fill out.”
- The increase of screenings with a lack of services and treatment options for youth.

**This plan is actively under development and this program description may change as the program evolves.**

#### PROGRAM DESCRIPTION

A team consisting of a Clinical Staff (Counselor or Clinician) and an Administrative Analyst, under the direct supervision of the Systems Performance Research and Evaluations Manager (a licensed Psychologist) will create an analytical and clinical partnership to implement the Trauma Informed Program Analysis and Mapping plan systematically throughout 13 different agency locations in Butte County.

This would be a 5-year initiative and would develop a formal recommendation to the field of Behavioral Health; forms, processes and recommendations would be made available to other Counties, Contractors and Providers to improve the field overall by developing internal tools and capacity.

Butte County recognizes that we are only a subsystem of a larger system. In order to touch the lives of all of our community members and their families this kind of work should be shared. The ultimate goal of this work is not only to improve the efficiency and effectiveness of our Behavioral Health department across the county but also to develop a deliverable that can be shared with other County agencies as well as other Counties throughout California. This will be a set of documents, measures, processes and other Trauma Informed tools that agencies can use to become a more efficient, and effective Trauma Informed System.

**This plan is actively under development and this program description may change as the program evolves.**

#### PROGRAM DESCRIPTION

The problem we face is as dramatic and heart-wrenching as it sounds: We're failing society by not offering adequate, integrated, timely, compassionate services that support the development of young children. The short-term impact is that children are not prepared to learn or have a foundation for healthy development due to unaddressed childhood trauma. The long-term impact is community trauma evidenced by elevated ACEs scores, as well as other negative outcomes such as school expulsions, mental health conditions, unemployment, homelessness, and family violence. Yet, the research offers insight and tools to remedy this, particularly in the younger years when social emotional development and early traumatic healing is crucial. It is time that resolving this problem becomes a community legacy.

#### **Building on A Foundation**

The Center will repurpose the dormant landmark of the "old courthouse" in Chico. It is located blocks from CSU Chico and downtown, and nestled in a historic neighborhood with public schools. The midcentury architecture, (including a round courtroom) will be redesigned to stimulate creativity and curiosity while valuing a sense of safety, belonging, and connection for those who enter. There will be great stewardship in the design to portray innovation that is cutting-edge, purposefully and welcoming.

The gift of this facility was quickly identified as an asset to a solution to help young children and the people who are important to them. It was also clear that this could not just be a location for one agency; it must be a collection of agencies with a common purpose and approach to service and education. It could not be a stand-alone structure; it must be a hub for services and education that radiates out into homes, schools, and organizations in the community. It would need to rely on the strengths and diversity of a network of rural communities. The mission would need to cross silos and deeply change institutions and systems.

#### **Planning & Development Committee**

In January 2018, a group of 18 cross-sector professionals and trauma-informed experts were assembled to comprise The Planning & Development Committee for The Center. Over the subsequent few months, the committee untangled traditional approaches and practices that research now evidences are less effective in helping people heal from trauma. We committed to rethink existing systems and pause to evaluate how our community is valuing research, humility, creativity, and relational capacity in the work we do.

The Planning and Development Committee has begun navigating through an innovative concept design process that will create the vision which will serve as the foundation for the work ahead. The first component has been to gain understanding... through national research, expert training, local data collection, and facilitated planning meeting. This component is now undertaking an asset and gaps analysis which will inform how we will proceed in development.

## **The Center is the Hub of Personal, Familial, Organizational, and Social Change**

- Children and families will receive direct services at the center, provided by a collection of multidisciplinary educators and service providers. Services at The Center might include therapeutic playgroups, parent child interactive therapy, assessment and screenings, and parent training.
- Parents and children will be connected to families, neighborhoods, schools, services providers, and other community members throughout the county, to empower parents and strengthen community relational capacity.
- The Center will provide integrated educational support. Education may be offered in the form of classes, labs, coaching, and cross-agency collaboration at the Center and through state-of-the-art distributed learning.
- Specialists will use formal education as one tool for teaching trauma informed practices, and will integrate one-on-one modelling, coaching, and support in multiple on-site and remote environments, such as early care and education settings or small rural schools.
- A multi-disciplinary training team will develop Learning Communities accommodating the needs of specific industries and roles (for example, elementary school principals, social service administrators, in-home case managers, or probation officers), tailoring instruction, consultation, and materials that will initiate new values, norms, policies, practices and expectations across agencies and service silos.
- Intersegmental partnerships will form at The Center when individuals from multiple industries assemble in collaborative, welcoming, cutting-edge temporary and permanent workspaces.
- Our Center will serve as the incubator for innovation and research. Evidence-based practices will serve as the foundation in developing services, training, and system infrastructure. Yet, Our Center will also be established as a leader of quality study and research practices including a sound evaluation component, as well as research partnerships with CSU Chico.
- The nucleus of organizational and community change efforts will stem from this work to offer local evidence to support trauma informed research. These successes will persuade local leaders, policy makers and funding agents to support The Center in immediate and long-term change in how local communities address healing trauma.

## CAPITAL FACILITIES & TECHNOLOGY

This component works towards the creation of a facility that is used for the delivery of MHSA services to mental health clients and their families or for administrative offices. Funds may be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and cost-effective services and supports for clients and their families.

Funding for facilities and technology does not get allocated annually; funds were delivered in one lump sum in the beginning of the MHSA program planning process. To date, Butte County Behavioral Health has no funds remaining in this component.

## WORKFORCE EDUCATION & TRAINING

In 2008, the former California Department of Mental Health (DMH) developed the first Workforce Education and Training Development Five-Year plan. The WET Five-Year Plan carries forth the vision of the MHSA to create a transformed, culturally-competent system that promotes wellness, recovery and resilience across the lifespan of age groups such as infants, children, adolescents, transition age youth, and older adults.

To accompany the WET Five-Year Plan 2008-2013, DMH developed a 10-year budget that allocated WET funding for specific purposes. The 10-year budget defined a one-time allocation of \$210 million to counties throughout California for local WET program implementation. Butte County was awarded \$1,128,900 to be budgeted over those ten years. These funds have been depleted and Behavioral Health is now using a small percentage of CS&S resources to fund the Workforce and Education Training component.

Between July 2012 and April 2014, a statewide stakeholder engagement process to identify mental health workforce needs and strategies was executed to guide the development of the second WET Five-Year Plan. This second WET Five-Year Plan covers the period of April 2014 to April 2019 and continues to expand upon the strategies and program accomplishments of the previous WET Five-Year Plan April 2008-April 2013.

“California’s public mental health system will develop and maintain a robust and diverse public mental health workforce capable of addressing mental health disparities by providing treatment, prevention, and early intervention services to individuals with severe mental illness that are consumer and family-driven, equitable and compassionate, culturally and linguistically responsive services, across the lifespan using effective methods that promote wellness, recovery and resilience and other positive behavioral health, mental health, substance use, and primary care outcomes across healthcare systems and community-based settings.” *Mission Statement (WET Five-Year Plan 2014-2019)*

**PROGRAM DESCRIPTION**

In collaboration with various stakeholders, including public mental health staff (both County and Contractors), consumers, family members, and local educational institutions, Butte County has created a Workforce Education and Training Plan. The County has hired a Workforce, Education and Training (“WET”) Coordinator to implement and coordinate the Plan. The WET Coordinator will ensure that the five fundamental elements of MHSA (consumer and family driven, community collaboration, recovery/resiliency strength-based services, integrated services, and culturally competency) are embedded within all training events. The coordinator works with Behavioral Health staff, leadership, and the WET workgroup to support planning, development and operation of a comprehensive workforce program that meets MHSA requirements and supports the development of our workforce.

**OVERVIEW OF TASKS**

- Develop and implement the WET plan through active collaboration with the WET workgroup, BH staff and leadership team, and other stakeholder groups as necessary.
- Coordinate and/or implement training for public mental health system to include Behavioral Health staff, contract providers, and consumers and family members based on the principles of wellness, recovery and resiliency, cultural competence, consumer/family driven mental health services, integrated services, and community collaboration.
- Regularly assess the training and educational needs of staff, interns, consumers and their families, volunteers, and contract organizations.
- Completion and monitoring of contracts with entities providing Workforce Education and Training programs and services.
- Participation in and support of state and regional education and training efforts to ensure coordination and reduce duplication of services.
- Participation in local initiatives which expand opportunities and fiscal support for workforce development, i.e. community colleges, ROP, Vocational Rehab, etc.
- As needed, assist in the development of courses with adult education, Butte County Office of Education, Butte College that would provide skill development/education that supports the principles of MHSA.
- Coordinate and provide oversight to all Workforce Education and Training activities and programs.
- Provide annual updates to WET plan and evaluate effectiveness of services and trainings provided.
- Prepare reports as required.

## OBJECTIVES

- Increase capability to meet special needs of clients
- Continually enhance development of staff to integrate advancements in the field (e.g. evidence-based practices, best practices, leadership and management practices, etc.)
- Promote the integration of wellness, recovery and resiliency concepts throughout the mental health delivery system (all levels of services)
- Develop cultural competence of staff throughout the mental health system
- Increase capacity and capability for the provision of clinical supervision (mentoring, coaching, etc.)
- Improve the coordination and streamlining of training efforts throughout the mental health system.
- Ensure that consumers, family members, and underserved and underrepresented communities are included as both trainers and participants.
- Design training interventions to meet the needs of a multidisciplinary workforce, including mental health, substance abuse, and primary care.
- Design trainings to cut across all tiers of the workforce, providing consistent messages and skill development.
- Enhance collaboration with community-based organizations (CBOs)

**PROGRAM DESCRIPTION**

Workforce training need assessment is an ongoing process. Based on the ongoing assessments, training will be provided across the mental health workforce, including clinical, administrative, and clerical staff, related to job specific knowledge and skills. Specific training topics and focus areas will be identified through surveys, site specific data, CS&S program training needs, PEI program training needs, and other methodologies as they are developed.

Two currently identified areas that have been scheduled and started include Crisis Intervention Team (CIT) training for staff, contractors, law enforcement, first responders, consumers, community members and other stakeholders; and the California Mental Health Care Management Program (CalMEND). In the case of CalMEND, support will also come from Butte County's Capital Facilities and Information Technology funding. Additional training will be scheduled based on needs identified by the WET Implementation Committee, Education and Training Survey, and the BH Department wide training plan. The staff and contractor Education and Training Survey indicated an interest in training regarding a variety of core/foundational knowledge such as law and ethics and crisis management and safety; and clinical skills such as trauma based therapy and CBT. Existing MHSA CS&S programs were asked to identify their training needs. As additional MHSA programs develop, they will identify additional training needs. Identified training needs and training outcomes will be reported in the annual plan update and incorporated into subsequent year training plans.

The WET Implementation Team will review workforce training need assessment data to make training recommendations for specific job classifications and service delivery areas. They will decide on which training modalities and intensity best meet the identified training needs and review evaluation of training outcomes.

All Butte County organized trainings will incorporate the concepts of cultural competency/diversity, wellness, recovery and resiliency. Outcome measures will be used to ensure effectiveness and fiscal efficacy. Trainings will be offered to staff, contract providers and consumers and family members, as appropriate.

**OVERVIEW OF TASKS**

- Conduct annual needs assessment of staff training needs
- Identify recommended training programs based on needs assessment from staff providing services
- Research available training resources (internal vs. external)
- Ensure structure and consistency of all trainings

- Coordinate efforts with Information Technology funding to ensure E-Learning opportunities are in place and coordinated for tracking, CEU's and employee/contractor support
- Implement training and skill development on evidence-based and other best-practices to better address the needs of our underserved clients to increase clients' wellness, recovery and resiliency in both the public and private service settings

#### OBJECTIVES

- Provide timely, relevant job specific knowledge and skills
- Give people the knowledge and skills they need to do their job, no matter what their position is
- Provide training as needed to develop and enhance staff, contractor, and consumer employee skill and knowledge in the five fundamental MHSA concepts
- Create a policy and criteria for participation in specified trainings
- Evaluate internal versus external resources for proposed trainings
- Research existing training modules that offer established credibility (CASRA, RICA, NAMI, SAMHSA, etc)
- Ensure the inclusion of diversity, wellness, recovery, resiliency in all training curricula
- Incorporate outcome measures to ensure efficacy of training programs
- Continue offering trainings for incoming staff, contracted providers and employed consumers / family members
- Develop a resource library available to all providers and consumers
- Address the issues of stigma and discrimination faced by mental health consumers and by family members.
- Ensure that staff has the opportunity to experience various client and family member viewpoints to better understand the client and family experience.

#### EVALUATIONS

- Consumers and family members will evaluate the effectiveness of their training experiences to allow them to:
  - Understand the public mental health system
  - How to navigate the system more easily
  - Develop skills to reduce stigma and discrimination

**PROGRAM DESCRIPTION**

E-Learning will be an invaluable resource that will allow BH to develop, deliver and manage educational opportunities and distance learning for mental health workforce including BH staff, consumers and family members, contractors, community based organizations and others. E-Learning will reduce training costs due to savings from sending people to training (travel, lodging, registration, etc.) It is an efficient way to provide CEUs for licensed/certified members of the mental health workforce. Behavioral Health has received extensive presentations by the two electronic learning management system providers in California. The department will be making a decision about which system to purchase.

In consultation with the WET Implementation Team, specific training topics will be determined depending on needs at any given time based on periodic assessments, cost/benefit, priorities, etc.

**OBJECTIVES**

- Complete the contract with e-learning provider.
- Provide greater ease for staff, community providers, consumers and family members to access training and educational courses which meet license requirements and/or provide career path development, as well as rehabilitation and consumer employment courses.
- Provide a community access portal for consumers and family members and key stakeholders to meet their training and information needs.
- Increase quality and availability of diverse training offerings while reducing cost.
- Provide compliance and quality control for legal requirements by linking to the County's existing education and licensing tracking system.

**PROGRAM DESCRIPTION**

The Inspired at Work curriculum was chosen as the training program for new consumer and family member employees. This curriculum is available at no charge and has been successfully used in San Mateo County for the past three years to train and support consumer and family member employees. Inspired at Work will be used to provide new consumers and family member employees with foundational knowledge for entering the BH workforce. Parts of the program, e.g. HIPPA training, will be used for all staff. In addition, the curriculum will be modified for specific job functions as appropriate.

Consumers and family member employees completing the course will receive a completion certificate during a graduation ceremony.

Completion of this course also qualifies parent partners' and peer advocates' time to be billed to MediCal. Currently BH holds a weekly peer support group for consumer and family members employed in the behavioral health workforce. This group, facilitated by a licensed clinician, discusses employment

# FUNDING SUMMARY

## APPENDIX

- A- 2018 MHSA Annual Update Community Presentation
- B- 2018 MHSA Annual Update Community Survey
- C- 2018 MHSA Annual Update Community Meeting Flyer
- D- 2017 MHSA Innovation Community Input Survey Responses
- E- 2017 MHSA Innovation Community Input Flyer
- F- 2017 MHSA Innovation Community Presentation